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## 17.02.08 - MISCELLANEOUS PROVISIONS

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**000. LEGAL AUTHORITY.**
These rules are adopted and promulgated by the Industrial Commission pursuant to the provision of Section 72-508, Idaho Code. (7-1-94)

**001. TITLE AND SCOPE.**
These rules shall be cited as IDAPA 17.02.08, "Miscellaneous Provisions." (7-1-94)

**002. WRITTEN INTERPRETATIONS.**
No written interpretations of these rules exist. (7-1-94)

**003. ADMINISTRATIVE APPEALS.**
There is no administrative appeal from decisions of the Industrial Commission in workers' compensation matters, as the Commission is exempted from contested-cases provisions of the Administrative Procedure Act. (7-1-94)

**004. -- 030. (RESERVED).**

**031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES UNDER THE IDAHO WORKERS' COMPENSATION LAW.**
Pursuant to Idaho Code Section 72-508 and Section 72-803, the Industrial Commission (hereinafter "the Commission") hereby substitutes the following for the January 28, 1975 amendment to the "Rules and Regulations Governing Charges for Medical Services Provided under the Idaho Workers' Compensation Law," dated May 2, 1973: (6-1-92)

01. Acceptable Charges Under the Idaho Workers' Compensation Law. Payors shall pay a Provider's reasonable charge for Medical Services furnished to industrially injured patients. (6-1-92)

02. Definitions. Words and terms used in this rule are defined in the subsections which follow. (6-1-92)

a. "Provider" means any person, firm, corporation, partnership, association, agency, institution or other legal entity providing any kind of Medical Services related to the treatment of an industrially injured patient which are compensable under Idaho's Workers' Compensation Law. (6-1-92)

b. "Payor" means the legal entity responsible for paying medical benefits under Idaho's Workers' Compensation Law. (6-1-92)

c. "Medical Services" means medical, surgical, dental or other attendance or treatment, nurse and hospital service, medicines, apparatus, appliances, prostheses, and related services, facilities, equipment and supplies. (7-1-95)

d. "Reasonable," except as provided in Subsections 031.02.g. and 031.02.h., means a charge does not exceed the Provider's "usual" charge and does not exceed the "customary" charge, as defined below. (7-1-95)

e. "Usual" means the most frequent charge made by an individual Provider for a given service to non-industrially injured patients. (7-1-95)

f. "Customary" means a charge which shall have an upper limit no higher than the 90th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given service. (7-1-95)

g. Provided, however, that for medical services which are not represented by CPT codes, reasonableness of charges shall be determined based on all relevant evidence available, including industry standards, invoices and catalog prices. (7-1-95)

h. Provided, further, that where a Medical Service is one that is exceptional, unusual, variable, rarely provided, or so new that a determination cannot be made as to whether the charge for the Medical Service meets the

criteria of Subsections 031.02.d. through 031.02.f. above, or where the Industrial Commission staff determines that its database is statistically unreliable, reasonableness of charges shall be determined based on all relevant evidence available. (7-1-95)

**032. BILLING AND PAYMENT REQUIREMENTS FOR MEDICAL SERVICES AND PROCEDURES PRELIMINARY TO DISPUTE RESOLUTION.**

01. Authority and Definitions. Pursuant to Idaho Code Section 72-508 and Section 72-803, the Industrial Commission hereby promulgates this rule augmenting IDAPA 17.02.08, Section 031 (formerly 17.01.03, Section 803.a, which became effective June 1, 1992). The definitions set forth in IDAPA 17.02.08, Section 031 are incorporated by reference as if fully set forth herein. (1-1-93)

02. Time Periods. None of the periods herein shall begin to run before the Notice of Injury/Claim for Benefits has been filed with the Employer as required by law. (1-1-93)

03. Provider to Furnish Information. A Provider, when submitting a bill to a Payor, shall inform the Payor of the nature and extent of Medical Services furnished and for which the bill is submitted. This information shall include, but is not limited to, the patient's name, the employer's name, the date the Medical Service was provided, the diagnosis, if any, and the amount of the charge or charges. (1-1-93)

a. CPT and ICD Coding. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the American Medical Association's appropriate Current Procedural Terminology (CPT) coding, including modifiers, for the year in which the service was performed and using current International Classification of Diseases (ICD) diagnostic coding, as well. (7-1-95)

b. Contact Person. The bill shall also contain the name, address and telephone number of the individual the Payor may contact in the event the Payor seeks additional information regarding the Provider's bill. (1-1-93)

c. Report to Accompany Bill. If required by the Payor, the bill shall be accompanied by a written report as defined by IDAPA 17.02.04.322.01.f. Where a bill is not accompanied by such Report, the periods expressed in Subsections 032.04 and 032.06, below, shall not begin to run until the Payor receives the Report. (7-1-95)

04. Prompt Payment. If the Payor acknowledges liability for the claim and does not send a Preliminary Objection to, or Request for Clarification of, any charge, as provided in Subsection 032.06, below, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill. The Commission will strictly apply all time limits and deadlines established by this rule. However, a reasonable good faith effort to comply with the other provisions of this rule will generally be sufficient to protect a party's rights hereunder. (1-1-93)

05. Partial Payment. If the Payor acknowledges liability for the claim and, pursuant to Subsection 032.06 below, sends a Preliminary Objection, a Request for Clarification, or both, as to only part of a Provider's bill, the Payor must pay the charge or charges, or portion thereof, as to which no Preliminary Objection and/or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. The Commission will strictly apply all time limits and deadlines established by this rule. However, a reasonable good faith effort to comply with the other provisions of this rule will generally be sufficient to protect a party's rights hereunder. (7-1-95)

06. Preliminary Objections and Requests for Clarification. (1-1-93)

a. Preliminary Objection. Whenever a Payor objects to all or any part of a Provider's bill on the ground that such bill contains a charge or charges that do not comport with the applicable administrative rule, the Payor shall send a written Preliminary Objection to the Provider within thirty (30) calendar days of the Payor's receipt of the bill explaining the basis for each of the Payor's objections. (1-1-93)

b. Request for Clarification. Where the Payor requires additional information, the Payor shall send a written Request for Clarification to the Provider within thirty (30) calendar days of the Payor's receipt of the bill, and shall specifically describe the information sought. (1-1-93)

c. Provider Contact. Each Preliminary Objection and Request for Clarification shall contain the name, address and phone number of the individual the Provider may contact regarding the Preliminary Objection or Request for Clarification. (1-1-93)

d. Failure of Payor to Object or Request. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill and/or a Request for Clarification within thirty (30) calendar days of receipt of the bill, it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (1-1-93)

07. Provider Reply to Preliminary Objection and/or Request for Clarification. (1-1-93)

a. Where a Payor has timely sent a Preliminary Objection, Request for Clarification, or both, the Provider shall send to the Payor a written Reply, if any it has, within thirty (30) calendar days of the Provider's receipt of each Preliminary Objection and/or Request for Clarification. (1-1-93)

b. Failure of Provider to Reply to Preliminary Objection. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (1-1-93)

c. Failure of Provider to Reply to Request for Clarification. If a Provider fails to timely reply to a Request for Clarification, the period in which the Payor shall pay or issue a Final Objection shall not begin to run until such clarification is received. (1-1-93)

08. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part and/or shall send to the Provider a written Final Objection, if any it has, to all or part of the bill within thirty (30) calendar days of the Payor's receipt of the Reply. (1-1-93)

09. Failure of Payor to Finally Object. Where the Payor does not timely send a Final Objection to any charge or portion thereof to which it continues to have an objection, it shall be precluded from further objecting to such charge as unacceptable. (1-1-93)

10. Investigation of Claim Compensability. Where a Payor is investigating the compensability of a claim as to which a Provider has submitted a bill, the Payor must send a Notice of Investigation of Claim Compensability to the Provider and the Patient within fifteen (15) calendar days of receipt of the Provider's bill. The Payor shall complete its investigation of claim compensability and notify the Commission, the Provider and the Patient of its determination within thirty (30) calendar days of the date the Notice of Investigation of Claim Compensability is sent. Where a Payor does not timely notify the Commission, the Provider and the Patient of its determination, the Payor shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (1-1-93)

a. Single Objection Sufficient. A single objection stating that liability has been denied shall be sufficient for each Provider from whom a bill is received. (1-1-93)

b. Effect of Commission Determination of Claim Compensability. The thirty (30) day period in which the Payor must pay the bill or send a Preliminary Objection and/or Request for Clarification shall recommence running on the date of entry of a final Commission order determining that the claim is compensable. (1-1-93)

c. Effect of Determination of Compensability. If the Payor, absent a Commission determination of claim compensability, concludes that it is liable for a claim, the thirty (30) day period in which the Payor must pay the bill or send a Preliminary Objection and/or Request for Clarification shall begin running on the date the Payor notifies the Commission, Provider and Patient that it accepts liability for the claim. (1-1-93)

11. Dispute Resolution Process. If, after completing the applicable steps set forth above, a Payor and Provider are unable to agree on the appropriate charge for any Medical Service, a Provider which has complied with the applicable requirements of this rule may move the Commission to resolve the dispute as provided in the Judicial Rule Re: Disputes Between Providers and Payors as Referenced in IDAPA 17.02.08.031 and 032 (formerly 17.01.03.803.a. and b.). (1-1-93)

12. Requirements Regarding Disputes Arising Before the Effective Date of this Rule. (1-1-93)

a. Written Demand Required. If, prior to January 1, 1993, a Payor notifies or has notified a Provider that it does not intend to fully pay any charge for Medical Services incurred prior to January 1, 1993, the Provider seeking payment for such charge must send a written Demand for Payment to the Payor no later than January 31, 1993. (Note: Should the matter ultimately proceed to the dispute resolution phase set forth in the Judicial Rule, the Commission will resolve the dispute by applying the administrative rule which was in effect at the time the charge was incurred. Hence, if the charge in dispute was incurred prior to June 1, 1992, the Commission will use this dispute resolution process to determine whether the Provider's charge is acceptable pursuant to the provisions of IDAPA 17.01.03.803, then in effect. However, if the charge in dispute was incurred on or after June 1, 1992, the Commission will use this dispute resolution process to determine whether the Provider's charge is acceptable pursuant to the provisions of IDAPA 17.02.08.031, now in effect.) (1-1-93)

b. All Provisions of this Rule Will Apply. Such a Demand shall substitute for the bill and Report referenced in Subsection 032.03 above, and must contain all the information required by that section. Service of a timely Demand for Payment will bring the other provisions of this rule into operation. (1-1-93)

c. Failure of Provider to Make Written Demand. Providers failing to make a written Demand for Payment within thirty (30) calendar days of the effective date of this rule shall be forever barred from invoking the Dispute Resolution Process set forth in the applicable Judicial Rule. Demands and/or billings submitted previously either to the Payor or to the Commission will not suffice. (1-1-93)

**033. RULE GOVERNING APPROVAL OF ATTORNEY FEES IN WORKERS' COMPENSATION CASES.**

01. Authority and Definitions. Pursuant to Idaho Code Sections 72-404, 72-508, 72-707, 72-735 and 72-803, the Commission promulgates this rule to govern the approval of attorney fees. (7-1-94)

a. "Available funds" means a sum of money to which a charging lien may attach. It shall not include any compensation paid or not disputed to be owed prior to claimant’s agreement to retain the attorney. (7-1-94)

b. "Approval by Commission" means the Commission has approved the attorney fees in conjunction with an award of compensation or a lump sum settlement or otherwise in accordance with this rule upon a proper showing by the attorney seeking to have the fees approved. (7-1-94)

c. "Charging lien" means a lien, against a claimant's right to any compensation under the Workers' Compensation laws, which may be asserted by an attorney who is able to demonstrate that: (7-1-94)

i. There are compensation benefits available for distribution on equitable principles; (7-1-94)

ii. The services of the attorney operated primarily or substantially to secure the fund out of which the attorney seeks to be paid; (7-1-94)

iii. It was agreed that counsel anticipated payment from compensation funds rather than from the client; (7-1-94)

iv. The claim is limited to costs, fees, or other disbursements incurred in the case through which the fund was raised; and (7-1-94)

v. There are equitable considerations that necessitate the recognition and application of the charging lien. (7-1-94)

d. "Fee agreement" means a written document evidencing an agreement between a claimant and counsel, in conformity with Rule 1.5, Idaho Rules of Professional Conduct (IRPC). (7-1-94)

e. "Reasonable" means that an attorney's fees are consistent with the fee agreement and are to be

satisfied from available funds, subject to the element of reasonableness contained in IRPC 1.5. (7-1-94)

i. In a case in which no hearing on the merits has been held, twenty-five percent (25%) of available funds shall be presumed reasonable; or (7-1-94)

ii. In a case in which a hearing has been held and briefs submitted (or waived) under Judicial Rules of Practice and Procedure (JRP), Rules X and XI, thirty percent (30%) of available funds shall be presumed reasonable; or (7-1-94)

iii. In any case in which compensation is paid for total permanent disability, fifteen percent (15%) of such disability compensation after ten (10) years from date such total permanent disability payments commenced. (7-1-94)

02. Statement of Charging Lien. (7-1-94)

a. All requests for approval of fees shall be deemed requests for approval of a charging lien. (7-1-94)

b. An attorney representing a claimant in a Workers' Compensation matter shall in any proposed lump sum settlement, or upon request of the Commission, file with the Commission, and serve the claimant with a copy of the fee agreement, and an affidavit or memorandum containing: (7-1-94)

i. The date upon which the attorney became involved in the matter; (7-1-94)

ii. Any issues which were undisputed at the time the attorney became involved; (7-1-94)

iii. The total dollar value of all compensation paid or admitted as owed by employer immediately prior to the attorney's involvement; (7-1-94)

iv. Disputed issues that arose subsequent to the date the attorney was hired; (7-1-94)

v. Counsel's itemization of compensation that constitutes available funds; (7-1-94)

vi. Counsel's itemization of costs and calculation of fees; and (7-1-94)

vii. The statement of the attorney identifying with reasonable detail his or her fulfillment of each element of the charging lien. (7-1-94)

c. Upon receipt and a determination of compliance with this Rule by the Commission by reference to its staff, the Commission may issue an Order Approving Fees without a hearing. (7-1-94)

03. Procedure if Fees are Determined Not to be Reasonable. (7-1-94)

a. Upon receipt of the affidavit or memorandum, the Commission will designate staff members to determine reasonableness of the fee. The Commission staff will notify counsel in writing of the staff's informal determination, which shall state the reasons for the determination that the requested fee is not reasonable. Omission of any information required by Subsection 033.02 may constitute grounds for an informal determination that the fee requested is not reasonable. (7-1-94)

b. If counsel disagrees with the Commission staff's informal determination, counsel may file, within fourteen (14) days of the date of the determination, a Request for Hearing for the purpose of presenting evidence and argument on the matter. Upon receipt of the Request for Hearing, the Commission shall schedule a hearing on the matter. A Request for Hearing shall be treated as a motion under Rule III(e), JRP. (7-1-94)

c. The Commission shall order an employer to release any available funds in excess of those subject to the requested charging lien and may order payment of fees subject to the charging lien which have been determined to be reasonable. (7-1-94)

d. The proponent of a fee which is greater than the percentage of recovery stated in Subsections 033.01.e.i., 033.01.e.ii., or 033.01.e.iii. shall have the burden of establishing by clear and convincing evidence entitlement to the greater fee. The attorney shall always bear the burden of proving by a preponderance of the evidence his or her assertion of a charging lien and reasonableness of his or her fee. (7-1-94)

04. Disclosure. Upon retention, the attorney shall provide to claimant a copy of a disclosure statement. No fee may be taken from a claimant by an attorney on a contingency fee basis unless the claimant acknowledges receipt of the disclosure by signing it. Upon request by the Commission, an attorney shall provide a copy of the signed disclosure statement to the Commission. The terms of the disclosure may be contained in the fee agreement, so long as it contains the text of the numbered paragraphs 1 and 2 of the disclosure. A copy of the agreement must be given to the client. The disclosure statement shall be in a format substantially similar to the following: (7-1-94)

**State of Idaho**
**Industrial Commission**

Client's name printed or typed
Attorney's name and address
printed or typed

DISCLOSURE STATEMENT

1. In workers' compensation matters, attorney's fees normally do not exceed twenty-five percent (25%) of the benefits your attorney obtains for you in a case in which no hearing on the merits has been completed. In a case in which a hearing on the merits has been completed, attorney's fees normally do not exceed thirty percent (30%) of the benefits your attorney obtains for you.

2. Depending upon the circumstances of your case, you and your attorney may agree to a higher or lower percentage which would be subject to Commission approval. Further, if you and your attorney have a dispute regarding attorney fees, either of you may petition the Commission to resolve the dispute.

I certify that I have read and understand this disclosure statement.

Client's Signature Date

Attorney's Signature Date

05. Effective Dates. Clauses i., ii., and iii. of Subsection 033.01.e. are effective as to fee agreements entered into on and after December 1, 1992. All other provisions shall be effective on and after December 20, 1993. (7-1-94)

**034. -- 060. (RESERVED).**

**061. RULE GOVERNING NOTICE TO CLAIMANTS OF STATUS CHANGE PURSUANT TO IDAHO CODE SECTION 72-806.**

01. Notice of Change of Status. As required and defined by Idaho Code Section 72-806, a worker shall receive written notice within fifteen (15) days of any change of status or condition. (1-6-92)

02. By Whom Given. Any notice to a worker required by Idaho Code Section 72-806 shall be given by: the surety if the employer has secured Workers' Compensation Insurance; or the employer if the employer is self-insured; or the employer if the employer carries no Workers' Compensation Insurance. (1-6-92)

03. Form of Notice. Any notice to a worker required by Idaho Code Section 72-806 shall be mailed within ten (10) days by regular United States Mail to the last known address of the worker, as shown in the records of the party required to give notice as set forth above. The Notice shall be given on IC Form 8, as prescribed by the Commission for this purpose, as substantially set forth below: (1-6-92)

**IC Form 8:**

**NOTICE OF CLAIM STATUS**

Injured Worker SSN

Date of Injury

Employer

Insurance Company

Address State Zip

This is to notify you of the denial or change of status of your workers' compensation claim as indicated in the statement checked below.

Your claim is denied.
Reason

Your benefit payments will bereducedincreased
Effective date
Reason

Your benefit payments will be stopped.Effective date
Reason

Your claim is being investigated.
A decision should be made by

Other Effective date
Explanation

See attached medical reports

Signature of insurance company adjuster/examinerdate
Name (typed or printed)

A sample copy of IC Form 8 is available from the;

Industrial Commission
317 Main Street
P. O. Box 83720
Boise, Idaho 83720-0041
telephone (208) 334-6000.

04. Medical Reports. As required by Idaho Code Section 72-806, if the change is based on a medical report, the party giving notice shall attach a copy of the report to the notice. (1-6-92)

05. Copies of Notice. The party giving notice pursuant to Idaho Code Section 72-806 shall send a copy of any such notice to the Industrial Commission, the employer, and the worker's attorney, if the worker is represented, at the same time notice is sent to the worker. (1-6-92)

**062. -- 999. (RESERVED).**