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17.02.07 - PROCEDURES TO OBTAIN COMPENSATION

IDAPA 17
TITLE 02
Chapter 07

17.02.07 - PROCEDURES TO OBTAIN COMPENSATION

000. LEGAL AUTHORITY.
This chapter is adopted pursuant to the provisions of Sections 72-432, 72-448, 72-508, 72-602, 72-701, 72-702, 72-703, 72-704, Idaho Code. (7-1-97)

001. TITLE AND SCOPE.
These rules shall be cited as IDAPA 17.02.07, "Procedures to Obtain Compensation," and shall apply to claims for compensation arising under the Workers' Compensation Act. (7-1-97)

002. WRITTEN INTERPRETATIONS.
No written interpretations of these rules exist. (7-1-97)

003. ADMINISTRATIVE APPEALS.
There is no administrative appeal from decisions of the Industrial Commission in workers' compensation matters, as the Industrial Commission is exempted from contested-cases provisions of the Administrative Procedure Act. (7-1-97)

004. -- 009. (RESERVED).

010. DEFINITIONS.
The following definitions shall be applicable to these rules. (7-1-97)

01. Commission. Means the Idaho Industrial Commission. (7-1-97)

02. Claim. Means Industrial Commission (IC) Form 1A-1 entitled "Workers Compensation First Report of Injury or Illness". If an application for hearing, referred to as a Complaint in the Judicial Rules, has been filed with the Commission, the IC Form 1A-1 is not required. (7-1-97)

03. Notice. Means both the employer's actual and constructive knowledge of the accident, injury or occupational disease. (7-1-97)

04. Employer. Is defined in Section 72-102(11), Idaho Code, and, for the purposes of these rules, includes sureties and adjusters. (7-1-97)

05. Claimant. Means a worker who is seeking to recover benefits under the Workers' Compensation Law. (7-1-97)

011. SUBMISSION OF FIRST REPORTS OF INJURY AND CLAIMS FOR COMPENSATION TO THE INDUSTRIAL COMMISSION.

01. Purpose. The Industrial Commission seeks to develop a form for reporting work-related injuries and occupational diseases that is compatible with emerging standards for electronic submission of data. This will allow for more timely entry of information into the database system from which statistical reports are generated, reduce the paper that the Commission currently receives, and is expected to reduce the cost of reporting for sureties, employers and the Commission. (7-1-97)

02. Procedure For Submitting Claims. In order to comply with Section 72-602, Idaho Code, Form 1A-1 shall be submitted to the Commission in substantially the same form as set forth below. At such time as the Commission institutes a system for on-line reporting of claims, claims may be submitted electronically. Fields that require clarification are listed below with explanations and/or applicable coding information: (7-1-97)

a. Dates: Use MM/DD/YYYY format. (7-1-97)

b. SIC Code: Code that represents the nature of employer's business as it is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget. (7-1-97)

c. Carrier: The surety issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant. In the case of a self-insured, the self-insured's information should be submitted. (7-1-97)

d. Claims Administrator: The name of the surety, adjuster, state fund, or self-insured responsible for administering the claim. (7-1-97)

e. Employment status: This is the claimant's work status. The valid choices are full-time, not employed, disabled, unknown, part-time apprentice, seasonal, part-time, on strike, retired, full-time apprentice, volunteer, or piece worker. (7-1-97)

f. Date disability began: The first day on which the claimant lost time from work due to the injury or disease. (7-1-97)

g. Type of injury/illness: Brief description of nature of injury or illness or the appropriate National Council on Compensation Insurance (NCCI) Detailed Claim Information (DCI) code. (7-1-97)

h. Part of body affected: Brief description or the appropriate DCI code(s). (7-1-97)

i. Department or location where accident or illness exposure occurred: Enter requested information or, if the accident or illness exposure did not occur on the employer's premises, enter address or location as specifically as possible. (7-1-97)

j. Nature of injury: Brief description or the appropriate DCI code(s). (7-1-97)

k. Work process the employee was engaged in when accident or illness exposure occurred: Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process. (7-1-97)

03. Retaining Claims Files. All employers shall maintain their respective claim files in accordance with Section 051. Upon request of the Commission, employers shall provide to the Commission, in whole or in part according to the request, a copy of the claim file at no cost to the Commission. (7-1-97)

a. All employers shall retain complete copies of claims files for the life of the claim or a minimum of five (5) years from the date of closure, whichever is shorter. (7-1-97)

b. For time-loss claims, closure will be the date upon which the employer files the final summary of payments. The Commission recommends that an employer retain a closed claim file for a minimum of five (5) years. (7-1-97)

04. Filing Not An Admission. Filing a claim is not an admission of liability and is not conclusive evidence of any fact stated therein. If a claim is submitted electronically, no signatures are required. (7-1-97)

05. Filing Considered Authorization. Filing of a claim shall be considered an authorization for the release of medical records that are relevant to or bearing upon the particular injury or occupational disease for which the claimant is seeking compensation. (7-1-97)

06. Report Form And Content. (7-1-97)

a. The Notice of Injury and Claim for Benefits required by this rule shall be submitted on eight and one-half by eleven inches (8 1/2" X 11") paper in a format substantially similar to that which follows. If the employer seeks to request additional information, the employer shall submit the proposed changes to the Commission for approval. Changes shall not be implemented prior to the receipt of the Commission's approval. (7-1-97)

b. Employers wishing to report electronically shall sign a written information sharing agreement with the Commission. This agreement will provide the effective date to send and receive electronic reports, the acceptable data to be sent and received, the method of transmission to be used, and other pertinent elements. The agreement must be signed by the employer and approved by the Commission prior to initial data submission. To ensure the accuracy of reported data, the Commission may make periodic audits of employer files. (7-1-97)

07. Timely Response Requirement. When the Commission requests additional information in order to process the Claim, the claimant or employer shall provide the requested information promptly. The Commission request may be either in writing or telephonic. (7-1-97)

012. -- 999. (RESERVED).

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # | PHONE #

SIC CODE | EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NUMBER)

POLICY PERIOD TO

CHECK IF SELF INSURED

CLAIMS ADMIN (NAME, ADDRESS &PHONE NO.)

CARRIER FEIN | POLICY NUMBER OR SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

LEGAL NAME (LAST, FIRST, MIDDLE) | BIRTH DATE | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX: M MALE; F FEMALE; U UNKNOWN

MARITAL STATUS: U UNMARRIED/ SINGLE/DIV.; M MARRIED; S SEPARATED; K UNKNOWN

OCCUPATION /JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

WAGE RATE PER: DAY / WEEK / MONTH / OTHER: | # DAYS WORKED/ WK | FULL PAY FOR DATE OF INJURY? YES NO | DID SALARY CONTINUE? YES NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK AM PM | DATE OF INJURY/ILLNESS | TIME OCCURED AM PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISIBILITY BEGAN

EMPLOYER CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE USING UPON OCCURRENCE

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN AT TIME OF OCCURRENCE | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN AT TIME OF OCCURRENCE

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE EMPOYEE ILL | CAUSE OF INJURY CODE

DATE RETURNED TO WORK | IF FATAL, DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO | WERE THEY USED? YES NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
0 NO MEDICAL TREATMENT
1 MINOR: BY EMPLOYER
2 MINOR CLINIC/HOSP
3 EMERGENCY CARE
4 HOSPITALIZED > 24 HR
5 ANTICIPATED MAJOR MED/LOST TIME

OTHER

SIGNATURE OF INJURED EMPLOYEE, OR SIGNATURE ON FILE; DATE | WITNESS TO ACCIDENT (NAME & PHONE NUMBER)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PREPARER'S PHONE NUMBER

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