

# ***Table of Contents***

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## **17.02.07 - Procedures to Obtain Compensation**

000. Legal Authority. ....	2
001. Title And Scope. ....	2
002. Written Interpretations. ....	2
003. Administrative Appeals. ....	2
004. -- 009. (Reserved). ....	2
010. Definitions. ....	2
011. Submission Of First Reports Of Injury And Claims For Compensation To The Industrial Commission. ....	2
012. -- 999. (Reserved). ....	4

**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**

<b>GENERAL</b>	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							
<b>CLAIMS CARRIER ADMIN</b>	CARRIER (NAME, ADDRESS & PHONE NUMBER)		POLICY PERIOD	CLAIMS ADMIN (NAME, ADDRESS & PHONE NO.)					
			TO						
			CHECK IF SELF INSURED						
	CARRIER FEIN	POLICY NUMBER OR SELF-INSURED NUMBER		ADMINISTRATOR FEIN					
AGENT NAME & CODE NUMBER									
<b>EMPLOYEE</b>	LEGAL NAME (LAST, FIRST, MIDDLE)		BIRTH DATE	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE			
	ADDRESS (INCL ZIP)		SEX	MARITAL STATUS	OCCUPATION /JOB TITLE				
			M MALE F FEMALE U UNKNOWN	U UNMARRIED/SINGLE/DIV. M MARRIED S SEPARATED	EMPLOYMENT STATUS				
	PHONE		# OF DEPENDENTS	K UNKNOWN	NCCI CLASS CODE				
	WAGE RATE	PER:	DAY	MONTH	# DAYS WORKED/ WK	FULL PAY FOR DATE OF INJURY?	YES NO		
			WEEK	OTHER:		DID SALARY CONTINUE?	YES NO		
<b>OCCURRENCE</b>	TIME EMPLOYEE BEGAN WORK	AM	DATE OF INJURY/ILLNESS	TIME OCCURED	AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN	
		PM			PM				
	EMPLOYER CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED			
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?			YES	TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
	NO								
	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 EMPLOYEE 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		
<b>TREATMENT OTHER</b>	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				
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				

# ***Subject Index***

## **C**

Claim 2  
Claimant 2

## **D**

Definitions, IDAPA 17.02.07,  
Procedures To Obtain  
Compensation 2

## **E**

Employer 2

## **F**

Filing Considered Authorization,  
Submission of First Reports of Injury  
& Claims for Compensation 3  
Filing Not an Admission, Submission of  
First Reports of Injury & Claims for  
Compensation 3

## **N**

Notice 2

## **P**

Procedure for Submitting Claims,  
Submission of First Reports of Injury  
& Claims for Compensation 2

## **R**

Report Form and Content, Submission  
of First Reports of Injury & Claims  
for Compensation 3

## **S**

Submission Of First Reports Of Injury  
& Claims For Compensation To The  
Industrial Commission 2

## **T**

Timely Response Requirement,  
Submission of First Reports of Injury  
& Claims for Compensation 4