

IDAPA 17 – IDAHO INDUSTRIAL COMMISSION

Administration Section

17.01.01 – Administrative Rules Under the Worker’s Compensation Law

Who does this rule apply to?

This rule applies to the following stakeholders:

- Injured Workers;
- Employers;
- Medical Providers;
- Adjusters;
- Attorneys;
- Sureties; and
- Third-Party Administrators (TPAs)

What is the purpose of this rule?

This rule covers the administration and regulation of the Idaho Worker’s Compensation Act, including, but not limited to: coverage requirements, benefits administration, medical fee schedule and process for medical fee disputes, reporting requirements, and claims administration requirements. For rules regarding the complaint and litigation process, please see the Judicial Rules of Practice and Procedure on the Commission’s website at <https://iic.idaho.gov/rules-and-legislation/>.

What is the legal authority for the agency to promulgate this rule?

This rule implements the following statutes passed by the Idaho Legislature:

Industrial Commission -

- [72-101, et. seq., Idaho Code](#) - Worker’s Compensation and Related Laws

Who do I contact for more information on this rule?

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IDAPA 17 – INDUSTRIAL COMMISSION

17.01.01 – ADMINISTRATIVE RULES UNDER THE WORKER'S COMPENSATION LAW

000. LEGAL AUTHORITY.

This chapter is adopted under the legal authority of 72-301, 72-301A, 72-304, 72-327, 72-432, 72-508, 72-528, 72-602, 72-803, and 72-806, Idaho Code. (7-1-21)T

001. TITLE AND SCOPE.

01. Title. The title of this chapter is “Administrative Rules Under the Worker's Compensation Law” IDAPA 17, Title 01, Chapter 01. (7-1-21)T

02. Scope. This chapter includes the Industrial Commission's worker's compensation rules. (7-1-21)T

002. WRITTEN INTERPRETATIONS.

The Industrial Commission uses the following guidelines for implementing the EDI reporting requirements set out in this Chapter: (7-1-21)T

01. EDI Guide and Tables. The Idaho Industrial Commission Claims EDI Implementation Guide and Trading Partner Tables (“EDI Guide and Tables”). The Idaho Industrial Commission Claims EDI Implementation Guide and Trading Partner Tables are available on the Commission's website at <https://iic.idaho.gov/>. (7-1-21)T

02. EDI Implementation Guide. International Association of Industrial Accidents Boards and Commissions (IAIABC) EDI Claims Release 3.0 Implementation Guide (“EDI Implementation Guide”). The IAIABC Claims Release 3.0 Implementation Guide is available at the IAIABC website at <https://www.iaiac.org>. (7-1-21)T

003 -- 009. (RESERVED)

010. DEFINITIONS.

The definitions set forth in Chapter 72, Idaho Code apply to these rules. In addition, the following terms have the meaning set forth below: (7-1-21)T

01. Adjustor. Means an individual who adjusts worker's compensation claims. (7-1-21)T

02. Ambulatory Payment Classification. Means the payment system adopted by CMS for outpatient services (7-1-21)T

03. Available Funds. Means a sum of money to which a Charging Lien may attach. It does not include any compensation paid or not disputed to be owed prior to Claimant's agreement to retain the attorney. (7-1-21)T

04. Ambulatory Surgery Center. Means a facility providing medical services on an outpatient basis only. (7-1-21)T

05. Approval by Commission. Means the Commission has approved attorney fees in conjunction with an award of compensation or an LSS or otherwise in accordance with Section 802 of this rule upon a proper showing by the attorney seeking to have the fees approved. (7-1-21)T

06. Average Wholesale Price. Means the average wholesale price for medicine obtained from pricing data provided by the original manufacturer of that medicine to industry-wide compilers of drug prices, e.g., Red Book and Medi-Span. (7-1-21)T

07. Charge. Means the expense or cost. For hospitals and ASCs, “charge” means the total charge. (7-1-21)T

a. Acceptable charge. Means a charge calculated in compliance with Section 803 of this rule or as billed by the Provider, whichever is lower, or the charge agreed to pursuant to a written contract. (7-1-21)T

b. Customary charge. Means a charge that has an upper limit no higher than the 90th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given medical service. (7-1-21)T

- c. Reasonable charge. Means a charge that does not exceed the Provider's "usual" charge and does not exceed the "customary" charge. (7-1-21)T
- d. Usual charge. Means the most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients. (7-1-21)T
- 08. Charging Lien.** Means a lien against a Claimant's right to any compensation under the Worker's Compensation Law, which may be asserted by an attorney who is able to demonstrate that: (7-1-21)T
- a. There are compensation benefits available for distribution on equitable principles; (7-1-21)T
- b. The services of the attorney operated primarily or substantially to secure the fund out of which the attorney seeks to be paid; (7-1-21)T
- c. It was agreed that counsel anticipated payment from compensation funds rather than from the client; (7-1-21)T
- d. The Claim is limited to costs, fees, or other disbursements incurred in the case through which the fund was raised; and (7-1-21)T
- e. There are equitable considerations that necessitate the recognition and application of the Charging Lien. (7-1-21)T
- 09. Claim.** Means filing for worker's compensation benefits through a Form 1A-1, First Report of Injury or Illness (FROI) or an application for hearing, referred to as a Complaint, with the Commission. (7-1-21)T
- 10. Claims Administrator.** Means an organization, including insurers, third party administrators, independent adjusters, or self-insured employers, that services worker's compensation claims. (7-1-21)T
- 11. Claimant.** Means a person who has filed a Claim for worker's compensation benefits and includes their agents, such as attorneys. (7-1-21)T
- 12. Commission.** Means the Idaho Industrial Commission. (7-1-21)T
- 13. Critical Access Hospital.** Means a hospital currently designated as a critical access hospital by CMS. (7-1-21)T
- 14. Current Procedural Terminology.** Means the medical code published by the American Medical Association. (7-1-21)T
- 15. Death Claim.** Means a Claim arising from the death of a worker as a result of a work-related injury or occupational disease. (7-1-21)T
- 16. Electronic Data Interchange.** Means a computer to computer exchange of data in a standardized format. (7-1-21)T
- 17. Fee Agreement.** Means a written agreement between a worker and an attorney in conformity with the Idaho Rules of Professional Conduct. (7-1-21)T
- a. Reasonable, as used in Section 802 of this rule, 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 Idaho Rules of Professional Conduct 1.5. (7-1-21)T
- 18. First Degree of Consanguinity.** Means the relationship between parents and their children whether related by blood or affinity. Adopted or step children and their adoptive or step parents are deemed to be within the first degree of consanguinity. (7-1-21)T

- 19. First Report of Injury.** Means the first filing of information with the Industrial Commission that a reportable workplace injury has occurred or an occupational disease has been manifested, as required by Section 72-602(1), Idaho Code; filed in accordance with these rules. (7-1-21)T
- 20. Gross Direct Premiums Written.** Means the gross sum of premiums on policies written, without any deduction for refunds or repayments resulting from cancellations. It does not include premiums on contracts between insurers or reinsurers. For all policies written, gross direct premiums written may reflect experience modifications, deviations, and retrospective rating. (7-1-21)T
- 21. Healthcare Common Procedure Coding System.** Means the set of healthcare procedure codes based on the American Medical Association's Current Procedural Terminology. (7-1-21)T
- 22. Hospital.** Means an acute care facility providing medical or rehabilitation services on an inpatient and outpatient basis. (7-1-21)T
- 23. IAIABC EDI Release 3.0.** Means the IAIABC authored EDI Release 3.0 standards that cover the transmission of claims (FROI and SROI) information through electronic reporting. (7-1-21)T
- 24. Impairment Rated Claim.** Means those claims in which the Provider establishes an impairment rating for the injured worker. (7-1-21)T
- 25. Implantable Hardware.** Means objects or devices that are made to support, replace, or act as a missing anatomical structure or to support or manage proper biological functions or disease processes and where surgical or medical procedures are needed to insert or apply such devices and surgical or medical procedures are required to remove such devices. The term also includes equipment necessary for the proper operation of the implantable hardware, even if not implanted in the body. (7-1-21)T
- 26. Indemnity Benefits.** Means payments made to or on behalf of worker's compensation Claimants, including temporary or permanent total or partial disability benefits, death benefits paid to dependents, retraining benefits, and any other type of income benefits, but excluding medical and related benefits. (7-1-21)T
- 27. Indemnity Claim.** Means any claim made for the payment of indemnity benefits. (7-1-21)T
- 28. Legacy Claim.** Means a FROI that was filed prior to the EDI implementation. (7-1-21)T
- 29. Litigated Case.** Means a case in which a complaint has been filed. (7-1-21)T
- 30. Medical Only Claim.** Means the injured worker will not suffer a disability lasting more than five (5) calendar days as a result of a job-related injury or occupational disease, nor be admitted to a hospital as an inpatient. (7-1-21)T
- 31. Medical Report.** Means and includes without limitation, all bills, chart notes, surgical records, testing results, treatment records, hospital records, prescriptions, and medication records. (7-1-21)T
- 32. Medicare Severity - Diagnosis Related Group.** Means a system adopted by CMS that groups hospital admissions based on diagnosis codes, surgical procedures, and patient demographics. (7-1-21)T
- 33. Net Premiums Written.** Means the amount of gross direct premiums on policies written less returned premiums and premiums on policies not taken. Paid dividends shall not be deducted for the purposes of calculating net premiums written. (7-1-21)T
- 34. Payor.** Means the entity that is responsible for making payment to a Provider for services rendered to treat an industrially injured patient and includes self-insured employers, sureties, adjusters, and their agents. (7-1-21)T
- 35. Payroll.** Means the gross amount paid by an employer for salaries, wages, or commissions earned

by its own direct employees, but not including any money paid to another entity or received from another entity for leased employees. (7-1-21)T

36. Pharmacy. Means a facility as defined in Section 54-1705(29), Idaho Code. (7-1-21)T

37. Supplemental or Subsequent Report of Injury. Means the filing of additional information with the Industrial Commission, regarding benefits paid or changes in the status or condition of an injured worker, of a Claim for benefits, as required by Sections 72-602(2), (3), and (4), Idaho Code; filed in accordance with these rules. (7-1-21)T

38. Termination of Disability. Means the date upon which the obligation of the Employer/Surety becomes certain as to duration and amount whether by settlement, decision, or periodic payments in the ordinary course of claims processing. If resolved by LSS, the termination of disability shall occur on the date the LSS is approved and an order approving is filed by the Industrial Commission. If resolved by decision, the termination of disability shall occur on the date the decision resolving all issues becomes final. (7-1-21)T

39. Time Loss Claim. Means the injured worker will suffer, or has suffered, a disability that lasts more than five (5) calendar days as a result of a job-related injury or occupational disease, or the injured worker requires, or required, in-patient treatment as a result of such injury or disease. (7-1-21)T

40. Trading Partner. Means an insurance carrier, self-insured employer, or Claims Administrator that has entered into a Trading Partner Agreement with the Industrial Commission. (7-1-21)T

41. Trading Partner Agreement. Means an agreement between the Industrial Commission and a Trading Partner that sets out the terms and conditions for the electronic reporting of information to the Commission. (7-1-21)T

011. ABBREVIATIONS.

The following abbreviations have the meaning set forth below: (7-1-21)T

01. APC. Means Ambulatory Payment Classification. (7-1-21)T

02. ASC. Means Ambulatory Surgery Center. (7-1-21)T

03. AWP. Means Average Wholesale Price. (7-1-21)T

04. CMS. Means Centers for Medicare and Medicaid Services. (7-1-21)T

05. CPT. Means Current Procedural Terminology. (7-1-21)T

06. EDI. Means Electronic Data Interchange. (7-1-21)T

07. FROI. Means First Report of Injury. (7-1-21)T

08. HCPCS. Means Healthcare Common Procedure Coding System. (7-1-21)T

09. IAIABC. Means International Association of Industrial Accident Boards and Commissions. (7-1-21)T

10. ISIF. Means the Industrial Special Indemnity Fund, which is commonly referred to as the Second Injury Fund. (7-1-21)T

11. LSS. Means Lumps Sum Settlement. (7-1-21)T

12. MSDRG. Means Medicare Severity Diagnosis Related Group. (7-1-21)T

13. NCCI. Means National Council on Compensation Insurance. (7-1-21)T

- 14. NDC. Means National Drug Code. (7-1-21)T
- 15. RBRVS. Means Resource-Based Relative Value Scale. (7-1-21)T
- 16. RVU. Means Relative Value Unit. (7-1-21)T
- 17. SROI. Means Supplemental or Subsequent Report of Injury. (7-1-21)T

012. LIBERAL CONSTRUCTION.

Rulemaking before the Industrial Commission should be just, speedy, and economical; unless prohibited by statute, the Industrial Commission may permit deviation from these rules when it finds compliance with them is impracticable, unnecessary, or not in the public interest. (7-1-21)T

013. -- 200. (RESERVED)

201. RULE GOVERNING 72-212(5) EXEMPTIONS.

01. Exemptions. Each person who elects to exempt themselves from coverage or revoke their exemption under Section 72-212(5), Idaho Code, must file an IC53 Declaration form with the Industrial Commission. The form is available on the Commission's website. (7-1-21)T

02. Form. The form must be signed by both the employee and the employer. An original and one (1) copy of the IC53 form shall be filed with the Commission. Upon approval by the Commission, the copy will be returned to the employee filing for an exemption or revocation of an exemption. (7-1-21)T

03. Approval by Commission. The Commission must approve the exemption or revocation of exemption. The Commission may require verification of information submitted. Fraud or misrepresentation in the information provided will void the exemption or revocation. (7-1-21)T

04. IC53 Form. If the employer is insured, it is the employer's responsibility to file a copy of the IC53 form with the employer's insurance company. (7-1-21)T

05. Effective Date. The effective date of the exemption or revocation of exemption shall be the date the properly completed form is received by the Commission. (7-1-21)T

06. Exemption Effective. The exemption shall remain in effect until a revocation of exemption is filed with the Commission, or, termination of employment with the designated employer, or upon the death of the employee, whichever occurs first. (7-1-21)T

202. -- 300. (RESERVED)

301. RULES GOVERNING QUALIFICATIONS TO WRITE INSURANCE OR SELF-INSURE.

01. Insurance Carriers. In order to gain approval from the Industrial Commission to underwrite worker's compensation insurance under Section 72-301, Idaho Code, an insurance carrier shall comply with the following requirements: (7-1-21)T

a. Deposit With State Treasurer. The carrier must receive approval from the Director of the Idaho Department of Insurance to underwrite casualty and surety insurance under Sections 41-506 and 41-507, Idaho Code, and shall initially deposit security in the amount of two hundred fifty thousand dollars (\$250,000) with the State Treasurer, under the provisions of Section 72-302, Idaho Code. (7-1-21)T

b. Application. To receive approval from the Industrial Commission, an insurance carrier must supply an application with: (7-1-21)T

- i. A statement from the Director of the Idaho Department of Insurance documenting compliance with

- Paragraph 01.a, above; (7-1-21)T
- ii. The latest audited financial statement of said carrier; (7-1-21)T
 - iii. The name and address of the agent for service of process in Idaho; (7-1-21)T
 - iv. The name and address of the Claims Administrator employing an Idaho licensed resident adjuster or the insurance carrier's own in-house Idaho adjusting staff with authority to make compensation payments and adjustments of claims arising under the Act. Each Claims Administrator shall have only one (1) mailing address on record at the Commission for claims adjusting purposes. If more than one (1) Claims Administrator is utilized in Idaho, a list of every such Claims Administrator and all corresponding policyholders shall be provided; (7-1-21)T
 - v. A statement that the carrier will distribute blank forms that are prescribed by the Commission to its insured; (7-1-21)T
 - vi. A statement that all surety bonds covering the payment of compensation will be filed with the Idaho State Treasurer for all employers insured. All carriers will use the continuous bond form set out on the Commission's website. (7-1-21)T
 - vii. A statement that renewal certificates on said bonds will be issued and filed with the Industrial Commission immediately, when and if renewed; (7-1-21)T
 - viii. A statement that all surety contract cancellations will be canceled in compliance with Section 72-311, Idaho Code; (7-1-21)T
 - ix. A statement that said carrier will deposit, in addition to other security required by this rule, further security equal to all unpaid outstanding awards of compensation; (7-1-21)T
 - x. A statement that said carrier will comply with the statutes of the state of Idaho and rules of the Industrial Commission and that payments of compensation shall be sure and certain and not unnecessarily delayed; and (7-1-21)T
 - xi. A statement that the carrier will make reports to the Commission as are required. (7-1-21)T
- 02. Self-Insured Employers.** In order to gain approval from the Industrial Commission to self-insure under Section 72-301, Idaho Code, an employer shall comply with the following requirements: (7-1-21)T
- a.** Payroll. Have an average annual Idaho Payroll over the preceding three (3) years of at least four million dollars (\$4,000,000). (7-1-21)T
 - b.** Application. Submit a completed application, available from the Industrial Commission's Fiscal Department, along with the application fee of two hundred fifty dollars (\$250), to the Idaho Industrial Commission, Attention: Fiscal Department. (7-1-21)T
 - c.** Documentation. Submit documentation demonstrating the sound financial condition of the employer, such as the most recent CPA reviewed or, if available, audited, financial statement. (7-1-21)T
 - d.** Claims Adjusting. Designate in writing a Claims Administrator employing an Idaho licensed resident adjuster including name and address. Each Claims Administrator shall have only one (1) mailing address on record at the Commission for claims adjusting purposes. (7-1-21)T
 - e.** Previous Claims. Provide a history of all worker's compensation claims filed with the employer or the employer's worker's compensation carrier, as well as all compensation paid, during the previous five (5) calendar years. (7-1-21)T
 - f.** Excess Insurance. Provide an insurance plan that must include excess insurance coverage and copies of all proposed policies of excess worker's compensation insurance coverage. (7-1-21)T

- g.** Actuarial Study. Provide an actuarial study prepared by a qualified actuary determining adequate rates for the proposed self-funded worker's compensation plan based upon a fifty percent (50%) confidence level. (7-1-21)T
- h.** Feasibility Study. Provide a self-insurance feasibility study that includes an analysis of the advantages and disadvantages of self insurance as compared to current coverage, and the related costs and benefits. (7-1-21)T
- i.** Custodial Agreement. Set up a custodial agreement with the State Treasurer for securities required to be deposited under Sections 72-301 and 72-302, Idaho Code. (7-1-21)T
- j.** Supplemental Information. Provide supplemental information as requested. (7-1-21)T
- k.** Initial Security Deposit. Prior to final approval, deposit an initial security deposit with the Idaho State Treasurer in the form permitted by Section 72-301, Idaho Code, or a self-insurer's bond in substantially the form as the Commission's self-insurer's compensation bond, available on the Commission's website, in the amount of one hundred fifty thousand dollars (\$150,000), plus five percent (5%) of the first ten million dollars (\$10,000,000) of the employer's average annual Payroll in the state of Idaho for the three (3) preceding years; along with such additional security as may be required by the Commission based on prior claims history. (7-1-21)T
- l.** Initial Guaranty Agreement. The Commission may allow or, where financial reports or other factors such as the high risk industry of the employer indicate the need, require an employer that is organized as a joint venture or a wholly owned subsidiary to provide a guaranty agreement from each member of the joint venture or the parent company. This guaranty agreement confirms the continuing agreement of each of the joint venture members or the parent company to guarantee the payment of all Idaho worker's compensation claims of employees of that joint venture or subsidiary employer. The guaranty agreement shall be in substantially the same form as the current sample Indemnity and Guaranty Agreement and, as applicable, the companion Consent of the Board of Directors, available on the Commission's website. (7-1-21)T
- m.** Written Approval. Obtain written approval from the Industrial Commission. (7-1-21)T
- n.** Idaho National Laboratory. An employer meeting the requirements of Section 72-301A, Idaho Code, does not have to comply with the requirements of Paragraphs 302.02.a., 02.f., 02.i., and 02.k., above. (7-1-21)T

302. RULES GOVERNING CONTINUING REQUIREMENTS TO UNDERWRITE INSURANCE OR SELF-INSURE.

- 01. Insurance Carriers.** An insurance carrier approved under IDAPA 17.01.01.301.01 shall comply with the following requirements: (7-1-21)T

 - a.** Maintain Statutory Security Deposits with the State Treasurer. (7-1-21)T

 - i.** Each insurance carrier shall maintain with the Idaho State Treasurer a security deposit in the amount of twenty-five thousand dollars (\$25,000) if approved by the Commission prior to July 15, 1988, or two hundred and fifty thousand dollars (\$250,000) if approved subsequently. (7-1-21)T
 - ii.** In addition to the security required in Subsection 01.a.i, of this rule, each insurance carrier shall deposit an amount equal to the total unpaid outstanding awards of said insurance carrier. Such deposit shall be in the form permitted by Section 72-301, Idaho Code. Surety bonds shall be in the form available on the Commission's website. If a surety bond is deposited, the surety company shall be completely independent of the principal and authorized to transact such business in the state of Idaho. A partial release of security deposited hereunder must be requested in writing and approved by the Commission. (7-1-21)T
 - iii.** Securities which are maintained to satisfy the requirements of this rule may be held in the federal reserve book-entry system, as defined in Section 41-2870(4), Idaho Code, and interests in such securities may be

transferred by bookkeeping entry in the federal reserve book-entry system without physical delivery of certificates representing such securities. (7-1-21)T

b. Appoint Agent for Service of Process. Each insurance carrier shall appoint the Director of the Department of Insurance as its agent to receive service of legal process. (7-1-21)T

c. Maintain Resident Idaho Office. Each insurance carrier shall maintain a Claims Administrator employing an Idaho licensed resident adjuster or the carrier's own adjusting offices or officers residing in Idaho. (7-1-21)T

i. Each authorized insurance carrier shall notify the Commission Secretary in writing of any change of the designated resident adjuster(s) for every insured Idaho employer within fifteen (15) days of such change. (7-1-21)T

ii. Each authorized insurance carrier will ensure that every in-state adjuster can classify and identify all claims adjusted on behalf of said insurance carrier, and that the in-state adjuster will provide such information to the Industrial Commission upon request. Further each in-state Adjustor must have full authority to: (7-1-21)T

(1) Investigate and adjust all claims for compensation; (7-1-21)T

(2) Pay all compensation benefits due; (7-1-21)T

(3) Accept service of claims, applications for hearings, orders of the Commission, and all process which may be issued under the Worker's Compensation Law; (7-1-21)T

(4) Enter into compensation agreements and LSSs with Claimants; (7-1-21)T

(5) Provide at the employer's expense necessary forms to any employee who wishes to file a Claim under the Worker's Compensation Law. (7-1-21)T

d. Supply Forms. Each insurance carrier shall distribute the required forms prescribed by the Commission to all employers it insures. A list of required forms is available on the Commission's website. (7-1-21)T

e. Comply with Industrial Commission Reporting Requirements. Each insurance carrier shall, within the time prescribed, file such reports and respond to such information requests as the Commission may require from time to time concerning matters under the Worker's Compensation Law. (7-1-21)T

f. Report Proof of Coverage. (7-1-21)T

i. Each insurance carrier shall report all proof of coverage to NCCI. NCCI is the designated agent to receive, process, and forward the proof of coverage information required by these rules to the Commission. The address of the Commission's designated agent is available on the Commission's website. (7-1-21)T

ii. The Industrial Commission adopts the IAIABC's electronic proof of coverage record layout and transaction standards as the required reporting mechanism for new policies, renewal policies, endorsements, cancellations, and non-renewals of policies. A copy of the record layout, data element requirements, and transaction standards is available on the Commission's website. Each insurance carrier shall report data for all mandatory elements in the current IAIABC proof of coverage record layout and transaction standards on each policy reported. (7-1-21)T

iii. The most recent proof of coverage information contained in the Industrial Commission's database shall be presumed to be correct for the purpose of determining the insurance carrier providing coverage. (7-1-21)T

g. Report New Policy, Renewal Policy, and Endorsement Information Within Thirty Days. Each insurance carrier shall report the issuance of any new worker's compensation policy, renewal policy, or endorsement to the Industrial Commission or its designated agent within thirty (30) days of the effective date of the transaction. (7-1-21)T

h. Report Cancellation and Non-Renewal of Policy Within Time Prescribed by Statute. Each insurance carrier shall report the cancellation and/or nonrenewal of any worker's compensation insurance policy to the Industrial Commission or its designated agent within the time frames prescribed by Section 72-311, Idaho Code. Receipt of cancellation or nonrenewal notices by the Commission's designated agent shall be deemed to have been received by the Commission. (7-1-21)T

i. Report Election of Coverage on Form IC52 or Similar Format. Each insurance carrier shall report election of coverage or revocation of election of coverage on or in a format substantially the same as Form IC52, "Election of Coverage," available on the Commission's website. (7-1-21)T

j. Report Deductible Policy. On or before March 3rd of each year, every insurance carrier shall submit a report of all deductible policies that were issued and in effect during the previous calendar year. That report shall be submitted in a form substantially similar to the current "Deductible Policy Report" available on the Commission's website. The report shall include the following information: insured name, policy number, effective and expiration dates, deductible amount, the premium charged for the policy before credit for the deductible, and the final premium after credit for the deductible. (7-1-21)T

k. Report Outstanding Awards. Each insurance carrier shall report to the Industrial Commission at the end of each calendar quarter, or more often as required by the Commission, any outstanding award. (7-1-21)T

i. The report of outstanding awards shall be filed with the Industrial Commission by the end of the month following the end of each calendar quarter. (7-1-21)T

ii. The report shall be filed even if there are no outstanding awards. In that event, the carrier shall certify the fact that there are no outstanding awards to be reported. (7-1-21)T

iii. The report shall be submitted on or in a format that is substantially the same as the current Form IC36A, "Report of Outstanding Awards - Insurance Carriers" available on the Commission's website. The report may be produced as a computerized spreadsheet or database printout. (7-1-21)T

iv. The report shall be signed and certified to be correct by a corporate officer. If an insurance carrier has designated more than one adjuster for worker's compensation claims in Idaho, a corporate officer of the insurance carrier shall prepare, certify, and file a consolidated report of outstanding awards. (7-1-21)T

v. The report shall list all outstanding awards, commencing with the calendar quarter during which the award is made or benefits are first paid, whichever occurs earlier. (7-1-21)T

l. Comply with Law and Rules. Each insurance carrier shall comply with the statutes of the state of Idaho and the rules of the Industrial Commission to ensure that payments of compensation shall be sure and certain and not unnecessarily delayed. (7-1-21)T

02. Self-Insured Employers. A self-insured employer approved under Subsection 301.02 shall comply with the following requirements: (7-1-21)T

a. Payroll Requirements. Maintain an average annual Idaho Payroll over the preceding three (3) years of at least four million dollars (\$4,000,000). Any self-insured employer that does not meet the Payroll requirement of this rule for two consecutive semi-annual premium tax reporting periods shall be allowed to maintain their self-insured status for six (6) months from the end of the last reporting period in order to permit them time to increase their Payroll or obtain worker's compensation coverage with an insurance carrier authorized to write worker's compensation insurance in the state of Idaho. (7-1-21)T

b. Security Deposit with Treasurer. (7-1-21)T

i. Maintain a primary security deposit with the Idaho State Treasurer in the form permitted by Section 72-301, Idaho Code, a self-insurer's bond form available on the Commission's website, or in substantially the same form, or in such other form approved by the Commission, in the amount of one hundred fifty thousand dollars

(\$150,000), plus five percent (5%) of the employers' average annual Payroll in the state of Idaho for the three (3) preceding years, not in excess of ten million dollars (\$10,000,000). If a surety bond is deposited, the surety company shall be completely independent of the principal and authorized to transact such business in the state of Idaho. In addition thereto, the self-insured employer shall deposit additional security in such amount as the Commission determines is necessary to secure the self-insured employer's total unpaid liability for compensation under the Worker's Compensation Law. No approved security shall be accepted for deposit above its par value. Additional deposits of approved security may be required semi-annually if the market value of an approved investment falls below its par value or if the total value of the employer's security deposit falls below the total security required to be maintained on deposit when calculated in accordance with this rule. (7-1-21)T

ii. Self-insured employers shall receive a credit for the primary security deposit against the self-insured employer's obligation to post the additional security required by Subparagraph 302.02.b.i. of this rule. (7-1-21)T

iii. Excess insurance coverage approved by the Commission may apply as a credit against the self-insured employer's obligation to post the additional security required by Subparagraph 302.02.b.i. of this rule. The Commission must be provided with thirty (30) days advance written notice of any change or cancellation of an approved excess insurance policy. No credit will be given for any excess insurance coverage provided by a surplus lines carrier, as described in Chapter 12, Title 41, Idaho Code. (7-1-21)T

iv. All security deposited by the self-insured employer shall be maintained as provided by Section 72-302, Idaho Code. (7-1-21)T

v. Any withdrawal or partial release of security deposited hereunder must be requested in writing and approved by the Commission. (7-1-21)T

c. Continue or Provide Guaranty Agreement. (7-1-21)T

i. A self-insured employer that is organized as a joint venture or a wholly owned subsidiary shall continue in effect any guaranty agreement that the Commission has previously allowed or required, until termination is permitted by the Commission. (7-1-21)T

ii. Where an adverse change in financial condition or other relevant factors such as claims history or industry risk indicates the need, a self-insured employer that is organized as a joint venture or a wholly owned subsidiary may be allowed to, or shall upon request, provide a guaranty agreement from each member of the joint venture or the parent company. This guaranty agreement confirms the continuing agreement of each of the joint venture members or the parent company to guarantee the payment of all Idaho worker's compensation claims of employees of that joint venture or subsidiary self-insured employer. The guaranty agreement shall be in substantially the same form as the current sample Indemnity and Guaranty Agreement, and as applicable, the companion Consent of the Board of Directors, available on the Commission's website. (7-1-21)T

d. Maintain a Licensed Resident Adjuster. Maintain an Idaho licensed, resident claims adjuster located within the state of Idaho who shall have full authority to make decisions and to authorize the payment of all compensation on said claims on behalf of the employer including, but not limited to, the following: (7-1-21)T

i. Investigate and adjust all claims for compensation; (7-1-21)T

ii. Pay all compensation benefits due; (7-1-21)T

iii. Accept service of claims, applications for hearings, orders of the Commission, and all process which may be issued under the Worker's Compensation Law; (7-1-21)T

iv. Enter into compensation agreements and LSSs with Claimants; (7-1-21)T

v. Provide at the employer's expense necessary forms to any employee who wishes to file a Claim under the Worker's Compensation Law. (7-1-21)T

e. File Reports. Report to the Industrial Commission semi-annually, or more often as required by the Commission, total unpaid liability on all open claims. (7-1-21)T

i. The semi-annual report of total unpaid liability shall be filed with the Industrial Commission by the end of the months of January and July. (7-1-21)T

ii. The report shall provide the aggregate number of open claims, including indemnity with medical and Medical Only Claims, along with the amount of any compensation paid on open claims, as of the end of each June and December. (7-1-21)T

iii. The report shall be filed even if there are no open claims. In that event, the employer shall certify the fact that there are no open claims to be reported. (7-1-21)T

iv. The report shall be submitted on or in a format that is substantially the same as the current Form IC-211, “Self-Insured Employer Report of Total Unpaid Liability,” available on the Commission's website. The report may be produced as a computerized spreadsheet or database printout. (7-1-21)T

v. The report shall be signed and certified to be correct by a corporate officer. If an employer has designated more than one adjuster for worker's compensation claims in Idaho, a corporate officer of the employer shall prepare, certify, and file a consolidated report of all unpaid liability. (7-1-21)T

vi. A self-insured employer shall also make, within the time prescribed, such other reports and respond to such information requests as the Commission may require from time to time concerning matters under the Worker's Compensation Law. (7-1-21)T

f. Submit to Audits by Industrial Commission. Each year a self-insured employer shall provide the Industrial Commission with a copy of its annual financial statements, or other acceptable documentation. Each self-insured employer shall submit to audit by the Commission or its designee at any time and as often as it requires to verify the amount of premium such self-insured employer would be required to pay as premium to the State Insurance Fund, and to verify compliance with the provisions of these rules and the Idaho Worker's Compensation Law. For the purpose of determining such premium for uninsured contractors of a self-insured employer, the most recent proof of coverage information contained in the Industrial Commission's database shall be presumed to be correct for the purpose of determining such coverage. (7-1-21)T

g. Comply with Law and Rules. Comply with the statutes of the state of Idaho and the rules of the Industrial Commission to the end that payment of compensation shall be sure and certain and not unnecessarily delayed. The Commission may withdraw its approval of any employer to operate as a self-insurer if it shall appear to the Commission that workers secured by said self-insured employer are not adequately protected and served, or the employer is failing to comply with the provisions of these rules or the Worker's Compensation Law. (7-1-21)T

h. Idaho National Laboratory. An employer meeting the requirements of Section 72-301A, Idaho Code, does not have to comply with Paragraph 303.02.a. and 302.02.b., above. (7-1-21)T

303. RULE GOVERNING THE COLLECTION OF PREMIUM TAX ON WORKER'S COMPENSATION INSURANCE POLICIES.

This rule governs the collection of premium tax on worker's compensation insurance policies. This procedure applies to all worker's compensation policies. (7-1-21)T

01. Procedure for Submitting Premium Tax Forms. The form IC 4008, available on the Commission's website, shall be used to report numbers of policies and the total gross premiums written. The original shall be sent to the Commission; a copy shall also be attached to the reporting entity's annual premium tax statement that is filed with the Idaho Department of Insurance. This form is due to the Commission by July 31 for the reporting period of January 1 through June 30; it is due by March 3 for the reporting period of July 1 through December 31. (7-1-21)T

304. RULE GOVERNING PREMIUM TAX COMPUTATION FOR SELF-INSURED EMPLOYERS.

01. Payroll Reports. No later than March 3rd and July 31st, self-insured employers shall file a semi-annual premium tax report with the Fiscal Department of the Commission. Self-insured employers shall use the Commission's current report form IC 4010, along with the accompanying computation form IC 4010a, available on the Commission's website. The premium tax payment due from a self-insured employer shall be based upon the manual premium calculated for each reporting period, as modified by an experience modification factor calculated by NCCI and submitted to the Commission in accordance with Subsection 304.02 of this rule. No other rating factor shall be allowed. If the self-insured employer elects to not provide such experience modification factor, the premium tax will be computed based upon the manual premium only. (7-1-21)T

02. Experience Modification. A self-insured employer that elects to use an experience modification factor in computing premium tax shall make an annual application to NCCI for an experience modification factor using the NCCI form ERM-6 and paying to NCCI any fees charged for providing that calculation. An NCCI experience modification factor may only be based on the employer's Idaho operations for which self-insured status is authorized. In order to have an experience modification factor considered for any reporting period, an employer must timely submit to the Commission's Fiscal Department: (7-1-21)T

- a. A copy of the completed form ERM-6 filed with NCCI; (7-1-21)T
- b. The resulting experience modification factor received from NCCI; and (7-1-21)T
- c. The completed IC 4010 Semi-Annual Premium Tax Form for Self-Insurers and IC 4010a Computation Form. (7-1-21)T

305. REQUIREMENTS FOR MAINTAINING IDAHO WORKER'S COMPENSATION CLAIMS FILES.

All insurance carriers, self-insured employers, and licensed adjusters servicing Idaho worker's compensation claims shall comply with the following requirements: (7-1-21)T

- 01. Idaho Office.** (7-1-21)T
 - a. All insurance carriers, self-insured employers, and licensed adjusters servicing Idaho worker's compensation claims shall maintain an office within the state of Idaho. The offices shall be staffed by adequate personnel to conduct business. (7-1-21)T
 - b. The insurance carrier or self-insured employer shall authorize and require a member of its in-state staff or an Idaho licensed resident adjuster to service and make decisions regarding claims pursuant to Section 72-305, Idaho Code. (7-1-21)T
 - c. As staffing changes occur and, at least annually, the insurance carrier, self-insured employer, or licensed adjuster shall submit to the Commission Secretary the names of those authorized to make decisions regarding claims pursuant to Section 72-305, Idaho Code. Each authorized insurance carrier shall designate only one (1) Claims Administrator for each policy of worker's compensation insurance. (7-1-21)T

02. Claim Files. All Idaho worker's compensation claim files shall be maintained within the state of Idaho in either hard copy or immediately accessible electronic format. Claim files shall include, but are not limited to: (7-1-21)T

- a. FROI and Claim for Benefits; (7-1-21)T
- b. Copies of bills for medical care; (7-1-21)T
- c. Copy of lost-time computations, if applicable; (7-1-21)T
- d. Correspondence reflecting reasons for any delays in payments, the resolution of such delays, and acceptance or denial of compensability; (7-1-21)T
- e. Employer's Supplemental Report; and (7-1-21)T

- f. Medical reports. (7-1-21)T
- 03. Correspondence.** All original correspondence involving adjusting decisions regarding Idaho worker's compensation claims shall be authorized from and maintained at in-state offices. (7-1-21)T
- 04. Date Stamp.** Each of the documents listed in Subsections 305.02 and 305.03, above, shall be date-stamped with the name of the receiving office on the day received, and by each receiving agent or vendor acting on behalf of the claims office. (7-1-21)T
- 05. Notice and Claim.** All First Reports of Injury, Claims for Benefits, notices of occupational illnesses, and fatalities shall be sent directly to the in-state adjuster for the insurance carrier or self-insured employer. The original copy of the FROI, Claim for Benefits, and notices of occupational illness and fatality shall be sent directly to the Industrial Commission. (7-1-21)T
- 06. Compensation Payments - Generally.** (7-1-21)T
- a. All compensation, as defined by Section 72-102, Idaho Code, must be issued from the in-state office. (7-1-21)T
- b. Except as ordered otherwise by the Commission, the insurance carrier or self-insured employer may make compensation payments by either: (7-1-21)T
- i. Check or other readily negotiable instrument; (7-1-21)T
- ii. When requested by the Claimant, electronic transfer payment to an account designated by the Claimant in accordance with the requirements of Subsection 305.07; or (7-1-21)T
- iii. When requested by the Claimant, electronic transfer payments made through an access card; if that option is made available by the carrier or self-insured employer, in accordance with the requirements of Subsection 305.08. (7-1-21)T
- c. If the Claimant is represented by an attorney who may have an attorney's lien for fees due on such compensation payments, the attorney must agree to payment by electronic transfer to Claimant's account or payment through an access card before such compensation may be paid other than by a check made payable to the Claimant and the attorney. (7-1-21)T
- 07. Electronic Transfer Payments.** (7-1-21)T
- a. A Claimant may request that the insurance carrier or self-insured employer make compensation payments by electronic transfer to a personal bank account by providing the insurance carrier or self-insured employer in writing: the name and routing transit number of the financial institution and the account number and type of account to which the Claimant wants to have the compensation electronically transferred. The insurance carrier or self-insured employer shall provide the Claimant with a written form to fill out the required information by this subsection within seven (7) days of receiving a request for electronic transfer of payments from the Claimant unless the Claimant has already completed an on-line electronic form provided by the carrier or employer. (7-1-21)T
- b. The insurance carrier or self-insured employer may make compensation payments to the Claimant by electronic transfer to an account designated by the Claimant if the Claimant: (7-1-21)T
- i. Requests in writing that payment be made by electronic transfer; (7-1-21)T
- ii. Provides the information required by Paragraph 305.07.a. above; and (7-1-21)T
- iii. Is reasonably expected to be entitled to receive compensation payments for a period of eight (8) weeks or more from the point that Subparagraphs 305.07.b.i. and 07.b.ii. are satisfied. (7-1-21)T

c. The insurance carrier or self-insured employer shall initiate payment by electronic transfer starting with the first benefit payment due on or after the twenty first day after the requirements of Paragraph 305.07.b., above are met, but shall continue to make timely payments by check until the insurance carrier or self-insured employer initiates benefit payment delivery by electronic transfer. (7-1-21)T

d. If the Claimant has previously been receiving benefit payments by electronic transfer and wants to receive benefits by check, the insurance carrier or self-insured employer shall initiate benefit payment delivery by check starting with the first benefit payment due to the Claimant on or after the seventh day after receiving a written request for such payments. (7-1-21)T

08. Access Card Payments. (7-1-21)T

a. Access card means any card or other payment method that may be used by a Claimant to initiate electronic fund transfer from an insurance carrier's or a self-insured employer's bank account. The term “access card” does not include stored value cards or prepaid cards that store funds directly on the card and that are not linked to an insurance carrier's or a self-insured employer's bank account. (7-1-21)T

b. An insurance carrier or a self-insured employer may pay compensation through an access card to a Claimant if there is written mutual agreement signed by the insurance carrier or self-insured employer and the Claimant. The insurance carrier or self-insured employer shall maintain accurate records of the mutual agreement for, at a minimum, four hundred and one (401) weeks from the date of injury. The written agreement shall contain an acknowledgment that the Claimant received and agreed to the written disclosure required by Paragraph 305.08.d. (7-1-21)T

c. An insurance carrier or a self-insured employer providing compensation payments to a Claimant through an access card shall: (7-1-21)T

i. Permit the Claimant to withdraw the entire amount of the balance of an access card in one transaction; (7-1-21)T

ii. Not reduce compensation payments paid to a Claimant through an access card for the following fees, surcharges, and adjustments: (7-1-21)T

(1) Overdraft services under which a financial institution pays a transaction (including a check or other item) when the Claimant has insufficient or unavailable funds in the account; (7-1-21)T

(2) ATM withdrawal or point of sale purchase for more than the card holds and the transaction is denied; (7-1-21)T

(3) ATM balance inquiries; (7-1-21)T

(4) Withdrawing money from network ATMs; (7-1-21)T

(5) Withdrawing money from a teller; (7-1-21)T

(6) Customer service calls; (7-1-21)T

(7) Activating the card; (7-1-21)T

(8) Fees for card inactivity; (7-1-21)T

(9) Closing account; (7-1-21)T

(10) Access card replacement through standard mail; (7-1-21)T

(11) Withdrawing the entire payment in one transaction; (7-1-21)T

- (12) Point of sale purchases, or (7-1-21)T
- (13) Any other fees or charges that are not authorized under Subparagraph 305.08.c.iii., and (7-1-21)T
- iii. Only permit a Claimant to be charged for the following: (7-1-21)T
 - (1) Fees for access card replacement through an expedited mail service; (7-1-21)T
 - (2) International transaction fees, and (7-1-21)T
 - (3) Out-of-network ATM fees. (7-1-21)T
- d.** Insurance carriers or self-insured employers shall provide a written disclosure to the Claimant contemporaneously with the written mutual agreement required under Paragraph 305.08.b. that includes: (7-1-21)T
 - i. A summary of the Claimant's liability for unauthorized electronic fund transfers; (7-1-21)T
 - ii. The telephone number and address of the person or office to be notified when the Claimant believes that an unauthorized electronic fund transfer has been or may be made; (7-1-21)T
 - iii. The type of electronic fund transfers that the Claimant may make and any limitations on the frequency of transfers; (7-1-21)T
 - iv. Any fees imposed for electronic fund transfers or for the right to make transfers, including a statement that fees may be imposed by an ATM operator that is out-of-network; (7-1-21)T
 - v. Fees for expedited card replacement or international transaction fees will be removed from the balance maintained in the bank account linked to the access card; (7-1-21)T
 - vi. A summary of the Claimant's right to receipts and periodic statements; (7-1-21)T
 - vii. All bank locations and network ATMs in the United States where the Claimant may access his or her funds at no cost; (7-1-21)T
 - viii. A statement informing the Claimant that they have a right to receive payments directly into their personal bank account through direct deposit or by check. (7-1-21)T
- e.** An insurance carrier or a self-insured employer shall provide the written disclosure and any notice of term or condition changes required under Paragraph 305.08.d. that: (7-1-21)T
 - i. Are printed in not less than twelve (12) point font; (7-1-21)T
 - ii. Include the full text to communicate all terms and conditions; (7-1-21)T
 - iii. Are written in a clear and coherent manner and wherever practical, words with common and everyday meaning shall be used to facilitate readability; and (7-1-21)T
 - iv. Are appropriately divided and captioned in a meaningful sequence such that each section contains an underlined, boldfaced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature of the subject matter included in or covered by the section. (7-1-21)T
- f.** An access card issued to a Claimant under this Subsection 305.08 shall: (7-1-21)T
 - i. Not bear any information that could reasonably identify the Claimant as a participant in the worker's compensation system; and (7-1-21)T
 - ii. Include on the front or back of the access card a toll-free customer service number and website

address. Customer service personnel shall be available by phone Monday through Friday during normal business hours (9 a.m. to 6 p.m. Mountain Time). (7-1-21)T

g. The insurance carrier or self-insured employer shall provide a written notice to the Claimant at least twenty one (21) days before the effective date of any change in a term or condition of the mutual agreement or disclosure, including terminating the access card program, increased fees, or liability for unauthorized electronic fund transfers. Any terms or conditions that violate the requirements of this Subsection 305.08 are null and void and may result in administrative action against the carrier or employer. An insurance carrier or employer shall provide a written notice of term or condition changes that: (7-1-21)T

i. Provides a comparison of the current terms and the changes; and (7-1-21)T

ii. References the Claimant's ability to request a change in method of payment to electronic fund transfer to his or her personal bank account in accordance with Subsection 305.07 or to payment by check. (7-1-21)T

h. An insurance carrier or a self-insured employer may close the access card account by issuing a check to the Claimant with the remaining balance of the access card if the account has been inactive for twelve (12) months or longer. (7-1-21)T

i. The insurance carrier or self-insured employer shall not remove money from the Claimant's account or access card except to remove permitted fees under Subparagraph 305.08.c.iii. or to close the account for inactivity of a period of twelve (12) months or more. An insurance carrier or a self-insured employer seeking to recoup overpayments shall follow the requirements of section 72-316, Idaho Code. (7-1-21)T

j. An insurance carrier or a self-insured employer is considered to have made a compensation payment the date the payment is available on the Claimant's access card. (7-1-21)T

09. Checks and Drafts. Checks must be signed and issued within the state of Idaho; drafts are prohibited. (7-1-21)T

a. The Commission may, upon receipt of a written Application for Waiver, grant a waiver from the provisions of Subsections 305.06 and 305.09 of this rule to permit an insurance carrier or a self-insured employer to sign and issue checks outside the state of Idaho. (7-1-21)T

b. An Application for Waiver must be accompanied by an affidavit signed by an officer or principal of the insurance carrier or self-insured employer, attesting to the fact that the insurance carrier or self-insured employer is prepared to comply with all statutes and rules pertaining to prompt payments of compensation. (7-1-21)T

c. All waivers shall be effective from the date the Commission issues the order granting the waiver. A waiver shall remain in effect until revoked by the Industrial Commission. At least annually, staff of the Industrial Commission may review the performance of any insurance carrier or self-insured employer for which a waiver under this rule has been granted to assure that the insurance carrier or self-insured employer is complying with all statutes and rules pertaining to prompt payments of compensation. (7-1-21)T

d. If at any time after the Commission has granted a waiver, the Commission receives information permitting the inference that the insurance carrier or self-insured employer has failed to provide timely benefits to any Claimant, the Commission may issue an order to show cause why the Commission should not revoke the waiver; and, after affording the insurance carrier or self-insured employer an opportunity to be heard, may revoke the waiver and order the insurance carrier or self-insured employer to comply with the requirements of Subsections 305.06 and 305.09 of this rule. (7-1-21)T

10. Copies of Checks. Copies of checks and/or electronically reproducible copies of the information contained on the checks must be maintained in the in-state files for Industrial Commission audit purposes. A copy of the first income benefit check, showing signature and date, shall be sent to the Industrial Commission the same day of issuance. (7-1-21)T

11. Prompt Claim Servicing. Prompt claim servicing includes, but is not limited to: (7-1-21)T

a. Making an initial decision to accept or deny a Claim for an injury or occupational disease within thirty (30) days of the date the Claims Administrator receives knowledge of the same. The worker shall be given notice of that initial decision in accordance with Section 72-806, Idaho Code. Nothing in this rule shall be construed as amending the requirement to start payment of income benefits no later than four (4) weeks or twenty-eight (28) days from the date of disability under the provisions of Section 72-402, Idaho Code. (7-1-21)T

b. Payment of medical bills in accordance with the provisions of Section 803 of these rules. (7-1-21)T

c. Payment of income benefits on a weekly basis, unless otherwise approved by the Commission. (7-1-21)T

i. The first payment of income benefits under Section 72-408, Idaho Code, shall constitute application by the insurance carrier or self-insured employer for a waiver to pay Temporary Total Disability (TTD) benefits on a bi-weekly basis, Temporary Partial Disability (TPD) benefits on other than a weekly basis, Permanent Partial Disability (PPD) benefits based on permanent impairment and Permanent Total Disability (PTD) benefits every twenty-eight (28) days, rather than on a weekly basis. (7-1-21)T

ii. Such waiver application shall be granted upon receipt and remain in effect unless revoked by the Industrial Commission in accordance with Subparagraph 305.11.c.iii. (7-1-21)T

iii. If at any time after a waiver has been granted pursuant to this section the Commission receives information permitting the inference that the insurance carrier or self-insured employer has failed to service claims in accordance with Idaho law, or that such waiver has created an undue hardship on a Claimant, the Commission may issue an order to show cause why the Commission should not revoke that waiver, and after affording the insurance carrier or employer an opportunity to be heard, may revoke the waiver with respect to all or certain Claimants and order the insurance carrier or self-insured employer to comply with the requirements of Subsection 305.11.c. of this rule. (7-1-21)T

d. Payment of the first Permanent Partial Disability (PPD) benefit based on permanent impairment no later than fourteen (14) days after receipt of the Medical Report providing the impairment rating. The first payment shall include payment of benefits retroactive to the date of medical stability. (7-1-21)T

e. Temporary Partial Disability (TPD) payments shall be calculated using the employee's pay period, whether weekly, bi-weekly, or semi-monthly. For employees paid pursuant to any other schedule, TPD benefits shall be calculated semi-monthly. TPD payments owed for a particular pay period shall issue no later than seven (7) days following the date on which employee is ordinarily paid for that pay period. (7-1-21)T

12. Audits. The Industrial Commission will perform periodic audits to ensure compliance with the above requirements. (7-1-21)T

13. Non-Compliance. Non-compliance with the above requirements may result in the revocation of the authority of an insurance carrier to write worker's compensation insurance or self-insured employer to self-insure its worker's compensation insurance obligations in the state of Idaho, or such lesser sanctions as the Industrial Commission may impose. (7-1-21)T

306. RULE PROHIBITING USE OF SICK LEAVE OR OTHER ALTERNATIVE COMPENSATION.

01. Employee Not Required to Take Sick Leave in Lieu of Compensation. No employer obligated to pay worker's compensation benefits to an employee as provided by the Worker's Compensation Law may require an employee to accept "sick leave" or other comparable benefit in lieu of the worker's compensation benefits provided by law. Section 72-318(2), Idaho Code, specifically provides that no agreement by an employee to waive his rights to compensation under the Worker's Compensation Law shall be valid. (7-1-21)T

02. Election of Sick Leave or Alternative Compensation Prohibited. Further, an employee may not elect to accept "sick leave" or other comparable benefit from an employer in lieu of worker's compensation benefits to which the employee is entitled under the Worker's Compensation Law. (7-1-21)T

307. RULE GOVERNING REPORTING INDEMNITY AND MEDICAL PAYMENTS AND MAKING PAYMENT OF INDUSTRIAL SPECIAL INDEMNITY FUND ASSESSMENT.

Pursuant to Section 72-327, Idaho Code, the state insurance fund, every authorized insurance carrier, and self-insured employer in Idaho shall report annually to the Industrial Commission the total gross amount of medical only and Indemnity Benefits paid on Idaho worker's compensation claims during the applicable reporting period. This report is used to calculate the pro rata share of the annual assessment for the ISIF, under Section 72-327, Idaho Code.

(7-1-21)T

01. Filing. The report of indemnity and medical payments shall be filed with the Industrial Commission simultaneously with the first Semi-Annual Premium Tax Report; which, pursuant to Section 72-523, Idaho Code, is due each year on March 3rd.

(7-1-21)T

02. Form. The report of indemnity and medical payments shall be submitted in writing on, or in a format substantially the same as the current Form IC2-327, available on the Commission's website.

(7-1-21)T

03. Report Required When No Indemnity Paid. If an entity required to report under this rule has no claims against which indemnity or medical payments have been made during the reporting period, a report shall be filed so indicating.

(7-1-21)T

04. Penalty for Late Filing. A penalty shall be assessed by the Commission for filing the report of indemnity and medical payments later than March 3rd each year.

(7-1-21)T

a. A penalty of two hundred dollars (\$200) for late filing of seven (7) days or less.

(7-1-21)T

b. A penalty of one hundred dollars (\$100) per day for late filing of more than seven (7) days.

(7-1-21)T

c. A penalty assessed by the Commission shall be payable to the Industrial Commission and be submitted with the April 1 payment of the ISIF assessment, following notice by the Commission of the penalty assessment.

(7-1-21)T

05. Estimating Indemnity Payments for Entities That Fail to Report Timely. If an entity required to report indemnity payments under these rules fails to report within the time allowed in these rules, the Commission will estimate the indemnity payments for that entity by using the indemnity amount reported for the preceding reporting period and adding twenty percent (20%).

(7-1-21)T

06. Adjustment for Overpayments or Underpayments. Overpayments or underpayments, including those resulting from estimating the indemnity payments of entities that fail to report timely, will be adjusted on the billing for the subsequent period.

(7-1-21)T

308. – 400. (RESERVED)

401. RULE GOVERNING COMPUTATION OF AVERAGE WEEKLY WAGE.

01. Amounts Paid over Base Rate. Sums paid by an employer to an employee, over and above the base rate of compensation agreed upon by the employer and the employee in a contract of hire, which are contingent and dependent upon the employee's increased physical exertion and/or efficiency shall be included in computing the employee's average weekly wage pursuant to Section 72-419(4)(a), Idaho Code. Said sums shall not be considered premium pay.

(7-1-21)T

02. Fringe Benefits. Also, in computing the average weekly wage, it shall be presumed that wages include, but are not limited to, cost of living increases, vacation pay, holiday pay, and sick leave.

(7-1-21)T

03. Premium Pay. Further, in computing the average weekly wage, it shall be presumed that premium pay includes, but is not limited to, shift differential pay and overtime pay.

(7-1-21)T

04. Examples Not Exclusive. The above-listed examples shall not be taken as exclusive in computing the average weekly wage. (7-1-21)T

402. RULE GOVERNING CONVERSION OF IMPAIRMENT RATINGS TO “WHOLE MAN” STANDARD.

01. Converting Single Rating of Body Part to Whole Person Rating. Impairment ratings shall be converted in accordance with the Industrial Commission Schedule, Section 72-428, Idaho Code, with the base of five hundred (500) weeks for the whole man. (7-1-21)T

02. Averaging Multiple Ratings. Where more than one (1) evaluating physician has given ratings, these shall be converted to the statutory percentage of the whole man, and averaged for the applicable rating. (7-1-21)T

03. Correcting Manifest Injustice. In the event that the Commission deems a manifest injustice would result from the above ruling, it may at its discretion take steps necessary to correct such injustice. (7-1-21)T

403. RULE GOVERNING COMPENSATION FOR DISABILITY DUE TO LOSS OF TEETH.

01. Compensation for Disability. A Claimant under the Worker's Compensation Law shall be entitled to compensation for permanent disability for the loss of each tooth other than wisdom teeth at the rate of one tenth of one percent (.1%) of the whole man. The loss of wisdom teeth shall not constitute any permanent disability. Compensation hereunder shall be in addition to payments for medical services including dental appliances and bridgework necessitated by the injury and any income benefits during the period of Claimant's recovery to which the Claimant be entitled. (7-1-21)T

02. Prima Facie Evidence. This rule and schedule shall be prima facie evidence of the percentage of permanent disability to be attributed to the loss of teeth. (7-1-21)T

404. SUBMISSION OF MEDICAL REPORTS FROM PROVIDERS

This procedure applies to all open worker's compensation claims where medical services are provided and which have not been denied by the Payor. (7-1-21)T

01. Procedure. In all cases in which a particular injury or occupational disease results in a worker's compensation Claim, the Provider shall submit written Medical Reports for each medical visit to the Payor. Payers and Providers may contract with one another to identify specific records that will be provided in support of billings. The Provider shall also submit the same written Medical Reports to the Claimant upon request. These reports shall be submitted within fourteen (14) days following each evaluation, examination, and/or treatment. The first copy of any such reports shall be provided to the Payor and the Claimant at no charge. If duplicate copies of reports already provided are requested by either the Payor or the Claimant, the Provider may charge the requesting party a reasonable charge to provide the additional reports. Whenever possible, billing information shall be coded using CPT. In the case of Hospitals, reports shall include a Uniform Billing Form 04. In the case of physicians and other Providers supplying outpatient services, this reporting requirement shall include a CMS 1500 form. (7-1-21)T

a. If an injury or occupational disease results in a Claim, the Employer/Surety or Provider shall submit written reports to the Commission upon request. Such request may either be in writing or telephonic. If a Claim is referred to the Rehabilitation Division, Medical Reports shall be furnished by the Payor or Provider directly to the office that requests such reports. The Payor or Provider shall consider this an on-going request until notice is received that the reports are no longer required. (7-1-21)T

b. If the injury or occupational disease results in a time-loss Claim, the Payor shall submit copies of medical records containing information regarding the beginning and ending of disability, releases to work whether light duty or regular duty, impairment ratings, physical restrictions to the Commission. Other Medical Reports shall be submitted to the Commission only upon request. (7-1-21)T

c. ISIF shall receive all copies of Medical Reports, without charge, from either the Claimant or the Payor, depending upon who seeks to join it as a party to a worker's compensation Claim. (7-1-21)T

d. If the Commission requests Medical Reports from the Payor or Provider, the information shall be provided within a reasonable time period without charge. If information is received for which the Commission has no need, the information may be discarded or destroyed. (7-1-21)T

02. Report Form and Content. Upon approval of the Commission, Medical Reports may be submitted in electronic or other machine-readable form usable to all parties. (7-1-21)T

03. Timely Response Requirement. When the Commission requests a Medical Report from a Payor or Provider for use in monitoring a worker's compensation Claim, the Payor or Provider shall provide the requested information promptly. (7-1-21)T

04. Forfeiture of Payment. If a Provider fails to give records to the Payor or Claimant, the Payor or Claimant may petition the Commission for an order requiring the Provider to provide the requested information. The petition shall set forth the Petitioner's efforts to obtain the information, the responses to those efforts, and why the Petitioner believes that the Provider has the information. In response to the petition, the Commission may enter an order requiring the Provider to furnish the requested records or demonstrate that the records are not available. If a Provider fails to provide records when ordered by the Commission, the Commission may enter an Order of Forfeiture. In the event such an order is entered, the Provider will forfeit its right to payment from both the Payor and Claimant, until such time as the records are provided. (7-1-21)T

405. RULE GOVERNING REIMBURSEMENT FOR TRAVEL EXPENSES.

01. Mileage Rate. If Claimant has access to, and is able to operate, a vehicle for transportation covered by Sections 72-432(13) or 72-433(3), Idaho Code, employer shall reimburse Claimant at the mileage rate then allowed by the State Board of Examiners for State employees. Such rate shall be published annually by the Industrial Commission, together with the average state wage for the upcoming period. All such miles shall be reimbursed, with fractions of a mile greater than one-half (1/2) mile rounded to the next higher mile and fractions of a mile below one-half (1/2) mile disregarded. (7-1-21)T

02. Commercial Transportation. If Claimant has no vehicle, or has access to a vehicle and is reasonably unable to utilize the vehicle for transportation covered by Sections 72-432(13) or 72-433(3), Idaho Code, Claimant's employer shall reimburse Claimant the actual cost of commercial transportation as evidenced by actual receipts. Notwithstanding the above provision, no Claimant shall be eligible for reimbursement of the actual cost of commercial transportation where such Claimant is unable to operate a motor vehicle due to the revocation or suspension of driving privileges because Claimant was under the influence of alcohol and/or drugs. (7-1-21)T

03. Request for Reimbursement. It shall be Claimant's responsibility to submit a travel reimbursement request to the employer. Such request shall be made on a form substantially the same as Industrial Commission Form IC 432(1), posted on the Commission's website. The Claimant must attach to the form a copy of a bill or receipt showing that the visit occurred. The employer shall furnish the Claimant with copies of this form. (7-1-21)T

04. Frequency of Requests. Claimant shall not request transportation reimbursement more frequently than once every thirty (30) days. However, notwithstanding this provision, should a Claimant request transportation reimbursement more frequently than every thirty (30) days, employer need not issue more than one reimbursement check in any thirty-day (30) period. (7-1-21)T

406. -- 500. (RESERVED)

501. RULE GOVERNING PROTECTION AND DISCLOSURE OF REHABILITATION DIVISION RECORDS.

01. Request for Disclosure. Pursuant to Section 74-105(10), Idaho Code, a party requesting rehabilitation records shall do so in writing and identify which provision of 74-105(10), Idaho Code, authorizes their request. (7-1-21)T

02. Requests from Other Agencies. If records are in the possession of the Rehabilitation Division by reason of an agreement to comply with valid confidentiality regulations of any agency of the state of Idaho, or agency of the United States, then disclosure shall be requested from the source agency, and not from the Rehabilitation Division. (7-1-21)T

502. RULE GOVERNING REPORTS OF ATTORNEY COSTS AND FEES IN LITIGATED CASES. When requested by the Commission, parties to a Litigated Case shall provide the Commission the information required by Section 72-528, Idaho Code. The form for Sureties is Form 1022 and the form for Claimant's attorneys is Form 1023; both are available on the Commission's website. (7-1-21)T

503. -- 600. (RESERVED)

601. SUBMISSION OF FROI AND SROI.

01. Purpose. Pursuant to Sections 72-602(1)-(2), Idaho Code, employers must submit a FROI and/or SROI in accordance with these rules. (7-1-21)T

02. EDI Reporting. The Commission requires electronic submission of FROIs and SROIs in accordance with the most current versions of the IAIABC EDI Release 3.0 and the Commission's EDI Guides and Tables from any employer not otherwise exempt by these rules. Each FROI and SROI must comply with formatting requirements and must contain the information identified as mandatory or mandatory conditional, as applicable. (7-1-21)T

03. Trading Partner Agreements. Before commencing with electronic reporting, Trading Partners shall sign a Trading Partner Agreement with the Commission, which the Commission must approve prior to submitting reports. This agreement must 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. This agreement will identify the insurance carrier, the Claims Administrator, the sender of the electronic files, and the electronic filing method. To ensure the accuracy of reported data, the Trading Partner must maintain their profile to reflect changes as they occur and the Commission may make periodic audits of Trading Partner files. In the event that a Trading Partner Agreement is entered into by a Claims Administrator, notice to the Trading Partner of a FROI shall be deemed to be notice to the underlying insurance carrier or self-insured employer. (7-1-21)T

04. Report Form and Content for Parties Exempt from EDI Requirements. (7-1-21)T

a. Individual injured workers, injured worker's legal counsel, and employers that are not insured are not required to comply with EDI requirements for FROIs and SROIs. SROIs filed on Legacy Claims will not be accepted via EDI. (7-1-21)T

b. Parties exempt from EDI requirements must submit FROIs on a form 1A-1 and SROIs on a form SROI-1, or in a format substantially similar. Both forms are available on the Commission's website. (7-1-21)T

05. Retaining Claims Files. Upon request of the Commission, insurance carriers, Claims Administrators, or 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. All insurance carriers, Claims Administrators, or employers shall retain complete copies of claims files for the life of the Claim and a minimum of five (5) years from the date of closure. (7-1-21)T

06. Filing Not an Admission. Filing a FROI 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. (7-1-21)T

07. 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. (7-1-21)T

08. 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.

(7-1-21)T

602. SUMMARIES OF PAYMENTS.

01. Summaries Requirement. A summary of payment shall be filed, in duplicate, by the surety or self-insured employer within one hundred twenty (120) days of Termination of Disability for all legacy indemnity claims upon which a surety or self-insured employer has made payments, except for those claims which are resolved by LSS. If all claim information has been provided via EDI as prescribed by Commission rules, an electronic summary of payment transaction must be filed within one hundred twenty (120) days of Termination of Disability for all Indemnity Claims. In the case of medical-only claims, no summaries of payment need to be filed. In the context of Death Claims and permanent total disability claims, interim summaries of payments shall be filed annually within the first quarter of each calendar year. Interim summaries shall be submitted setting forth substantially the same information required by Final Summaries of Payment, including the balance of payments made to the beginning of the current calendar year, payments during the calendar year, and a total of payments made. This total balance shall be carried forward as the amount of payments made to the beginning of the current year. The Final Summary shall be so designated. Supporting documentation shall be attached to any Legacy Claim summary of payment filed with the Commission. If all claim information has been filed electronically, supporting documentation must be provided upon Commission request.

(7-1-21)T

02. Form. The summary of payment for Legacy Claims shall be submitted in a format substantially similar to IC Form 6, available on the Commission's website. The final SROI transaction shall be reported electronically for non-Legacy Claims.

(7-1-21)T

03. Approval. Within ninety (90) days of receipt of the Legacy Claim Summary of Payment or SROI electronic transaction as set forth above, the Industrial Commission shall notify the surety or self-insured employer of any inability to reconcile the summary to its records and request additional information. If the surety or self-insured employer does not receive a request for additional information within the ninety (90) day period, the surety or self-insured employer may proceed with closure. In the event the Commission requests additional information, whether in writing or telephonic, the surety or self-insured employer shall submit the requested information within fifteen (15) working days. If the surety or self-insured employer is unable to furnish the requested information, the surety or self-insured employer shall notify the Commission, in writing, of its inability to respond and the reasons therefor within the fifteen (15) working days. The Commission may schedule a show cause hearing to determine whether or not the surety or self-insured employer should be allowed to continue its status under the worker's compensation laws, including whether the employer should be allowed to continue self-insured status.

(7-1-21)T

04. Change in Status of Employer. In case of any default by the Employer or in the event the Employer shall fail to pay any final award or awards, by reason of insolvency or because a receiver has been appointed, the Employer shall submit a summary of payments for every time-loss and Death Claim within one hundred twenty (120) days of the default, insolvency, or appointment of a receiver. This summary will be designated as an interim summary and does not relieve the Employer, successor or receiver from continued reporting requirements. The receiver or successor shall continue to report to the Commission, including the submission of summaries of payments and schedules of outstanding awards.

(7-1-21)T

603. -- 800. (RESERVED)

801. RULE GOVERNING CHANGE OF STATUS NOTICE TO CLAIMANTS.

01. Notice of Change of Status. As required and defined by Section 72-806, Idaho Code, a worker shall receive written notice within fifteen (15) days of any change of status or condition, including, but not limited to, whenever there is an acceptance, commencement, denial, reduction, or cessation of medical or monetary compensation benefits to which the worker might presently or ultimately be entitled. Such notice is required when benefits are curtailed to recoup any overpayment of benefits in accordance with the provisions of Section 72-316, Idaho Code.

(7-1-21)T

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

(7-1-21)T

03. Form of Notice. Any notice to a worker required by Section 72-806, Idaho Code, 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 in a format substantially similar to IC Form 8, available on the Commission's website. (7-1-21)T

04. Medical Reports. As required by Section 72-806, Idaho Code, if the change is based on a Medical Report, the party giving notice shall attach a copy of the report to the notice. (7-1-21)T

05. Copies of Notice. The party giving notice pursuant to Section 72-806, Idaho Code, 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. The party giving notice may supply the copy to the Industrial Commission in accordance with the Commission's rule on electronic submission of documents. (7-1-21)T

802. RULE GOVERNING APPROVAL OF ATTORNEYS FEES

01. Purpose. The Industrial Commission promulgates this rule to govern the approval of attorney fees. (7-1-21)T

02. Charges Presumed Reasonable: (7-1-21)T

a. 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 (7-1-21)T

b. 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 (7-1-21)T

c. 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. (7-1-21)T

03. Statement of Charging Lien. (7-1-21)T

a. All requests for approval of fees shall be deemed requests for approval of a Charging Lien. (7-1-21)T

b. An attorney representing a Claimant in a Worker's Compensation matter shall in any proposed LSS, 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: (7-1-21)T

i. The date upon which the attorney became involved in the matter; (7-1-21)T

ii. Any issues which were undisputed at the time the attorney became involved; (7-1-21)T

iii. The total dollar value of all compensation paid or admitted as owed by employer immediately prior to the attorney's involvement; (7-1-21)T

iv. Disputed issues that arose subsequent to the date the attorney was hired; (7-1-21)T

v. Counsel's itemization of compensation that constitutes Available Funds; (7-1-21)T

vi. Counsel's itemization of costs and calculation of fees; and (7-1-21)T

vii. Counsel's itemization of medical bills for which Claim was made in the underlying action, but which remain unpaid by employer/surety at the time of LSS, along with counsel's explanation of the treatment to be given such bills/claims following approval of the LSS. (7-1-21)T

viii. The statement of the attorney identifying with reasonable detail his or her fulfillment of each element of the Charging Lien. (7-1-21)T

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. (7-1-21)T

04. Procedure if Fees Are Determined Not to Be Reasonable. (7-1-21)T

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 Paragraph 802.02.b may constitute grounds for an informal determination that the fee requested is not reasonable. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

d. The proponent of a fee which is greater than the percentage of recovery stated in Subsection 802.02 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. (7-1-21)T

05. Disclosure Statement. 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 following text: (7-1-21)T

a. In worker’s 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. (7-1-21)T

b. 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 Industrial Commission, PO Box 83720, Boise, ID 83720-0041, to resolve the dispute. (7-1-21)T

803. MEDICAL FEES.

01. General Provisions for Medical Fees. The following provisions shall apply to Commission approval of claims for medical benefits. (7-1-21)T

a. Acceptable Charge. Payors shall pay Providers the acceptable charge for medical services. (7-1-21)T

b. Coding. The Commission will generally follow the coding guidelines published by CMS and by the American Medical Association, including the use of modifiers. (7-1-21)T

c. Disputes. Disputes between Providers and Payors are governed by Subsection 803.06 of this rule

and JRP 19. (7-1-21)T

d. Outside of Idaho. Reimbursement for medical services provided outside the state of Idaho may be based upon the agreement of the parties. If there is no agreement, services shall be paid in accordance with the worker's compensation fee schedule in effect in the state in which services are rendered. If there is no fee schedule in effect in such state, or if the fee schedule in that state does not allow reimbursement for the services rendered, reimbursement shall be paid in accordance with these rules. (7-1-21)T

02. Acceptable Charges For Medical Services Provided By Physicians Under The Idaho Worker's Compensation Law. (7-1-21)T

a. The Commission adopts the RBRVS, published by CMS, as amended, as the standard to be used to determine acceptable charges by physicians. (7-1-21)T

b. Modifiers. Modifiers for physicians will be reimbursed as follows: (7-1-21)T

i. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (7-1-21)T

ii. Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. (7-1-21)T

iii. Modifier 80: Twenty-five percent (25%) of coded procedure. (7-1-21)T

iv. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (7-1-21)T

c. Conversion Factors. The standard for determining the acceptable charge for a medical service, identified by a code assigned to that service in the latest edition of the Physician's CPT, published by the American Medical Association, as amended, is calculated by the application of the total facility or non-facility RVU for services as determined by place of service in the latest RBRVS in effect on the first day of January of the current calendar year, to the following corresponding conversion factors. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. (7-1-21)T

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Anesthesia	00000 - 09999	Anesthesia	\$60.33
Surgery - Group One	22000 - 22999	Spine	\$135.00
	23000 - 24999	Shoulder, Upper Arm, & Elbow	
	25000 - 27299	Forearm, Wrist, Hand, Pelvis & Hip	
	27300 - 27999	Leg, Knee, & Ankle	
	29800 - 29999	Endoscopy & Arthroscopy	
	61000 - 61999	Skull, Meninges & Brain	
	62000 - 62259	Repair, Neuroendoscopy & Shunts	
Surgery - Group Two	63000 - 63999	Spine & Spinal Cord	\$124.00
	28000 - 28999	Foot & Toes	
	64550 - 64999	Nerves & Nervous System	

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Surgery - Group Three	10000 - 19999	Integumentary System	\$88.54
	20000 - 21999	Musculoskeletal System	
	29000 - 29799	Casts & Strapping	
	30000 - 39999	Respiratory & Cardiovascular	
	40000 - 49999	Digestive System	
	50000 - 59999	Urinary System	
	60000 - 60999	Endocrine System	
	62260 - 62999	Spine & Spinal Cord	
	64000 - 64549	Nerves & Nervous System	
	65000 - 69999	Eye & Ear	
Radiology	70000 - 79999	Radiology	\$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90749	Immunization, Injections, & Infusions	\$49.00
	94000 - 94999	Pulmonary / Pulse Oximetry	
	97000 - 97799	Physical Medicine & Rehabilitation	
	97800 - 98999	Acupuncture, Osteopathy, & Chiropractic	
Medicine - Group Two	90750 - 92999	Psychiatry & Medicine	\$70.00
	93000 - 93999	Cardiography, Catheterization, Vascular Studies	
	95000 - 96020	Allergy / Neuromuscular Procedures	
	96040 - 96999	Assessments & Special Procedures	
	99000 - 99607	E / M & Miscellaneous Services	

(7-1-21)T

d. Anesthesiology. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the current Anesthesia Base Units assigned to that CPT Code by CMS, plus the allowable time units reported for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time units will not be used for CPT Code 01996. (7-1-21)T

e. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant evidence, as determined by the Commission. Where a service with a CPT Code, RVU, and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Paragraph 02.c, above, determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Subsection 06, below. (7-1-21)T

f. Medicine Dispensed by Physicians. Reimbursement to physicians for any medicine shall not exceed the acceptable charge calculated for that medicine as if provided by a Pharmacy under Subsection 04 of this rule without a dispensing or compounding fee. Reimbursement to physicians for repackaged medicine shall be the AWP for the medicine prior to repackaging, identified by the NDC reported by the original manufacturer. Reimbursement may be withheld until the original manufacturer's NDC is provided by the physician. (7-1-21)T

g. Adjustment of Conversion Factors. The conversion factors set out in this rule may be adjusted each fiscal year (FY) by the Commission to reflect changes in inflation or market conditions in accordance with Section 72-803, Idaho Code. (7-1-21)T

03. Acceptable Charges For Medical Services Provided By Hospitals And Ambulatory Surgery Centers Under The Idaho Worker's Compensation Law. The following standards shall be used to determine the acceptable charge for Hospitals and ASCs. (7-1-21)T

a. Critical Access Hospitals. The standard for determining the acceptable charge for inpatient and outpatient services provided by a Critical Access Hospital is ninety percent (90%) of the reasonable charge. Implantable hardware charges shall be reimbursed at the rate of the actual cost plus fifty percent (50%). (7-1-21)T

b. Hospital Inpatient Services. The standard for determining the acceptable charge for inpatient services provided by Hospitals, other than Critical Access Hospitals, is calculated by multiplying the base rate by the current MS-DRG weight for that service. The base rate for inpatient services is ten thousand two hundred dollars (\$10,200). Inpatient services that do not have a relative weight shall be paid at eighty-five percent (85%) of the reasonable charge; however, Implantable Hardware charges billed for services without an MS-DRG weight shall be reimbursed at the rate of actual cost plus fifty percent (50%). (7-1-21)T

c. Hospital Outpatient and ASC Services. The standard for determining the acceptable charge for outpatient services provided by Hospitals (other than Critical Access Hospitals) and for services provided by ASCs is calculated by multiplying the base rate by the Medicare Hospital Outpatient Prospective Payment System APC weight in effect on the first day of January of the current calendar year. The base rate for Hospital outpatient services is one hundred forty dollars and seventy-five cents (\$140.75). The base rate for ASC services is ninety-one dollars fifty cents (\$91.50). (7-1-21)T

i. Medical services for which there is no APC weight listed shall be reimbursed at seventy-five percent (75%) of the reasonable charge. (7-1-21)T

ii. Status code N items or items with no CPT or HCPCS code shall receive no payment except as provided in Subparagraph 803.03.c.ii.(1) or 803.03.c.ii.(2) of this rule. (7-1-21)T

(1) Implantable Hardware may be eligible for separate payment under Subparagraph 03.d.iii. of this rule. (7-1-21)T

(2) Outpatient laboratory tests provided with no other Hospital outpatient service on the same date, or outpatient laboratory tests provided on the same date of service as other Hospital outpatient services that are clinically unrelated may be paid separately if billed with modifier L1. Payment shall be made in the same manner that services with no APC weight are paid under Subparagraph 803.03.c.i. of this rule. (7-1-21)T

iii. When no medical services with a status code J1 appears on the same Claim, two (2) or more medical procedures with a status code T on the same Claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%). When a medical service with a status code J1 appears on the same Claim, all medical services with a status code T shall be paid at fifty percent (50%). (7-1-21)T

iv. When no medical services with a status code J1 appears on the same Claim, status code Q items with an assigned APC weight will not be discounted. When a medical service with a status code J1 appears on the same Claim, status code Q items shall be paid at fifty percent (50%). (7-1-21)T

d. Additional Hospital Payments. When the charge for a medical service provided by a Hospital (other than a Critical Access Hospital) meets the following standards, additional payment shall be made for that service, as indicated. (7-1-21)T

i. Inpatient Threshold Exceeded. When the charge for a Hospital inpatient MS-DRG coded service exceeds the sum of thirty thousand dollars (\$30,000) plus the payment calculated under the provisions of Paragraph 03.b. of this rule, then the total payment for that service shall be the sum of the MS-DRG payment and the amount charged above that threshold multiplied by seventy-five percent (75%). Implantable charges shall be excluded from the calculation for an additional inpatient payment under this Subparagraph. (7-1-21)T

ii. Inpatient Implantable Hardware. Hospitals may seek additional reimbursement beyond the

MSDRG payment for invoiced Implantable Hardware where the aggregate invoice cost is greater than ten thousand dollars (\$10,000). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed three thousand dollars (\$3,000). Handling and freight charges shall be included in invoice cost. (7-1-21)T

iii. Outpatient Implantable Hardware. Hospitals and ASCs may seek additional reimbursement beyond the APC payment for invoiced Implantable Hardware where the aggregate invoice cost is greater than five hundred dollars (\$500). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed one thousand dollars (\$1,000). Handling and freight charges shall be included in invoice cost. (7-1-21)T

e. Adjustment of Hospital and ASC Base Rates. The Commission may periodically adjust the base rates set out in Paragraphs 803.03.b. and 803.03.c. of this rule to reflect changes in inflation or market conditions. (7-1-21)T

04. Acceptable Charges For Medicine Provided By Pharmacies. The following standards shall be used to determine the acceptable charge for medicine provided by pharmacies. (7-1-21)T

a. Brand/Trade Name Medicine. The standard for determining the acceptable charge for brand/trade name medicine shall be the AWP, plus a five dollar (\$5) dispensing fee. (7-1-21)T

b. Generic Medicine. The standard for determining the acceptable charge for generic medicine shall be the AWP, plus an eight dollar (\$8) dispensing fee. (7-1-21)T

c. Compound Medicine. The standard for determining the acceptable charge for compound medicine shall be the sum of the AWP for each drug included in the compound medicine, plus a five dollar (\$5) dispensing fee and a two dollar (\$2) compounding fee. All components of the compound medicine shall be identified by their original manufacturer's NDC when submitted for reimbursement. Payors may withhold reimbursement until the original manufacturer's NDC assigned to each component of the compound medicine is provided by the Pharmacy. Components of a compound medicine without an NDC may require medical necessity confirmation by the treating physician prior to reimbursement. (7-1-21)T

d. Prescribed Over-the Counter Medicine. The standard for determining the acceptable charge for prescribed over-the-counter medicine filled by a Pharmacy shall be the reasonable charge plus a two dollar (\$2) dispensing fee. (7-1-21)T

05. Acceptable Charges For Medical Services Provided By Other Providers Under The Idaho Worker's Compensation Law. The standard for determining the acceptable charge for Providers other than physicians, Hospitals or ASCs shall be the reasonable charge. (7-1-21)T

06. Billing And Payment Requirements For Medical Services And Procedures Preliminary To Dispute Resolution. This rule governs billing and payment requirements for medical services provided under the Worker's Compensation Law and the procedures for resolving disputes between Payors and Providers over those bills or payments. (7-1-21)T

a. 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. (7-1-21)T

b. 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. Failure to submit a bill complying with this Paragraph 06.b to the Payor within one hundred twenty (120) days of the date of service will result in the ineligibility of the Provider to utilize the dispute resolution procedures of the Commission set out in Paragraph 803.06.i. of this rule for that service. (7-1-21)T

i. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the

American Medical Association's appropriate CPT coding, including modifiers, the appropriate HCPCS code, the diagnostic and procedure code set version required by CMS and the original NDC for the year in which the service was performed. (7-1-21)T

ii. 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. (7-1-21)T

iii. If requested by the Payor, the bill shall be accompanied by a written report as defined by Subsection 010.31 and required by Section 404 of these rules. Where a bill is not accompanied by such Report, the periods expressed in Paragraphs 803.06.c and 803.06.e. of this rule, shall not begin to run until the Payor receives the Report. (7-1-21)T

c. Prompt Payment. Unless the Payor denies liability for the Claim or, pursuant to Paragraph 803.06.e. of this rule, sends a Preliminary Objection, a Request for Clarification, or both, as to any charge, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill or upon acceptance of liability, if made after bill is received from Provider. (7-1-21)T

d. Partial Payment. If the Payor acknowledges liability for the Claim and, pursuant to Paragraph 803.06.e. of this rule, 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 or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. (7-1-21)T

e. Preliminary Objections and Requests for Clarification. (7-1-21)T

i. 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. (7-1-21)T

ii. 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. (7-1-21)T

iii. Each Preliminary Objection and Request for Clarification shall contain the name, address, and phone number of the individual located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. (7-1-21)T

iv. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill or a Request for Clarification within thirty (30) calendar days of receipt of the bill, or provide an in-state contact in accord with Subparagraph 06.e.iii., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (7-1-21)T

f. Provider Reply to Preliminary Objection or Request for Clarification. (7-1-21)T

i. 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 or Request for Clarification. (7-1-21)T

ii. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (7-1-21)T

iii. 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. (7-1-21)T

g. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part or 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. (7-1-21)T

h. 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. (7-1-21)T

i. 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 Paragraph 803.01.c. of this rule. If Provider's motion disputing CPT or MS-DRG coded items prevails, Payor shall pay the amount found by the Commission to be owed, plus an additional thirty percent (30%) of that amount to compensate Provider for costs and expenses associated with using the dispute resolution process. For motions filed by a Provider disputing items without CPT or MS-DRG codes, the additional thirty percent (30%) shall be due only if the Payor does not pay the amount found due within thirty (30) days of the administrative order. (7-1-21)T

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