COLORADO WORKERS' COMPENSATION RULES SEE SIGNIFICANT UPDATES WITH HB 21-1050 AND HB 21-1207

With the trifecta of a Democratic-controlled Governor's office, Senate, and House, the claimant's bar in Colorado has successfully promoted legislation that includes an overhaul of the workers' compensation rules. The legislation in House Bill 21-1050 and House Bill 21-1207 went into effect as of September 7, 2021 and will impact how claims are valued and managed. The new rules and procedures include some minor rewording of statutory language, but the most impactful changes are summarized below, along with a more detailed explanation of several of the more noteworthy updates.

House Bill 21-1050

The following are effective and apply to all open claims as of September 7, 2021:

- Indemnity benefits are considered paid on the date of receipt or three days after mailing if postmarked at least three business days before the payment is due*;
- 24-month Division Independent Medical Examination (IME) requires a "seed IME" to take place at least 20 months after injury, and the treating physician is given 15 days after service of the report to respond;
- A benefit or penalty must be at issue before compensability is considered ripe for litigation;
- Mileage must be submitted 120 days after incurred, and paid within 30 days;
- The 10-day jurisdictional cutoff for prehearings is removed, providing pre-hearing judges the authority to resolve discovery disputes up to the date of hearing; and
- Compensability orders are now subject to review or appeal, whereas previously compensability orders with no specific benefit at issues were not subject to review.

And the following apply to claims arising after September 7, 2021:

- Medical and temporary indemnity cannot be apportioned;
- Conservator services are now a compensable medical benefit;
- Offsets of Social Security are prohibited if those benefits were already being received at the time of the injury;
- The maximum benefit cap on indemnity is reduced from 25% to 19%;
- An employer/insurer is prohibited from withdrawing an initial admission of liability when two years or more have passed since the date the admission was filed, except in cases of fraud*; and
- The earnings threshold for Permanent Total Disability (PTD) is raised to $7,500 with annual adjustments thereafter.

Several of these are of particular note for claims handlers, see the two asterisks above. First, and effective immediately on all open claims, Rule 5-6(B)(C) introduces a new standard on when indemnity benefits are considered paid. The revisions introduce complexity to what was once a straightforward rule. Previously, indemnity benefits were considered paid if they were mailed on the date of the admission, and every two weeks thereafter. This allowed a claims examiner to control what was in their power (the date of mailing of benefits), and not be subject to what is outside of their control (delivery by the postal service).

Under the new rule, benefits are considered paid when they are ***received***, not when they are mailed. This means the Claimant must have receipt of the indemnity benefits on the date they are due. This brings up an obvious issue. How can a claims examiner know the exact date a check will be delivered, particularly if the delivery is delayed? To resolve this issue, the new rule will consider payment "received" if the check is mailed and postmarked at

least three business days before payment is due. To add further complexity, this does not apply to benefits paid with an admission, but does apply to subsequent payments.

Claims examiners must be cognizant of multiple issues given this new rule. First, you can no longer pay benefits with the admission and put them on automatic payment every two weeks. The changing timelines outlined above (due on date initial admission is filed versus due three business days prior for subsequent checks) must be taken into account. Second, the paid benefit must be ***postmarked*** three business days before payment is due. This will be significant in situations where a check is mailed late in the day and is not postmarked until the following day. Ultimately, there will be a steep learning curve with this new rule to ensure it is applied properly. Failing to strictly comply with this rule could be a focus for penalty claims filed by claimants, as any technical violation of the statute can be subject to a penalty claim. Getting in compliance as soon as possible is critical to mitigating these penalty exposures.

A second significant change with the new legislation is that the employer and insured no longer have the ability to withdraw an admission after two years have passed from the date of the initial admission. Thus far the rules and interpreting caselaw have allowed respondents to move to withdraw an admission when evidence arises that indicates the claim should have been contested and denied. This would typically occur after an IME, arising from an initial dispute on whether further medical care is indicated, where the IME physician determines that not only is no further care indicated, but the claimant suffered no compensable injury whatsoever. This would occasionally happen years after the initial admission. Now, Respondents must complete their investigation and move to withdraw the admission, if at all, within two years, ***unless*** there is fraud.

This two-year limitation will be most impactful with medical causation issues in claims. For example, an employee suffers what appears to be a compensable lifting injury while moving a box, but later a pre-existing condition is discovered that draws into question whether the current symptoms are causally related to the industrial injury. Under the prior rule, we could rely on this IME to withdraw our admission. Now, the admission can only be withdrawn within the two-year window. To avoid being stuck with an erroneous admission, we recommend diligently investigating all claims at the outset, with a focus on any employer knowledge of pre-existing conditions. If there is any question of compensability a Notice of Contest can be filed. Or, if an admission is filed and there is some question of whether symptoms arose from the admitted injury, we recommend conducting an IME timely and within the two-year limit so the admission can be withdrawn if necessary.

House Bill 21-1207

House Bill 21-1207 is more narrowly tailored, specifically addressing the definition of "overpayments" as contemplated by the Workers' Compensation Act. This bill was introduced to address situations where a Division IME physician would change the date of Maximum Medical Improvement (MMI) to a point earlier in time, resulting in what could be a significant overpayment of Temporary Total Disability (TTD) benefits. Respondents then had the ability to seek reimbursement of this overpayment from a Claimant directly or through an offset of future benefits. Under HB 21-1207 this would no longer be deemed an "overpayment" and could not be recouped. Now, overpayments are limited to money received by the claimant as a result of 1) fraud, 2) error due to miscalculation, omission, or clerical error, 3) duplicate benefits, or 4) paid in excess of an admission existing at the time benefits are paid. Going forward, if Respondents assert an overpayment offset or credit, it is critical to first ensure that it aligns with the updated definition and is in fact recoverable.

Overall, the changes introduced by House Bill 21-1050 and 21-1207 are significant for the handling of workers' compensation claims going forward. Our workers' compensation team at Hall & Evans has been meeting with employers and third-party administrators to explain the legislation and what action is needed to comply. If you have any questions and would like further details or training for your team about these Bills and the changes they bring, please contact Paul R. Popovic or Douglas J. Kotarek.