



**State
Fiscal-year
2006
Prompt First
Action Report**
on Minnesota Workers'
Compensation Claims

Workers' Compensation Division
Minnesota Department of Labor and Industry
443 Lafayette Road N.
St. Paul, MN 55155

December 2006

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Additional copies of this report are available by calling the Workers' Compensation Division at (651) 284-5030 or toll-free at 1-800-342-5354.

Information in this report can be obtained in alternative formats by calling the department at 1-800-342-5354 or (651) 297-4198/TTY.

Please visit our Web site at:
www.doli.state.mn.us.



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Prompt First Action Report table

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Introduction

The 1995 Minnesota Legislature passed Minnesota Statutes §176.223 that states in part “The department shall publish an annual report providing data on the promptness of all insurers and self-insurers in making first payments on a claim for injury. The report shall identify all insurers and self-insurers and state the percentage of first payments made within 14 days from the last date worked for each of the insurers and self-insurers. The report shall also list the total number of claims and the number of claims paid within the 14-day standard.” Because the insurer’s responsibility for promptness lies also with the denial of a claim, the *Prompt First Action Report on Minnesota Workers’ Compensation Claims* combines data related to the promptness of first payments and denials.

Minnesota Statutes §176.231, Subdivision 1 states, "Where ... injury occurs which wholly or partly incapacitates the injured worker from performing labor or service for more than three calendar days, the employer shall report the injury to the insurer on a form prescribed by the commissioner within ten days from its occurrence. An insurer and self-insured employer shall report the injury to the commissioner no later than 14 days from its occurrence.”

Department actions upon receipt of the data

The department evaluates data submitted on the *First Report of Injury* and the *Notice of Insurer’s Primary Liability Determination* forms to determine whether the first payment or denial of benefits is timely. The *First Report of Injury* form is used to report work-related injuries and illnesses to the department. The *Notice of Insurer’s Primary Liability Determination* form is used by the insurer to report the acceptance or denial of the claim and to communicate information about the payment of benefits.

If during the evaluation the data is inconclusive, a letter asking for the missing or incomplete data is sent to the insurer (see Appendix C). A list of claims, where the first actions were believed to be untimely, is sent to each insurer on a quarterly basis. A review period of approximately 30 days is allowed to refute the accuracy of the department’s data.

Explanation of Prompt First Action Report table

The table enclosed identifies insurance companies and self-insured employers that filed lost-time claims for the previous five state fiscal-years (July 1 through June 30) and the number and percentage of those claims that were paid or denied within the statutory 14-day deadline.

Conclusion

In fiscal-year 2006, 87.1 percent of the 28,714 lost-time claims had a timely first action. This is an increase from fiscal-year 2005 where 85.7 percent of the 29,177 lost-time claims had a timely first action.

In reviewing the statistics, this increase is due to a number of items, including the following:

- A drop in the number of Minnesota Assigned Risk Plan claims. These claims usually have a timeliness percentage about 8 to 10 percent below the insurance industry average.
- Several insurance companies with a large number of claims increased their timeliness (one of them by 4.8 percent).
- The self-insurance industry increased its overall performance .2 percent.

The Workers' Compensation Division anticipates that increased use of technology, electronic data exchange, and early intervention will continue to improve the overall first action timeliness.

First Report of Injury

See Instructions on Reverse Side
 PRINT or TYPE your responses.
 Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA Case #	
3. DATE OF CLAIMED INJURY		4. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm	5. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home Address		10. Home phone #	11. Date of birth
City	State	Zip Code	12. Occupation
13. Regular department		14. Date hired	
15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week
19. Employment Status		<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer	
20. Weekly value of:	Meals	Lodging	2 nd Income
21. Apprentice		<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Tell us how the injury occurred and what the employee was doing before the incident (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."			
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.	
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate name and address of place of occurrence		26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI
		28. Date employer notified of injury	29. Date employer notified of lost time
		30. Return to work date	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone)		33. HOSPITAL/CLINIC (name and address) (if any)	
		34. Emergency Room Visit <input type="checkbox"/> Yes <input type="checkbox"/> No	
		35. Overnight in-patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
36. EMPLOYER Legal name		37. EMPLOYER DBA name (if different)	
38. Mailing address		39. Employer FEIN	40. Unemployment ID#
City	State	Zip Code	41. Employer's contact name and phone #
42. Physical address (if different)		43. Witness (name and phone)	
City	State	Zip Code	44. NAICS code
		45. Date form completed	
46. INSURER name		51. CLAIMS ADMIN COMPANY (CA) name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA	
47. Insured legal name		52. CA address	
48. Policy # or self-insured certificate #		City	State Zip Code
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #

GENERAL INSTRUCTIONS TO THE EMPLOYER

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. Self-insured employers have 14 days to file this form with the Department of Labor and Industry (Department). It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will forward a copy of this form** to the Department, if necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form within **seven** days of the occurrence.

Employers are required to complete this form. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department's web site at www.doli.state.mn.us. Employees are not responsible for completing this form.

SEND REPORT TO INSURER IMMEDIATELY – DO NOT WAIT FOR DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS FOR COMPLETING THIS FORM

- Item 2: OSHA Case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 15-20: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and notify your insurer if the employee misses time due to this injury after that date.
- Item 39: Fill in your Federal Employment ID number (FEIN). For information on this number, see www.firstgov.gov and click on Employer ID Number under Business.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR/SELF-INSURED EMPLOYER

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (per Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

- Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
- Items 47-48: Fill in the legal name of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
- Item 49: Fill in the insurer's Federal Employment ID number (FEIN) number.
- Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
- Item 53-54: Fill in the claims administrator's FEIN and claim number.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Notice of Insurer's Primary Liability Determination

See instructions on reverse side.
Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

Amended

SOCIAL SECURITY NUMBER	DATE OF INJURY	DATE OF DEATH (if applicable)
EMPLOYEE		
EMPLOYER		
INSURER/SELF-INSURER/TPA		
INSURER CLAIM NUMBER		

First date of lost time	Date employer notified of this lost time	Initial date of return to work	Average weekly wage at date of injury
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If the initial return to work was followed by a new period of lost time, complete the following information:

First date of new period of lost time: _____ Date employer notified of this lost time: _____

1. Your claim is ACCEPTED and wage loss benefits will be paid.

Benefit type: <input type="checkbox"/> Temporary Total (TTD) <input type="checkbox"/> Temporary Partial (TPD) <input type="checkbox"/> Permanent Total (PTD) <input type="checkbox"/> Dependency (DEP)			
Date of payment	Amount of payment	Time period covered with this payment Date from _____ Date through _____	Compensation rate
Any ongoing payments will be made on _____ (day of week) at _____ (weekly, biweekly, etc.) intervals.			

Check all that apply	<input type="checkbox"/> Full wage continuation by the employer under M.S. § 176.221, subd. 9. <input type="checkbox"/> TPD payment made according to the wage loss verification received by the insurer on _____ (date). <input type="checkbox"/> Fatality with dependents. Payment is being made according to dependent information, which must be ATTACHED . <input type="checkbox"/> Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.
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2. Your claim is ACCEPTED. However, wage loss benefits will not be paid at this time for the following reason:

Check only one	<input type="checkbox"/> A. Injury did not cause lost time from work beyond the three calendar day waiting period. If employee's work schedule is not Monday through Friday, explain: _____ <input type="checkbox"/> B. Verification of reduced wages for TPD has not been received from the employee or employer. <input type="checkbox"/> C. Other reason (include legal and factual basis): <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>
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3. Primary liability is DENIED for the claimed work related injury and/or death. (Check one or both)

Reason for denial (include legal and factual basis):

NAME OF THE PERSON MAKING THIS DETERMINATION (print)	PHONE NUMBER	EXTENSION	DATE SERVED (must be completed)
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INSTRUCTIONS TO EMPLOYEE/HEIRS AND DEPENDENTS

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR RECORDS

General Information

This liability determination is the opinion of the insurer. If the claim has been denied, this opinion may not be final. If you have questions about any of the information on this form, you should first contact the person making this determination (see name and phone number on the front side of this form). If you still have questions, contact the Department of Labor and Industry (DLI), Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you (listed below). For the hearing impaired, please call our Telecommunication Device for the Deaf (TDD) at (651) 297-4198. If there are problems with your claim, there are several options available to resolve them informally.

Minnesota Department of Labor and Industry
5 North Third Avenue West, Suite 400
Duluth, MN 55802-1614
Telephone: (218) 733-7810
1-800-365-4584

Minnesota Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4301
Telephone: (651) 284-5030
1-800-342-5354

Time Limitations

If the injury claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after your employer/insurer filed a written report of your claimed injury with DLI, not to exceed six years after the date of the claimed injury. If you have an occupational disease, you have three years to begin legal proceedings from the date you learned that the cause of the disease might be work related and the disease first caused disability.

If the death claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after the employer/insurer filed the written notice of death with DLI, except that:

- 1) For claims where the employer/insurer did not pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of injury** resulting in the death.
- 2) For claims where the employer/insurer did pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of death**.

In very rare circumstances, there may be exceptions to the time limits noted above.

Vocational Rehabilitation

If the insurer is denying primary liability for your claim and you disagree, cannot return to your former employment, and would like vocational rehabilitation assistance, contact DLI, Vocational Rehabilitation Unit at (651) 284-5038.

Instructions to Insurer/Claims Administrator

1. If the claim is a fatality with dependents and payment is being made, attach dependent information.
2. The reason for a denial must be clear and specific, and state a legal and factual basis in language which is easily understood. If the reason for a denial is based on medical information, attach medical reports or summary of any health care provider contacts that support your reason for denial.
3. This form may be filed more than once if your liability determination changes. (Examples: when you initially deny primary liability, but later accept liability; when you initially accept a claim and pay wage loss benefits, but later deny primary liability within 60 days pursuant to M.S. § 176.221, subd 1; when you accept liability, but are unable to pay TPD benefits until verification of wage loss is received, but later issue the first TPD check.)
4. If you file this form more than once, check the Amended box in the upper left-hand corner for each subsequent filing.
5. Do not use this form to reinstate benefits. Use the Notice of Benefit Reinstatement (NOBR) form.
6. If you indicate that the employer paid "full wage," you must also file a Notice of Intention to Discontinue (NOID) at the appropriate time showing the date of return to work or other reason for discontinuance and the payment data on the back of the form as required by M.S. § 176.221, subd. 9.
7. The date served must be completed each time you file this form.
8. The boxes (in the upper left-hand corner on the front of the form) containing claim identifying information must be fully completed each time you file the form. The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must also be completed, if applicable, each time you file the form, regardless of your liability determination.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

April 28, 2006



ATTN: WORKERS' COMP CLAIM MANAGER
INSURER / TPA
ADDRESS
CITY STATE ZIPCODE

Sample

Re: Employee Name / Employer Name
SSN: 555-55-5555 D/I: 99/99/1999
Your Claim #: Claim Number

On 4/21/2006, we received a Notice of Insurer's Primary Liability Determination (NOPLD) form regarding the above claim. We have reviewed the information provided on the NOPLD and First Report of Injury forms and have found that the following information is incomplete (as indicated by an "X"):

- The first day of lost time: _____
- The date the employer was notified of initial lost time: _____
- The date of return to work: _____
- The first day of the new period of lost time: _____
- The date the employer was notified of the new period of lost time: _____
- The average weekly wage: _____

Please complete the requested information in the space provided and return this letter as soon as possible. This information is necessary in order for us to determine the timeliness of your initial action and/or whether the lost time exceeded the waiting period on the claim. Thank you for your anticipated cooperation.

Sincerely,

Workers' Compensation Division
State of Minnesota