FISCAL-YEAR 2008

PROMPT FIRST ACTION REPORT ON WORKERS' COMPENSATION CLAIMS

IN THE WORKERS' COMPENSATION SYSTEM

MINNESOTA DEPARTMENT OF
LABOR & INDUSTRY
WORKERS' COMPENSATION DIVISION

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

December 2008

The total estimated cost of publishing this report is $3,000.

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.

Visit the DLI Web site at:
www.doli.state.mn.us

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Introduction

The 1995 Minnesota Legislature passed Minnesota Statutes §176.223 that states in part the Minnesota Department of Labor and Industry "... 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 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 of Labor and Industry 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. It is also used to clarify or change information previously submitted on the *First Report of Injury*.

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 quarterly. 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 Prompt First Action Report table 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. This report includes claims received during each fiscal-year with claimed lost time beyond the three calendar-day waiting period. These claims do not include asbestosis and other litigated claims in which the lost-time determination is inconclusive at the time this report is published.

Conclusion

In fiscal-year 2008, 88.3 percent of the 26,249 lost-time claims had a timely first action. This is an increase from fiscal-year 2007, where 88.0 percent of the 26,873 lost-time claims had a timely first action.

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

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030

First Report of Injury

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

Reset

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #				
3. DATE OF CLAIMED INJURY	4. Time of injury ☐ am ☐ pm		5. Time employee began work on date of injury ☐ am ☐ pm		
6. EMPLOYEE Name (last, first, middle)			7. Gender ☐ M ☐ F	8. Marital Status ☐ Married ☐ 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 ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer	
20. Weekly value of:	Meals	Lodging	2nd Income	21. Apprentice ☐ Yes ☐ 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? ☐ Yes ☐ 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) ☐ Yes ☐ No ☐ 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 ☐ Yes ☐ No 35. Overnight in-patient ☐ Yes ☐ 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) ☐ Insurer ☐ 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 #

Copies to: Insurer, Employer, Employee, and Workers' Compensation Division (if no insurer)

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.
PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

Reset

N L 0 1

DO NOT USE THIS SPACE

☐ **Amended**

WID or SSN	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

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: ☐ Temporary Total (TTD) ☐ Temporary Partial (TPD) ☐ Permanent Total (PTD) ☐ 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

- ☐ Full wage continuation by the employer under M.S. § 176.221, subd. 9.
- ☐ TPD payment made according to the wage loss verification received by the insurer on _____(date).
- ☐ Fatality with dependents. Payment is being made according to dependent information, which must be **ATTACHED**.
- ☐ Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.

☐ **2. Your claim is ACCEPTED. However,** wage loss benefits will not be paid at this time for the following reason:

Check only one

- ☐ 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: _____
- ☐ B. Verification of reduced wages for TPD has not been received from the employee or employer.
- ☐ C. Other reason (include legal and factual basis):

☐ **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)

Distribution: Workers' Compensation Division, Employer, Insurer, Employee/Heirs and Dependents

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	443 Lafayette Road North	Mailing Address
Duluth, MN 55802-1614	St. Paul, MN 55155-4301	Workers' Compensation Division
Telephone: (218) 733-7810	Telephone: (651) 284-5030	PO Box 64221
1-800-365-4584	1-800-342-5354	St. Paul, MN 55164-0221

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 24, 2008

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 4/21/2008, 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"):

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

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. Please complete the requested information in the space provided and return this letter to the following address as soon as possible.

Department of Labor & Industry
Workers' Compensation Division
PO Box 64221
St Paul MN 55164-0221

Thank you for your anticipated cooperation.

Sincerely,

Workers' Compensation Division
State of Minnesota