DEPARTMENT OF LABOR AND INDUSTRY

PROMPT FIRST ACTION REPORT ON WORKERS' COMPENSATION CLAIMS

IN THE WORKERS' COMPENSATION SYSTEM

FISCAL-YEAR 2017

Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road N.
St. Paul, MN 55155
Phone: (651) 284-5030
Web: www.dli.mn.gov

As requested by Minnesota Statutes § 176.223: This report cost approximately $3,000 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as audio, Braille or large print. Printed on recycled paper.

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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 date the employer was notified of claimed lost time beyond the waiting period 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."

Minnesota Statutes § 176.221, subdivision 1, states, "Within 14 days of notice to or knowledge by the employer of an injury compensable under this chapter the payment of temporary total compensation shall commence." This statute also gives insurers the same 14-day deadline to deny the claim and to communicate this decision to the injured worker and the department. Minnesota Rules part 5220.2540, subpart 1, further applies this 14-day deadline to the first payment or denial of temporary partial benefits.

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 claimed 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* form.

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.

After the report is published each year, insurers that had any claims listed in the report for the current fiscal-year are notified of their performance in comparison to all insurance companies, self-insured employers and the system as a whole. For those insurers with a significant number of claims that have a performance level substantially above or below the average, the notices provide additional information (see Appendix D).

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 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 2017, 90.5 percent of the 23,049 lost-time claims had a timely first action. This percentage is slightly higher than fiscal-year 2016, where 90.1 percent of the 23,407 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 maintain or improve the overall first action timeliness percentage.

MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

First Report of Injury

See Instructions on Reverse Side

Print in ink or type
Enter dates in MM/DD/YYYY format

FRO 1

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)	8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried	
10. Home address	11. Home phone #	12. Date of birth	13. Date hired
City State Zip Code	14. Occupation	15. Regular department	16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *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 Name and address of the place of the 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. RTW same employer ☐ Yes ☐ No	32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated		
35. Certified Managed Care Organization (if any)			

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) - if more than 1 attach a separate sheet	
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 and FEIN	52. CA address	
48. Policy # (including effective dates) or self-insured certificate #	City State Zip Code	
49. Insurer FEIN / 50. Date insurer received notice	53. CA FEIN	54. CA claim #

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. 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 of Labor and Industry's web site at www.dli.mn.gov.

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 where 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. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when 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 with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON 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 17-21: 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. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- 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 answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see https://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Lost-or-Misplaced-Your-EIN.
- 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 if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
(For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 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.

NL01

DO NOT USE THIS SPACE

☐ **Amended**

WID number or SSN	Date of injury	Date of death (if applicable)
Employee (last, first, middle initial)		
Employer		
Insurer/Self-insurer/TPA		Notes
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: ☐ Tempoary Total (TTD) ☐ Tempoary 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 (area code)	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). If there are problems with your claim, there are several options available to resolve them informally.

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330 Duluth, MN 55802-2368 Telephone: (218) 733-7810 1-800-342-5354	443 Lafayette Road North St. Paul, MN 55155-4301 Telephone: (651) 284-5030 1-800-342-5354 Fax: (651) 284-5731	Mailing address Workers' Compensation Division PO Box 64221 St. Paul, MN 55164

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 document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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 Minnesota Statutes § 609.52, subdivision 3.

DEPARTMENT OF LABOR AND INDUSTRY

April 18, 2017

RE0031

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

Re: Employee Name / Employer Name
WID: 9999999999 D/I: 99/99/2017
Your Claim #: Claim Number

On 4/14/2017, we received a Notice of Insurer's Primary Liability Determination (NOPLD) form regarding the above claim. Please provide the following missing information (as indicated by an "X") and return this letter to the address listed below:

___X___ The first day of lost time or wages: _____

___X___ The date the employer was notified of the lost time or wages: _____

___X___ The date of initial return to work: _____

___X___ The first day of the new period of lost time or wages: _____

___X___ The date the ER was notified of the new period of lost time or wages: _____

___X___ The employee's average weekly wage: _____

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

Thank you,

Workers' Compensation Division

DEPARTMENT OF LABOR AND INDUSTRY

January 27, 2017

ATTN: WORKERS COMP CLAIM MANAGER
INSURER
ADDRESS
CITY ST ZIP

Each year, the Minnesota Department of Labor and Industry (DLI) publishes its *Prompt First Action Report on Workers' Compensation Claims*. This report details the number and percentage of claims that were paid or denied within the statutory 14-day deadline for each workers' compensation insurance company and self-insured employer during the previous five fiscal years.

Please find below the statistics for your company for fiscal-year 2016, along with the overall statistics for insurance companies, self-insured employers, and the system as a whole. If you wish to review the complete report, you can find it on our website at www.dli.mn.gov/WC/PromptFirstAction.asp.

	Number of claims	**Number timely**	**Percent timely**
Insurer	claims	timely	percent %
Insurance Companies	17,274	15,233	88.2 %
Self-Insured Employers	6,133	5,848	95.4 %
All Companies	23,407	21,081	90.1 %

I would like to thank your company for its notable performance in the recent *Prompt First Action Report*. The ability to pay or deny a high percentage of claims within the 14-day deadline indicates your company's strong claims management.

Thanks to the claims management efforts of companies like yours, Minnesota now leads the nation with the highest percentage of claims paid or denied within the statutory limits.

Our agency appreciates the dedication and performance of your company in 2016.

Sincerely,

Lisa Smith
Workers' Compensation Division

DEPARTMENT OF LABOR AND INDUSTRY

January 27, 2017

ATTN: WORKERS COMP CLAIM MANAGER
INSURER
ADDRESS
CITY ST ZIP

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All Companies	23,407	21,081	90.1 %

When compared to the average for all Insurance Companies, your company experienced a lower percentage of claims that were paid or denied within the statutory deadline. DLI seeks to improve the overall promptness of the entire industry and would like to help your company improve its performance. Our agency offers the following services:

- basic adjuster training at DLI;
- onsite training upon request; and
- an online basic adjusters training manual.

For information about these items, please visit our website at www.dli.mn.gov/WC/TrainingIns.asp.

If you have any questions, please feel free to contact me at (651) 284-5273.

Sincerely,

Lisa Smith
Workers' Compensation Division