Provided By Heffernan Insurance Brokers

ARIZONA EMPLOYMENT LAW

Arizona Workers' Compensation – Claims Process

Workers' compensation is a system of no-fault insurance that provides monetary and medical benefits to employees (or their survivors) for work-related injuries, diseases or deaths. Workers' compensation is governed by state law.

The Arizona Workers' Compensation Act (WCA) establishes the process for handling workers' compensation claims in the state. The Industrial Commission of Arizona (Commission) investigates and handles claims. The processing of a claim typically begins with a notice of injury and may end up in administrative or judicial appeal.

INITIAL REPORTS OF INJURY

Employees must immediately notify their employers of any work-related injury. An employer must then notify the Commission and its insurance carrier (if applicable) within **10 days**.

EMPLOYEE'S CLAIM FOR BENEFITS

Employees can file a claim for benefits with the Commission using one of two forms: the Workers Report of Injury or the Worker's and Physician's Report of Injury.

Regardless of the form used, employees must file a claim with the Commission within **one year** of an injury; otherwise they risk losing their right to any workers' compensation benefits. This one-year period starts when:

- An injury becomes manifest; or
- An employee first knows, or should know, that he or she sustained a work-related injury.

However, the one-year deadline does **not** apply in cases where an employer begins paying benefits and later denies or disputes an employee's claims.

If the one-year deadline applies and an employee fails to file a claim by the deadline, the Commission may excuse the failure only if:

- The failure was due to the employer's reliance on a material misrepresentation made by the employer, the employer's insurance carrier or the Commission; or
- The employee was insane, legally incompetent or incapacitated at any time between the injury and the end of the one-year period.

STATE RESOURCES

Arizona Industrial Commission website

General Information
The Commission provides general information about workers' compensation requirements here.

Employer's First Report
Employers may report their employees' work-related conditions to the Commission here.

New Claims System to Launch in 2019
Information about a new claims system that the Commission plans to launch in 2019 is available here.

INITIAL COMPENSABILITY DETERMINATION

After the Commission receives an employee's claim for benefits, it will provide notice of the claim to the employer (or insurance carrier, if applicable). Employers then have 21 days to either accept or deny the claim.

INITIAL BENEFIT PAYMENT

If an employer accepts a claim, it must begin paying benefits to the injured employee within **21 days** after receiving notice that the claim has been filed. Employers must report the initial benefit payment to the Commission using a Notice of Claim Status form. Thereafter, payments must be made **at least every two weeks** while the employee is temporarily totally disabled.

AVERAGE MONTHLY WAGE (AMW) DETERMINATION

Within **30 days** of making an initial benefit payment, the employer must provide notice of the employee's average monthly wage (AMW) amount and the basis for its determination to both the employee and the Commission.

After receiving the employer's AMW notice, the Commission gives the employee a 10-day opportunity to review the calculation and submit additional wage information. The Commission then makes its own independent calculation of the AMW and issues a final AMW determination. If the Commission's AMW determination is different from the amount the employer used in paying the initial benefits, the employer must pay the difference retroactively.

CLAIM STATUS CHANGES

An injured employee's treating physician has a duty to provide reports about an employee's condition to the employer **every 30 days** while providing active medical care for a work-related disability. If an employer changes or terminates payments of benefits based on this information or for any other reason, the employer must notify the employee and the Commission of the change using a Notice of Claim Status form.

When a physician discharges an employee from active treatment, the physician must determine whether the employee sustained any permanent impairment, and, if so, assign a rating for the impairment. If an impairment rating is for anything other than the specific injuries listed in the WCA's permanent partial disability schedule, the employer must notify the Commission within **30 days** after the date of the physician's report and request a determination of any further benefits payable to the employee. The Commission will then issue an award for any permanent disability benefits within another **30 days**.

DISPUTED CLAIMS

Employers and any other party may file a Request for Hearing to contest any Commission determination on a claim. All hearing requests must be filed within **90 days** of the determination that a party wishes to contest.

Employees may also dispute any claim decision made by employers or insurance carriers. They must file a hearing request with the Commission within **90 days** from the date of the employer's notice of:

- Claim denial;
- Change in benefits; or
- Termination of benefits.

ADMINISTRATIVE PROCEEDINGS

The Commission refers all hearing requests to its Administrative Law Judge (ALJ) Division. The ALJ Division then assigns a specific ALJ to preside over the case. After giving all interested parties at least **20 days' notice**, the presiding ALJ conducts a hearing.

At the hearing, the parties may present witness testimony and offer other evidence to support their claims and defenses. The ALJ then issues a written decision regarding the claim within **30 days** of the hearing.

REQUESTS FOR REVIEW

Any party aggrieved by an ALJ decision may file a Request for Review within **30 days** after the date of the decision. If no party files a timely Request for Review, the ALJ's decision becomes final as of the decision date.

If a party does file a timely Request for Review, the same presiding ALJ who held the hearing and made the original decision may affirm, reverse, rescind, modify or supplement the decision within **60 days** after the request. An ALJ's Decision on Review becomes final after **30 days** unless, within that time, one of the parties applies for judicial review.

JUDICIAL APPEALS

Any party dissatisfied with an ALJ's Decision on Review can appeal to the state court of appeals within **30 days**. The Arizona Supreme Court provides the following and highest level of review in the state. The parties must continue complying with the terms of the ALJ's decision while any judicial appeals are pending.

MORE INFORMATION

Contact Heffernan Insurance Brokers or visit the Commission website for more information on workers' compensation laws in Arizona.