WEST VIRGINIA
SECRETARY OF STATE
BETTY IRELAND
ADMINISTRATIVE LAW DIVISION

Form #5

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY ADOPTION OF A PROCEDURAL OR INTERPRETIVE RULE OR A LEGISLATIVE RULE EXEMPT FROM LEGISLATIVE REVIEW

AGENCY: Workers' Compensation Commission TITLE NUMBER: 85

CITE AUTHORITY: W. Va. Code §§23-1-1a(j)(3), 23-4-1 et seq.

RULE TYPE: PROCEDURAL _____ INTERPRETIVE _____

EXEMPT LEGISLATIVE RULE X

CITE STATUTE(s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW
W. Va. Code §§23-1-1a(j)(3)

AMENDMENT TO AN EXISTING RULE: YES ___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: * Note: This rule repeals and replaces 85CSR1, "Administration of the Workers' Compensation Fund"

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 1

TITLE OF RULE BEING PROPOSED: "Claims Management and Administration"

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS June 1, 2005

Authorized Signature

$ 14.50

TITLE 85
EXEMPT LEGISLATIVE RULE
WORKERS' COMPENSATION COMMISSION

SERIES 1
CLAIMS MANAGEMENT AND ADMINISTRATION

§85-1-1. General.

1.1. Scope. –This exempt legislative rule establishes the requirements and procedures to be followed by the West Virginia Workers' Compensation Commission, parties to claims pending before the Commission, health care providers, vocational professionals, and others involved in the administration of claims.

1.2. Authority. -- Pursuant to W.Va. Code Section 23-1-a(j)(3), rules adopted by the Workers' Compensation Board of Managers are not subject to legislative approval as would otherwise be required under W.Va. Code Section 29A-3-1 *et seq*. Public notice requirements of that chapter and article, however, must be followed.

1.3. Filing Date. --

1.4. Effective Date. --

1.5. Repeal of former rule. -- WV 85 CSR 1, "Administration Of The Workers' Compensation Fund," filed April 5, 2004, and effective May 5, 2004 is hereby repealed and replaced by the provisions of this exempt legislative rule. WV 85 CSR 6, "Time Limits for the Administrative Processing of Adjudications and Awards," filed May 23, 1985 and effective May 23, 1985 is hereby repealed and replaced by the provisions of this exempt legislative rule.

§85-1-2. Definitions.

As used in this exempt legislative rule, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

2.1. "Executive Director" means the executive director of the West Virginia Workers' Compensation Commission pursuant to W.Va. Code §23-1-1b.

2.2. "Commission" means the West Virginia Workers' Compensation Commission as provided for by W. Va. Code §23-1-1.

2.3. "Injury" and derivative words have the meaning ascribed to the term "injury" by W. Va. Code §23-4-1.

2.4. "Injured worker" means an employee entitled to workers' compensation benefits as the result of a work-related injury, as provided under W. Va. Code §23-4-1.

2.5. "Injured worker's employer" or "employer" means an employer within the meaning of West Virginia Code Section 23-2-1, *et seq.*

2.6. "Filing" shall mean actual receipt by the Commission.

2.7. "Paid" shall mean the time the check is deposited in the mail or presented in person to the claimant, claimant's attorney or anyone acting in his behalf.

2.8 "Receipt by the Commission" shall mean the day the document is scanned or otherwise entered into the Commission's computer system.

2.9 "Acted upon" shall mean, but shall not be limited to, any one of the following: 1) receipt and processing by Commission personnel; 2) contacting an injured worker, employer, or medical provider in any fashion requesting more information; 3) review and examination by the Commission's medical personnel; 4) conducting a potential overpayment analysis; 5) cross checking with other state agencies for relevant information; and 6) and other similar administrative steps which must be taken before a request can be ruled upon.

2.10 "Private carrier" shall mean an insurer authorized by the insurance commissioner to provide workers' compensation insurance pursuant to Chapter twenty three of the West Virginia Code.

§85-1-3. Injured Worker's Report of Injury and Application for Compensation.

3.1. General.

Immediately after a work-place injury, an injured worker 1) should seek necessary medical care; 2) shall immediately on the occurrence of the injury or as soon as practicable give or cause to be given to the employer or any of the employer's agents a written notice of the occurrence of the injury; and 3) should file a workers' compensation claim or request that one be filed on his or her behalf. Failure to immediately give notice to the employer of the injury shall weigh against a finding of compensability in the weighing of the evidence mandated by West Virginia Code Section 23-4-1g and will dilute the credibility and reliability of the injured workers' claim. Notice provided to the employer within ~~forty-eight (48) hours~~ two (2) working days of the injury shall be deemed immediate notice. Enforcement of an employer's personnel policy requiring that an injured worker report an injury immediately shall not be deemed a discriminatory practice under Chapter 23 of the West Virginia Code.

3.2 Benefit rate calculation; wage information

It is the joint responsibility of the injured worker and the employer to ensure that the correct wage information is provided to the Commission or private carrier so that the correct benefit rate can be paid the injured worker. If inaccurate wage information is received by the Commission or private carrier, the Commission or private carrier will, upon receipt of accurate wage information, adjust~~ed~~ prospectively the benefit rate. There shall be no retroactive adjustments to previous underpayments beyond two (2) years. The submission of inaccurate

wage information submitted by the employer or the receipt of benefits based on inaccurate wage information by the injured worker may serve as evidence of abuse or fraud under the applicable provisions of the West Virginia Code.

§85-1-4. Employer's Report of Injuries.

4.1 General

The injured worker's employer shall report to the Commission or private carrier every injury sustained by any person in its employ within five (5) days of the employer's receipt of the employee's notice of a desire to file a claim for injury or within five (5) days after the employer has been notified by the Commission or private carrier that a claim for benefits has been filed, whichever is sooner. Failure to comply with this reporting requirement may result in the employer being fined by the Commission, and upon termination of the Commission, the Insurance Commissioner, up to $250 per occurrence. Any employer that has five (5) or more occurrences within a rolling three hundred sixty-five (365) day period shall be fined up to $500 per occurrence as determined in the sole discretion of the Commission and upon termination of the Commission, the Insurance Commissioner.

4.2. Benefit rate calculation; wage information

It is the joint responsibility of the injured worker and the employer to ensure that the correct wage information is provided to the Commission or private carrier so that the correct benefit rate can be paid the injured worker. If inaccurate wage information is received by the Commission or private carrier, the Commission or private carrier will, upon receipt of accurate wage information, adjusted prospectively the benefit rate. There shall be no retroactive adjustments to previous underpayments beyond two (2) years. The submission of inaccurate wage information submitted by the employer or the receipt of benefits based on inaccurate wage information by the injured worker may serve as evidence of abuse or fraud under the applicable provisions of the West Virginia Code.

4.3. The Commission may require employers to file forms and reports electronically or telephonically through written policy.

§85-1-5. Special Rules for Owner and Officer Claims

5.1_Owners and officers; Coverage denials when the employer is delinquent or in default.

5.1.a. Until termination of the Commission, ~~E~~employers who fail to subscribe for workers' compensation coverage shall not be afforded coverage for its partners, the proprietor or its corporate or executive officers, nor shall coverage be afforded to any "employee" for whom the employer may elect to forego coverage under the provisions of W. Va. Code §23-2-1(g) including, but not limited to, members of corporate boards of directors or certain members of a limited liability company.

5.1.b. Employers who are delinquent or in default of their workers' compensation obligations shall not be afforded workers' compensation coverage for its partners, the proprietor or its corporate or executive officers, nor shall coverage be afforded to any "employee" for whom the employer may elect to forego coverage under the provisions of W. Va. Code §23-2-1(g) including, but not limited to, members of corporate boards of directors or members of a limited liability company.

1. Coverage for the "employees" specified in this provision shall not be afforded if the employer is delinquent or in default on the date of injury, and this exclusion will continue for the life of that injury. For example, if, at some time after the date of injury, the employer cures its default or delinquency status, the "employee" nevertheless will not be covered for the injury that occurred during the period of default or delinquency and benefits will never be payable for that injury.

2. In those cases where the employer is in good standing at the time of the injury and the "employee's" injury is therefore covered, but the employer then becomes delinquent or in default, then coverage shall terminate for the "employees" specified in this policy for the time period of the delinquency or default. No indemnity or medical benefits shall be paid for lost wages or medical treatment provided during this period of default or delinquency. If the employer fails to cure the delinquency or default within thirty (30) days notice thereof, then the claim shall be closed, coverage for the injury shall be barred for the life of that injury, and benefits paid to date shall be deemed an overpayment collectable from any future benefit awarded to the "employee."

3. In those cases where the employer appears to be in good standing at the time of the injury and the employer appears to have workers' compensation coverage, but the employer then becomes delinquent or goes into default retroactively (for example, as a result of underreporting payroll for a time period) so as to include the date of injury, then coverage shall not be afforded for the "employee" and this exclusion will continue for the life of that injury.

A. Provided: If the total delinquency or default is less than two hundred dollars ($200.00) of premium tax, then the commission will afford the employer an opportunity to cure its retroactive delinquency status by the issuance of a thirty (30)day notice to cure to the employer. If the employer cures its default or delinquency in accordance with this provision, the "employee" will be covered for the injury that occurred during the period of default or delinquency and benefits will be payable for that injury.

4. Benefits paid during periods of delinquency or default for "employees" denied coverage under this provision shall be considered overpayments.

5. When coverage for an injury is denied to an "employee" as a result of the employer's delinquency or default, the injured "employee" may only contest the commission's order through the provisions of 85 C.S.R. 7, "Rules for Selected Hearings," and the provisions of W. Va. Code §23-2-17. Until the conclusion of the W. Va. Code §23-2-17 process and the determination of whether the "employee" is afforded coverage, action in the claim will be held in abeyance.

6. The provisions of this section shall govern owner and officer claims that would have been payable from the Old Fund created in West Virginia Code Section 23-2C-2(l) if the employer otherwise had been in good standing.

7. Upon termination of the Commission, owners and officers of employers that are in policy default under Chapter twenty-three of the West Virginia Code shall not be eligible for benefits from the Uninsured Employer Fund created in West Virginia Code Section 23-2C-2(o) and Section 23-2C-8.

§85-1-6. Special Rules for Temporary Total Disability Claims.

6.1. To qualify for temporary total disability benefits, the injured worker must have missed more than three (3) ~~consecutive, regularly scheduled work~~ days due to the compensable injury before benefits become payable. To receive temporary total disability benefits for the first three (3) days ~~of regularly scheduled work days missed~~, the injured worker must have missed more than seven (7) ~~consecutive, regularly scheduled~~ days ~~of work~~ due to the compensable injury.

6.2. If an individual retires, he or she is disqualified from receiving temporary total disability indemnity benefits as a result of an injury received from the place of employment from which he or she retired, unless the application for benefits was received prior to his or her retirement. Individuals who have retired also shall be barred from reopening for indemnity benefits an earlier claim filed in connection with an injury received at the place of employment from which he or she retired. This section shall not preclude payments of benefits otherwise due an injured worker if the retiree has returned to employment and suffers a compensable injury and shall not preclude payment of benefits if the compensable injury causes the individual to retire.

6.3. If a period of disability includes a reasonably ascertainable period of time during which the injured worker would not have been compensated from his or her employer, then temporary total disability indemnity benefits shall not be paid during that period. This Section shall not apply to periods of time caused by a reduction in force, lay-off, or time-off provided in connection with an employee benefit.

§85-1-7. Special Rules for Permanent Partial Disability Claims.

7.1. Notice.

Upon the making of or refusing to make an award of benefits, the Commission or private carrier shall send to each interested party a written notice setting forth its decision and the terms thereof and informing the parties of their right to protest its decision by filing objection thereto in writing at any time within thirty (30) days after receipt of notice.

7.2. Computation of awards.

When an injured worker is found to be entitled to a permanent partial disability award, the award shall be computed in accordance with the law in effect when the award is payable.

7.3. Payment of permanent partial disability award.

Permanent partial disability awards shall be paid in monthly installments equal to the impairment awarded. For instance, a 10% permanent partial disability award would be paid over a ten (10) month period with the first payment being made the month following the award.

§85-1-8. Special Rules for Permanent Total Disability Claims.

[RESERVED]

§85-1-9. Special Rules for Non-Awarded Partial Benefits.

9.1. Non-awarded partial disability benefits will only be payable if the weight of the evidence indicates that a permanent impairment exists.

~~9.2. If an injured worker's temporary total disability benefits have been exhausted in terms of reaching the 104 week maximum, or any other maximum set by the Legislature, he or she will only be eligible to receive non-awarded partial benefits if the authorized treating physician has recommended a fifteen percent (15%) or more permanent partial disability award and the recommendation is consistent with the extent of the injured worker's injuries and guidelines for impairment utilized by the Commission.~~

9.3~~2~~. Non-awarded partial disability benefits shall not be payable in a claim that has been re-opened for temporary total disability benefits if a permanent partial disability award was previously made in the claim.

9.4~~3~~. Non-awarded partial disability benefits paid prior to entry of the permanent disability award are to be deducted from the permanent partial disability award when it is granted. If the non-awarded partial disability benefits exceed the amount of the award, the injured worker will not be entitled to any further benefits from the award. The excess is considered to be an overpayment and shall be collected from any future disability award in the same or any future claim, including, but not limited to, an award for temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits.

9.5~~4~~. The Commission or private carrier may cease paying non-awarded partial disability benefits if the Commission or private carrier concludes that the amount of non-awarded partial disability benefits already paid will likely exceed the expected partial disability award and may, as soon as practicable thereafter, enter a permanent partial disability award based on the most current information available and the guidelines set forth in 85 C.S.R. 20, if applicable.

9.6~~5~~. If the injured worker begins to receive rehabilitation benefits, non-awarded partial disability benefits shall not be paid until the rehabilitation process is completed.

9.76. Non-awarded partial disability benefits shall be immediately suspended if the injured worker fails, without good cause, to present for an examination or rating. If suspended with good cause, Bbenefits can be reinstated, without back pay, once the injured worker presents for the examination or rating.

9.87. Non-awarded partial disability benefits are paid at the same rate as the permanent partial disability rate.

§85-1-10. Time Standards

10.1. Injury and occupational disease claims. -- Those claims based upon injuries and occupational diseases other than occupational pneumoconiosis that are filed with the Commission or private carrier upon properly executed, prescribed forms shall be ruled on within fifteen (15) working days from the date of receipt of all required information by the Commission or private carrier. The Commission or private carrier shall consider all information and proof properly submitted in connection with each claim. Whenever it is of the opinion that a claim has not been adequately or properly developed for consideration, it may require the parties to produce additional evidence. The fifteen (15) working days to rule on the claim shall be tolled during this evidence gathering process.

10.2. Occupational Pneumoconiosis claims. -- Non-medical rulings shall be entered in occupational pneumoconiosis claims within fifteen (15) working days from the date of receipt by the Commission or private carrier of properly executed, prescribed forms from all parties involved. The Commission or private carrier shall consider all information and proof properly submitted in connection with each claim. Whenever the Commission or private carrier is of the opinion that a claim has not been adequately or properly developed for consideration, it may require the parties to produce additional evidence. The fifteen (15) working days shall be tolled during this evidence gathering process.

10.3. Medical Treatment. -- Requests for authorization of medical treatment shall be acted upon within fifteen (15) working days from the date of receipt by the Commission or private carrier.

10.4. Appliances, Devices, and Supplies. -- Requests for authorization of purchase of prosthetic or other appliances, devices or medical supplies shall be acted upon within fifteen (15) working days from the date of receipt by the Commission or private carrier.

10.5. Medical evaluations.

a. Referral of claimants to physicians for examinations and evaluations as required by West Virginia Code Section 23-4-7(a)(d), shall be made within twenty (20) working days of the end of the one hundred twenty (120) day period of temporary total disability.

b. Examinations and evaluations to be performed by the Occupational Pneumoconiosis Board shall be scheduled and notice of the scheduling shall be transmitted to the parties within sixty (60) days from the date of non-medical rulings directing referral to the Board.

10.6. Permanent disability rulings.

a. Permanent disability evaluation reports received from physicians to whom claimants have been referred by the Commissioner or private carrier in claims based upon injuries and occupational diseases other than occupational pneumoconiosis shall be acted upon ~~in a timely manner~~ within thirty (30) days.

b. Findings of the Occupational Pneumoconiosis Board shall be transmitted to the parties within ~~ten (10)~~ thirty (30) working days from the date of examination by the Board.

10.7 Petitions for reopening.

a. Petitions for reopening of claims for temporary total disability benefits and/or medical benefits shall be ruled upon within ten (10) working days from the date of receipt in the Commission or private carrier. The Commission or private carrier shall consider all information and proof properly submitted in connection with each claim. Whenever it is of the opinion that a claim has not been adequately or properly developed for consideration, it may require the parties to produce additional evidence. The ten (10) working days to rule on the claim shall be tolled during this evidence gathering process.

b. Petitions for reopening of claims upon a permanent disability basis shall be ruled upon within thirty (30) days from the date of receipt in the Fund.

10.8. Applications for modification of awards. -- Applications for modification of awards filed by employers shall be ruled upon within twenty (20) working days from the date of receipt in the Fund.

§85-1-11. Child Support and Spousal Support Orders

11.1. W. Va. Code § 23-4-18 allows child and/or spousal support payments to be withheld from an injured worker's compensation and sent to the Bureau for Child Support Enforcement. The term "compensation" refers to temporary total disability benefits, temporary partial rehabilitation benefits, non-awarded partial benefits, permanent partial disability benefits and permanent total disability benefits only.

11.2. The amounts to be withheld from an injured worker's compensation will be those which are set out in the withholding notice issued pursuant to the West Virginia Domestic Relations Act.

11.3. When an award of compensation is for permanent partial or non-awarded partial benefits, the Commission or private carrier can withhold 100% of those benefits to collect payment of child and/or spousal support benefits.

11.4. When compensation is for temporary total, temporary partial, rehabilitation temporary total, permanent total, or dependent benefits, the Commission or private carrier may only withhold the amount or amounts specified on the withholding notice, subject to the limitations set out in Table 1a.

§85-1-12. Overpayments

12.1. Overpayments include the receipt of any monies from the Commission or private carrier to which it is subsequently determined the injured worker was not entitled to receive or have paid on his or her behalf and include, but shall not be limited to, the payment of temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, dependents benefits, fatal (104 week) benefits, travel reimbursement, and medical benefits.

12.2. Overpayments to injured workers may be collected by the Commission or private carrier by withholding future disability benefits payable to the injured worker or the worker's dependents in the same or other claims. The overpayment specifically can be withheld from temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, dependents benefits, fatal (104 week) benefits, travel reimbursement, and any other monies awarded or paid by the Commission or private carrier. ~~Amounts due as a result of the Commission's subrogation rights or as a result of restitution or other related orders shall be deemed an overpayment for administrative purposes and subject to the provisions of this Rule.~~

12.3. Collection of overpayments from temporary total disability benefits, permanent total disability benefits, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, dependents benefits, and fatal (104 week) benefits shall be limited to thirty percent (30%) of the periodic benefit amount (i.e. weekly, bi-weekly, monthly, etc.); Provided that if the overpayment was based upon fraud, abuse, or mistake, caused in whole or in part, by the injured worker or his or her agent, then the amount of the overpayment may be recovered in full by withholding 100% of the periodic benefit amount until the overpayment is recaptured.

12.4. Collection of overpayments from travel reimbursement, permanent partial disability benefits and non-awarded partial disability benefits shall not be limited and may be withheld in full until the overpayment is satisfied.

§85-1-13. Occupational Pneumoconiosis and Occupational Disease Claims.

13.1. Occupational disease claims that involve disability or death resulting from occupational pneumoconiosis must be filed, processed, and litigated in accordance with statutory

provisions proscribing the administration of occupational pneumoconiosis claims. Claims involving cancers caused by inhalation of minute particles of dust over a period of time in the course of and resulting from employment are occupational pneumoconiosis claims and must be filed, processed and litigated as such. Statutes of limitation for occupational pneumoconiosis cancer claims will begin to run on the date when the occupational cancer was made known to the claimant by a physician or on the date when the claimant should reasonably have known of the cancer, whichever shall last occur.

13.2. Carpal tunnel and all other nerve entrapment syndromes of the upper extremity shall be filed as occupational disease claims unless the syndrome is a secondary diagnosis to an otherwise compensable injury.

13.3. An occupational disease claim filed based on the opinion of a psychologist shall be denied. Psychologists are not treating physicians and are not permitted to certify occupational disease disability.

§85-1-14 Special Rules on Closure of Claims

14.1. Medical benefits in all no lost time claims and claims for temporary total disability benefits shall cease and the claim administratively closed six (6) months after the last date of service in the claim. A protestable order shall be issued by the Commission or private carrier upon said administrative closure. Nothing in this provision shall be deemed to abridge an injured worker's right to attempt to reopen the claim at a later date under applicable law.

§85-1-15. Procedures for Suspension for Claimant Abuse

15.1. When evidence is obtained justifying a finding that an injured worker has engaged or is engaging in abuse, including, but not limited to, engaging in physical activities inconsistent with his or her compensable workers' compensation injury, or when evidence is obtained establishing a failure to undergo examinations or needed treatment, then the injured worker's temporary total disability benefits will be suspended by the Commission or private carrier.

15.2. Abuse may also include working at an unreported job while drawing temporary total disability benefits, making false or misleading statements to the Commission or private carrier or a health care provider for the purpose of securing any benefit, and altering, falsifying, destroying, or concealing workers' compensation related records.

15.3. Any claimant found to be engaging in abuse or who fails to undergo examinations or needed treatment shall receive a notice of benefit suspension. This notice will not be protestable. The injured worker will have thirty (30) days to submit evidence justifying the reinstatement of benefits. If justification is not established, then the injured worker will receive notice that the claim has been closed for temporary total disability payments and said notice shall be protestable. If justification is established, benefits will be reinstated with back benefits awarded.

15.4 In claims pending prior to approval of a managed health care plan, failure to select a treating physician from an approved managed health care plan within sixty (60) days of notification to do so will result in a suspension of medical and indemnity benefits until said selection is made, unless the injured worker is eligible to opt-out of the managed care plan network.

§85-1-16. Travel Expenses - Medical Examination and Treatment.

16.1. General.

Claimants are entitled to reasonable travel, meals and lodging expenses actually incurred in connection with authorized medical examinations or treatment. In making a determination of the reasonableness of such expenses, the Commission or private carrier shall utilize the travel regulations for State employees as a guide, unless specific provisions to the contrary are otherwise contained herein. Claimants may be reimbursed for mileage in connection with medical examination or treatment at a rate of 15 cents ($0.15) per mile. This rate shall not apply to mileage reimbursement requests involving treatment provided when the Commission or private carrier requires the claimant to undergo the medical examination and has selected the physician, or when an employer is required to reimburse reasonable travel and other expenses, as provided for in the W. Va. Code §23-4-8. The rate provided for in the travel regulations for State employees shall apply to these latter reimbursement requests.

16.2. Physical limitations.

Where a medical vendor certifies that a claimant, because of the state of his health, requires special travel arrangements in order to report for an authorized examination, the claimant shall be reimbursed for the cost of such arrangements.

16.3. Claimant's residence.

It shall be the policy of the Commission and private carriers to arrange for examination as near as practicable to the claimant's residence. If the claimant changes his residence after his or her date of injury to a location outside of West Virginia or to a location substantially further from the state than the residence on the date of injury, the following limitations shall be observed:

a. Where the change of residence is necessitated by reason of health or financial hardship, as determined in the sole discretion of the Commission or private carrier, upon a proper showing of such reasons the Commission or private carrier shall, in writing, endorse the change of residence and direct payment of meal and lodging expenses as follows:

1. Where the distance between the residence and the situs of the examination is less than four hundred (400) miles, meal and lodging expenses shall be payable as provided in Subsections 1~~5~~6.1 and 1~~5~~6.2 of these Rules;

2. Where the distance between the residence and the situs of the examination is greater than four hundred (400) miles, expenses actually incurred en route shall

be payable, to a maximum amount of the round trip air fare, economy class, between the closest airports offering scheduled commercial passenger service, as of the date said examination was scheduled;

3. Where the claimant objects to any order or finding, and the employer does not object thereto, and the claimant is subsequently directed to report for examination upon request of the employer, the claimant will be entitled to reimbursement of expenses from point of entry into West Virginia;

b. Where the claimant's change of residence is not necessitated by reason of health or financial hardship, expenses shall be payable only from point of entry into West Virginia.

§85-1-17. Litigated Claims

17.1. An authorized treating physician appearing at a hearing to give testimony regarding an examination of an injured worker will be paid a fee by the Commission, private carrier, or self-insured employer commensurate with the service rendered for such appearance and testimony.~~: Provided, That the examination was made at the request of the Commission. If the treating physician or other medical vendor appears to give testimony on behalf of the injured worker or employer regarding an examination made at the instance of such injured worker or employer, except as provided in 93 C.S.R. 1, payments must be made by the party requesting the testimony.~~

17.2. A treating physician or other medical vendor appearing at a hearing or deposition will be paid a fee commensurate with the service rendered for such appearance and testimony as otherwise provided for in the ~~Commission's~~applicable fee schedule.

17.3. Stay Pending Appeal. Pursuant to West Virginia Code Section 23-5-9(g), the Commission or private carrier shall not be required to implement an Order from the Office of Judges until either 1) the time period to appeal the Order has expired without appeal; or 2) the matter has been resolved by the Board of Review, whichever is later.

§85-1-18. Miscellaneous Administrative Matters

18.1. Incidents that do not result in material medical treatment, or that are not reasonably expected to result in medical treatment need not be reported to the Commission or private carrier by the worker or the employer.

18.2 If mail sent by the Commission to an injured worker, an employer, a vendor or any other party to a claim is returned due to an incorrect address, a reasonable effort will be made to determine the correct address. If after reasonable effort and due diligence a correct address cannot be located, the Commission shall cease mailing correspondence to the party until such time as a correct address is provided.

§85-1-19. Preferred Drug List.

19.1. Purpose. In accordance with the provisions of the Workers' Compensation Act [23-4-3(a)(3)] that require pharmacists, filling a prescription for medication for a workers' compensation claimant, to dispense a generic brand of the prescribed medication if the generic brand exists and in accordance with HCAP's responsibility to establish guidelines for reasonably required heath care treatment for occupational injuries and diseases, HCAP shall establish a Preferred Drug List (PDL) for the purposes of:

a. Improving the quality of care of claimants by utilizing a PDL of generics and brand medications in the absence of generics;

b. Affecting cost savings in the provision of heath care services by determining what is reasonably required; and

c. Optimizing pharmaceutical care and cost effectiveness.

19.2. Determinations. Considering the purposes the PDL, HCAP shall determine:

a. Therapeutic classifications;

b. Generic medications associated with each therapeutic class; and

c. Certain brand name medications associated with each therapeutic class for which a generic medication is not available.

19.3. Medications prescribed that are not listed on the PDL are subject to the approval of the Commission. In determining whether to approve or not approve the prescription, the Commission shall consider whether any generic or brand name medication for the same therapeutic class is listed on the PDL. If a generic or brand name medication is listed for that therapeutic class, the Commission shall not authorize the prescription.

a. Medications prescribed for off-label use shall require pre-approval by the commission, self-insured employer, or private carrier.

b. "Off-label use" means that the medication is prescribed for a condition, which is inconsistent with the manufacturer's label or instructions.

19.4. Procedure. Determinations made by HCAP shall be made in the following manner.

a. HCAP shall make any determination or determinations at a public meeting or meetings held in accordance with the provisions of this rule.

b. The determinations shall be filed with the office of the secretary of state for publication in the state register pursuant to the provisions of W.Va. Code, §29A-2-1 et seq.

19.5. Review. HCAP shall review the listings and classes of the PDL at least every six months as calculated from the effective date of this rule. The PDL may be reviewed and updated more often in the discretion of HCAP in accordance with the purposes and procedures contained within this section.

19.6. The current PDL, as adopted by HCAP, remains in force and effect in all existing and future claims until such time as HCAP adopts or revises the PDL.

19.7 Upon termination of the Commisison, each private carrier may establish a PDL for the purposes set forth in Section 19.1.

§85-1-19. Severability

If any provision of these rules or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not affect the provisions or the applications of these rules which can be given effect without the invalid provisions or application and to this end the provisions of these rules are declared to be severable.

TABLE 1a

Family	Arrears	Percentage
Not supporting another family	Less than 12 weeks old	Maximum of 50%
Not supporting another family	Greater than 12 weeks old	Maximum of 55%
Supporting another family, even just a spouse	Less than 12 weeks old	Maximum of 40%
Supporting another family, even just a spouse	Greater than 12 weeks old	Maximum of 45%

COPY

BEFORE THE
WEST VIRGINIA WORKERS' COMPENSATION
BOARD OF MANAGERS

****

IN THE MATTER OF:	)	**STEVE WHITE, CHAIRMAN**
PUBLIC HEARING	)	**RULE 1 - CLAIMS**
(NOVEMBER 19, 2004)	)	**ADMINISTRATION**

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Transcript of proceedings had in the above-styled meeting were held as therein appears before the WEST VIRGINIA WORKERS' COMPENSATION BOARD OF MANAGERS, held at the Charleston Civic Center, Suite 209, 200 Civic Center Drive, Charleston, West Virginia, at 1:00 p.m., on the 19th day of November, 2004.

****

BILLANTI & ASSOCIATES
COURT REPORTERS
1033 RIDGEMONT DRIVE
ELKVIEW, WV 25071
304-965-7444

APPEARANCES:

MEMBERS OF THE WEST VIRGINIA
WORKERS' COMPENSATION BOARD OF MANAGERS

STEVE WHITE, Chairman

PAUL THOMPSON, Member

GENE BAILEY, Member

BOB PHALEN, Member

MARGARET RICE, Recording Secretary

(VIA TELEPHONE)

DOUGLAS MERRITT, Member

EVERETTE SULLIVAN, Member

INDEX:

(P R O C E E D I N G S)

(1:00 P.M)

CHAIRMAN WHITE: I call to order the meeting of the Workers' Compensation Board of Managers. We have two members who are participating in this meeting via telephone. We do have a quorum.

This is a public hearing with respect to five rules that have been submitted to the Secretary of State's Office and we are now in the public comment period.

The first rule that we have before us is Rule 1, Claims Administration. I would like to open the public hearing with respect to Rule 1, claims administration. Mr. Bowen.

MR. BOWEN: Thank you very much, Mr. Chairman. Good afternoon members of the Board of Managers. I'm Henry Bowen and I'm actually rising to speak on behalf of myself as a practitioner of Workers' Compensation and not on behalf of the West Virginia Self-Insurers Association that I normally appear in front of you on behalf of that

association.

Gentlemen, there are in Rules 1, 2, 3 and 9, a volume of sections that have created discussion within the employer representative community.

All of us, for a variety of professional reasons, have been unable to complete our work, including written comments on these rules.

The primary concern that I had is, I know it's unusual, but not unprecedented was to ask if the Board of Managers would enlarge the time frame for receipt of written comments so that we could tender to the general counsel and to the Board of Managers written comments on these rules.

I have managed personally to complete comments on Rule 9, but I have not completed my comments on 1, 2 or 3, although I did have a chance to speak to the general counsel about a specific concern in Rule 1.

And so in lieu of specific section by section comment, I would simply ask if the

chair would entertain a request to allow all members of the public an additional time frame in which to submit written comments on these rules to the Workers' Compensation Commission.

CHAIRMAN WHITE: Thank you, Mr. Bowen.

MR. BOWEN: Thank you.

CHAIRMAN WHITE: I'm aware that there are a number of people that feel that they need more time on these rules. It would be my intention to not schedule the vote in the December meeting, but January 12th unless there's objection from other members, which would mean that the comment period would be extended to a date prior to that.

I will ask the Commission, Director Burton or Mr. Obrokta what a reasonable time period would be in order to keep it scheduled so we could have a vote on these rules on January the 12th.

MR. BURTON: Mr. Chairman, we could do it as long as the information was back to us by January 5th. That would give Mr. Obrokta enough

time to take a look at it and then get some information back to you-all for you-all to review prior to a vote on January the 12th.

If you could extend it through January the 5th, which hopefully -- I would just encourage the general public to get those in as quickly as possible.

We will meet with some who have already asked for those meetings to occur. We will meet with them as soon as possible and try to get it wrapped up, but you can extend it until January the 5th and then have a board meeting on January the 12th for the vote.

CHAIRMAN WHITE: We will extend the comment period to January 5th with the matters with respect to Rules 1, 2, 3 and 9 scheduled to come before the Board of Managers on January the 12th. Mr. Weaver?

MR. WEAVER: Mr. Chairman, thank you. My name is Bob Weaver. I'm a lawyer with Pat Maroney's office here in Charleston, and have some comments regarding this proposed Rule 1.

Concerning Section 3.1, about halfway down through the section, the sentence beginning with the word "Failure to immediately . . ." and the following sentence, would ask that those be deleted.

They are unnecessary and they are contrary to statute which allows the individual six months to file an injury claim and certainly whoever is ruling upon these claims at the self-insured or at the Commission has the ability to factor in, if they think it's necessary, some delay in filing the claim which they think is not reasonable.

I think when you insert language in this rule and include the word "shall," that you are dictating, as a matter of fact, if it's more than 48 hours that that's going to weigh against the claimant. That's not the intention of the statute and I think it goes against the whole spirit of the Workers' Compensation law.

CHAIRMAN WHITE: What language precisely were you asking to be omitted?

MR. WEAVER: The following sentence that beings with "Notice provided," that those two sentences be deleted.

We have filed our written comments or faxed them to Mr. Obrokta. I don't know if he has them or not, but they were faxed over earlier today.

Next, and maybe this has already been taken care of, but Section 4.2, which reads "Benefit rate calculation and wage information," appears to be duplicitous of Section 3.2 with the same heading. I don't know if it got in there twice or if it's already been removed, a more recent copy that maybe we don't have.

Concerning Rule 6.1 on page 4, we would ask that that be deleted and just leave it as it is under the current law. This rule can potentially work a hardship against some people if they don't necessarily work a five-day week, and the current law certainly is adequate to cover those situations.

In Section 6.2, top of page 5, we

would ask that beginning at line 2 after the word "benefits" and before the word "as," that they insert "for any days after his or her retirement date."

What that does is, you cannot collect temporary total disability benefits for any days after you have retired, but if there are days that were being pursued before you retired and all of a sudden you retire, you maintain your ability to be able to pursue those days that are prior to your retirement date. As I read it, I didn't think that was clear.

On line 3 of the same section, after the word "for," we insert the words "temporary total disability" before the words "indemnity benefits" and that makes it consistent with what is up in line 1 of this section; otherwise, it may be construed to apply to permanent partial disability benefits and I don't believe that's the intent.

Then lastly, in the same section on line 4, after the word "benefits," something in or

something needs to be inserted. That's just a matter of cleanup on that same section.

The next section is 6.3. We would ask that it be amended and would leave the language up to Mr. Obrokta, but to include "exceptions for labor disputes, plant closures or any other general work stoppage."

This will, as I read it, if there's some period of time that the claimant would not have been compensated, then TTD will not be paid.

If you are off on TTD and for some reason the plant closes, you are out the door, or if there's some sort of labor dispute that goes on or you are off on TTD and then a strike occurs, then you are not going to receive your temporary total. These are both things that are beyond the claimant's ability to control. We would just ask that consideration be given to that.

Section 7.3, on the payment of permanent partial disability awards, we would ask that this be deleted and that the payment of permanent partial disability awards continue as it

is now, because currently if someone is off on temporary total for a month and it takes several months before the permanent partial award is processed, then they will come back with a permanent partial award and it will bump up against the last payday of temporary total and then come forward. So part of that would come as a chunk and the remainder would come out in monthly installments.

What this does is just allow the Commission to delay payment that's due and owing to the claimant and I don't think there's any rationale other than delaying payment. The current system that's there works and it works fine.

Section 9.2 regarding rules for non-awarded partial benefits, we would ask that this be deleted in its entirety.

There are numerous individuals who may have been off for the 104 week maximum period now, but oftentimes the physician who is treating them does not rate individuals for permanent

partial disability and they will not offer an opinion regarding permanent partial disability and if that happens, then under this proposed rule the claimant will not receive any NAP benefits.

NAP benefits all along have been the bridge between the cessation of temporary total benefits and the payment of permanent partial award.

I don't see any way that this can work with the number of practitioners who don't rate people for permanent partial disability, but rather they are just their treater or care giver.

We would ask that that be stricken and that things be allowed to continue as is so the claimant isn't put under a hardship and having to go without benefits for who knows how long that period of time may be between the time that their 104 weeks runs out before they are finally able to be rated for permanent partial.

Section 9.5, we would ask that this section be deleted. I don't even know how the Commission would plan to do this, but they

indicate that if they conclude that the amount of NAP benefits already paid will likely exceed the expected permanent partial disability award, that they are going to stop your NAP benefits.

I don't know how one does that within a reasonable degree of medical certainty, but I don't think that there is a way to do that. I think it's just too arbitrary to talk about will likely exceed. That's nothing concrete that you can understand or quantify so that someone has an understanding of what that means.

I think that that needs to be deleted and that the system allow to continue to pay NAP benefits as they do currently.

Section 10.6(a) under "permanent disability rulings," we would ask that the phrase "shall be acted upon in a timely manner" be removed and you insert "within 15 working days."

If you will note going through this section, most every section has a number of days tied to it, 15 days, 20 days, what have you, and then they get down to acting upon reports from

doctors for permanent partial disability ratings and all of a sudden they want to do it in a timely manner. Once again, there's no parameters and it's not acceptable.

Section 12.2, we would ask that the words "dependent benefits, fatal (104 week) benefits" be deleted. This removes a repayment burden from a widow or other dependent for benefits that may have been overpaid to a deceased claimant and obviously, the widows have no way to make payment.

The same comment regarding 12.3.

On 13.1, we would delete the sentence that begins "Claims involving cancers," because this is contrary to the statutory provisions of 23.4.1, which specifically mandate that an occupational disease of the lungs be processed as an injury claim by the Commission, not before the OP Board.

On Section 14.1, "Special rules on closure of claims," we would delete it in its entirety. It's contrary to the statute which

allows a five year period in which to receive medical treatment before there's any possible closure.

When they amended the law in '95, I believe, they said if you go more than five years without substantial medical treatment, we reserve the right to close the claim. That's been the way it is since then, but now they are looking to further reduce this period of time saying that they can administratively close within six months and this is clearly in conflict with the statute.

On Section 17.1, this goes to the heart of the issue that I deal with daily, as most of the lawyers in this room do, and that is, doctors, deposition fees, costs, hearings and so on.

As I understood what was told to me, that this language was an attempt to keep things status quo as they are currently. I can tell you that that is not what this language does.

I'm not saying it was intended to do that, but we would ask the language be changed to

read as follows: "The Commission or self-insured employer will pay a treating physician appearing at a hearing or deposition to give testimony regarding treatment or an examination of an injured worker a fee commensurate with the service rendered for such appearance and testimony.

If the treating physician or other medical vendor appears to give testimony regarding an examination made at the request of such injured worker or employer, accept as provided in 93 CSR 1, payment must be made by the party who submitted the examination report into evidence." That's the way that it's done currently.

If I refer a claimant out to get a different PPD opinion and I put the report into evidence, then I have to pay if the employer's lawyer wants to cross-examine the doctor and vice versa; if they referred the claimant out and I want to cross their doctor, then they have to pay it.

If it's the claimant's treating physician on an issue which comes up all the time,

such as temporary total closure, denial of reopening, denial of medical treatment, diagnosis code and things of that nature, as the claimant's treating physician that deposition fee or expense has always been paid by the Commission.

We are just asking for nothing new, just that things be left the way they are and that this language as proposed by accepted.

Then lastly, 17.3, "Stay pending appeal," we would ask that this be deleted, because I think it's contrary to statute. Even though it cites statute, I believe I read it differently, because that says "An Office of Judges' order shall stand unless it is reversed on appeal."

It doesn't say to not process it until the entire appeal process expires. It just says that it will stand if the appeal gets reversed once it's taken up.

If they log jam every Office of Judges' order, we could bring Judge Leach in here and talk about how many orders that they generate

a month, we are not going to get anywhere.

We are going to have thousands upon thousands of orders pending while waiting for them to go up on appeal and once again, I disagree with the statutory instruction that's been given. Thank you.

CHAIRMAN WHITE: Thank you, Mr. Weaver. Were there other parties desiring to comment? Mr. Adkins?

MR. ADKINS: Thank you very much. My comments echo those of Mr. Weaver. We did not coordinate this in any fashion, but we each went over these independently and as he spoke, I went off my checklist of the things that he spoke about so those things that he spoke about, I am concerned about as well.

There is, again, on 3.1, my complaint is with the language that begins "Failure to immediately give notice to the employer of the injury" and ending with "the injured worker's claim."

There's really no basis for that

rule and it will work to the hardship of the claimant, because a lot of claimants out there, a number of them don't want to file claims because they are afraid that it will have an impact on their job, say, I don't want to file a claim.

And then something will happen like they will have a back injury on a Wednesday and it looks okay to them, but then by Friday or Saturday they can't get out of bed, they go to the doctor and then they find out they do have a medical problem and, of course, 48 hours has gone by.

I don't see that there's any real need for that kind of language in this rule. It basically says that nobody is to trust claimants and I don't think that that's appropriate.

I echo the comments about special rules for temporary total disability. 6.1, it talks about three consecutive regularly scheduled work days, and this is an example of some of the things I've seen in these rules where things are added to or taken away from the statute as it exists.

There's no reference to working days in the code. It just says days. God did not create the world in six working days. He created them in six consecutive days and that's what the code says here.

It says, "If the period of disability does not last longer than three days from the date the employee leaves work as the result of an injury, no award" and so forth. So it's three days. It doesn't say three working days.

The code doesn't say that and this is an example I've seen from time to time of inserting adjectives and adverbs into rules which reduce benefits that claimants get and that shouldn't be there, because it's not there.

This also appears, going backward, and this is one that Mr. Weaver did not mention, but it's 4.2, relating that "There shall be no retroactive adjustment to previous underpayments beyond two years."

There's any number of people that

have come to see me and I've looked at their cases and found out that they were paid at the incorrect rate. That's not because of anything that Workers' Compensation people did. It's just because they got either inaccurate or no information from the employer.

I try to catch them as quickly as I can, but sometimes if it's an old claim and for example, you might find out where the man had worked another job, that didn't get included and again, the statute doesn't put any two year limitation. The statute said it's based on the date of injury, period.

There's no qualification that says in the code that you only have two years to make a change. It's not there. I don't think by administrative regulation that you can do that and so I would like to see that part administered as well -- eliminated as well.

The Rule 9.2 on NAP benefits, "If an injured worker's temporary total disability benefits have exhausted and he gets a

recommendation of more than 15 percent, then no non-awarded partial benefits can be paid." Again, I think that that's not what the statute says.

Again, 9.5, which will "exceed the expected partial disability award," that's not defined. It just says that -- I don't know how that would be administered.

Somebody would say, well, we expect this award to be thus and so and that's why you send people out for examination, is to find out what the disability is.

I think the law as it is right now should stay the same and benefits should be paid in accordance with the practice as we have right now.

10.6(a), again, and I've had some personal experience with this, you get a report back, a PPD report, and you call your client, it's been three months since he got his exam and you haven't heard anything so you go to E-Comp or you go and you find out, well, here's the report. Nobody has done anything about it and so you call

up and please do something. More time goes by, please do something. Somebody goes on vacation, it gets changed around and so forth.

There have been a number of cases, even this year, where I got so frustrated and so exasperated that I had to file mandamus claims against the Commission just to get them to enter the PPD award.

This is basically going to give the Commission an excuse to avoid timely entry of PPD awards. I think there should be 15 days or 30 days. I'm not unreasonable about this sort of thing. I don't expect them to respond on the 15th, 16th day or the 31st day.

The Fund has never worked that way and I've been doing it for 35 years, but you have to be reasonable. If 3 or 4 months goes by and nothing happens, you have got to do something about it. You have got to represent your client so there ought to be some time in there.

The phrase "acted upon" concerns me and I think it comes from the Commission staff

experience and the Supreme Court on what the term "acted upon" means. Basically, they created "act upon" definition. That's 2.9.

It's overly broad in my estimation and it basically gives you a forever time period; review and examination, more information, cross checking or other similar administrative steps. You might add vacation time or sick days if you want to go that far with it. It's just too broad.

I have not had the opportunity to make written comment to this, as Mr. Bowen has not, and I plan to put some of this in writing as well, but I think it's too overly broad.

Again, on the PPD about basically making PPD benefits payable prospective only. I know why this is here. It helps your cash flow. I'll tell you, everybody wants to help. I want to help the cash flow, but there's got to be some balance in this process here.

If somebody has filed a petition to reopen their claim and it sits around for a year or more, then it finally goes out for evaluation

and then they get an award, it's prospective only. It doesn't go back anyway. It's been from time immemorial that PPD is picked up from the expiration of TTD or last period of permanent partial disability award.

It's not necessarily the Commission's responsibility to do this, but there are problems associated with many of these people that are on social security disability and the offsets that occur between social security disability and Workers' Compensation.

I haven't had time to fully analyze that or not, but some of these things may have an unintended result or effect on a person's social security disability benefit if they are on social security disability.

I'd like to address one area here that Mr. Weaver didn't address and that's 15, "Procedures for suspension for claimant abuse." I had one of these.

Obviously, we don't want to pay people that are abusing the system, but basically

it says that if we find that you have abused the system, we are going to cut off your benefits. But there's no -- again, when I was up here the other time about due process, there's no rebuttal. There's no way for the claimant to say no, I wasn't abusing it.

I had one of these cases where they said a fellow had abused it and cut off his benefits. We filed an appeal, went to hearing and nobody showed up from the Commission. Who wants a letter from the Workers' Compensation Fund, you have been abusing your -- it's sort of like a star chamber proceeding. You don't have any input into it so there ought to be some due process provisions in that.

Again on 17.1, everybody in the community, representatives, both the claimants and the employers, are concerned about this situation with respect to who pays whom.

Treating physicians, in my experience, we get them to hearings for purposes of treatment issues and periods of temporary total

disability benefits, very seldom do we get to them in terms of permanent partial disability examinations.

If you want to limit it to that, I suppose that maybe someone produces in that report, but something which is directly related to treatment -- I have this all the time. I have a situation in which the Commission refuses to reopen a case because this problem is not part of the compensable injury.

It is part of the compensable injury. So you have a deposition, you go through the medical records, you prove it and it's going to create -- if the claimants have to absorb this, they are not going to do it.

They don't have the money to pay the doctors $300 and pay the court reporter fees another $100 or something like that. It's expensive, but we are in an expensive situation. I would think that the present rule should be -- or the present practice should be maintained.

Those are my comments. I hope that people take those into consideration. I thank you very much for your time.

CHAIRMAN WHITE: Thank you, Mr. Adkins. Any further public comment with respect to Rule 1?

(No responses were given.)

CHAIRMAN WHITE: I hereby declare the public comments public hearing with respect to Rule 1 closed.

(WHEREUPON, the hearing was concluded at 1:40 p.m.)

REPORTER'S CERTIFICATE

STATE OF WEST VIRGINIA,

COUNTY OF KANAWHA, to wit:

I, the undersigned, David T. Bolin, Courter Reporter and Notary Public, do hereby certify that the foregoing is, to the best of my skill and ability, a true and accurate transcript of the proceedings had before the **West Virginia Workers' Compensation Board of Managers** as set forth in the caption hereof, and that this is the original transcript thereof for the files of the Committee.

GIVEN UNDER MY HAND THIS 29th DAY OF NOVEMBER, 2004.

MY COMMISSION EXPIRES JULY 27th, 2014.

Court Reporter

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
DAVID T. BOLIN
1033 Ridgemont Drive
Elkview, WV 25071
My Commission Expires July 27, 2014

WEST VIRGINIA WORKERS' COMPENSATION BOARD OF MANAGERS
PUBLIC HEARING
NOVEMBER 19, 2004 – 1:00 P.M.
85CSR1 – CLAIMS ADMINISTRATION

ATTENDANCE SHEET

The Board is required to keep a list of individuals attending its meetings and of those who wish to address the Board.

NAME	COMPANY	Do you wish To speak? (Yes/No)
T. McElroy	[illegible]	N
Edward Miller	[illegible]	Yes
Roger Tincher	Steptoe & Johnson	No
Bonnie Harold	Builders Supply Assn. of WV	NO
Admin State	Consentra	N
M Keeper	Accordia	No
Hilary R	WSSIA	Yes

WEST VIRGINIA WORKERS' COMPENSATION BOARD OF MANAGERS
PUBLIC HEARING
NOVEMBER 19, 2004 – 1:00 P.M.
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ATTENDANCE SHEET

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NAME	COMPANY	Do you wish To speak? (Yes/No)
Bob Weaver	Thomas P. Maroney, LC	Yes

FAX TRANSMISSION COVER SHEET

Rev. 4-4-03

UNION GROUP, LTD.

PO BOX 105
BRIDGEPORT, WV 26330

MAIN OFFICE: (304) 623-3844 FAX: (304) 623-3843

DATE: 1/5/2005

TO: WV WC Board of Managers FROM: Jim Herron

COMPANY: PAGES INCLUDING COVER: 4

FAX NO.: (304) 926-1880 HARDCOPY IN MAIL: ☐

SUBJECT: Comments on Pending WC Changes

MESSAGE:

Please see attached.

Comments on Rules 1 and 9

IF THERE IS A PROBLEM WITH THIS TRANSMISSION PLEASE CALL US AT: (304) 623-3844 THANK YOU.

Union Group, Ltd.

Quality Union Craftsmanship

1/3/05

Workers Compensation Commission Board of Managers
4700 MacCorkle Ave. SE
Charleston, WV 25304

RE: Request for Public Comments on Proposed Rules-Ends 1/5/05

Our comments are as follows:

1. Rule 85CSR1
   a. RE- Notification of Injuries by Employer

      (i.) We object to this notification procedure. Furthermore, we request ability to pay for all injuries under a set amount i.e.:$5,000, and those injuries paid out of pocket by employer not count against our policy. This pay out of pocket would be on a employer decided basis and would be optional.

2. Rule 85CSR9
   a. RE- Inclusion of entire Gross Wages for employees out of state.

      (i.) We request that for purposes of determining premiums due for all employees working in or out of state, fringe benefits, per diem, and mileage expenses are not included.

   b. RE- Extraterritorial Coverage for out of state employers

      (i.) It has come to our attention that many out of state employers are not paying proper Workers Compensation Premiums to anyone. We request that Certified Payrolls reflect Workers Compensation premiums paid to outside agencies, state or private, and audit procedures be instituted.

      (ii.) Due to the difficulty in obtaining out of state coverage for our Risk Group, 5037 Painting Steel and other Structures over Two Stories, we request that we have the option to use our West Virginia Workers Compensation coverage on <u>any</u> out of state construction contract for <u>any</u> length of time for our employees, regardless of their place of residence or place of hire. This will help us obtain out of state contracts so that we

P.O. Box 105 • Bridgeport, WV 26330 • (304) 623-3871

may keep more West Virginia workers employed, both in the field and back in the offices.

Enclosed is a recent bid tabulation on a small job that reflects how low out of state contractors bid in our class. The results are the same on West Virginia DOT jobs, only in larger numbers. I am certain a large percentage of wages never has WC paid on them, as it is under or unreported. If this situation does not change we will be forced out of business. Incidentally we have paid $323,461 the last two years in Workers Compensation premiums. Thank you for your consideration. I can be reached at (304) 623-3844 ext 302.

James E. Herron
President

JANE LEW PUBLIC SERVICE DISTRICT - WATER DIVISION
LEWIS COUNTY, WEST VIRGINIA

CONTRACT #2 - CLEANING OF A [illegible] GALLON STEEL RESERVOIR
BID TABULATION

Bid Opening: September 25, at 2:00 PM, LPT
Thrasher Engineering Project #[illegible]

OUT OF STATE — OUT OF STATE — In State

Item	Qty.		Description	D & M PAINTING CORP., Washington, PA, WV License [illegible] Unit Price	Total Cost	GLOBAL PAINTING CO., Campbell, OH, WV License [illegible] Unit Price	Total Cost	[illegible], INC., Charleston, WV, WV License [illegible] Unit Price	Total Cost	SPECIALTY GROUPS, INC., Bridgeport, WV, WV License [illegible] Unit Price	Total Cost
1	1	LS	Videotaping of Project Area	300.00	$300.00	100.00	$100.00	[illegible]	$[illegible]	[illegible]	$[illegible]
2	1	LS	Mobilization/Demobilization	4,000.00	$4,000.00	800.00	$800.00	2,000.00	$2,000.00	[illegible]	$[illegible]
3	1	LS	Interior Surface Preparation Including Spot Blasting, & Weld Repairs	24,000.00	$24,000.00	27,000.00	$27,000.00	[illegible]	$[illegible]	45,000.00	$[illegible]
4	60	EA	Pit Filling	4.00	$240.00	10.00	$600.00	10.00	$600.00	30.00	$1,800.00
5	1	LS	Interior Painting and Painting	11,000.00	$11,000.00	15,000.00	$15,000.00	[illegible]	$[illegible]	[illegible]	$[illegible]
6	1	LS	Exterior Surface Preparation Including Pressure Washing, Spot Blasting, and Painting Per SSPC-SP11	4,000.00	$4,000.00	13,200.00	$13,200.00	15,000.00	$15,000.00	8,700.00	$8,700.00
7	1	LS	Exterior Overcoating, New Rubber Gaskets and Bolts for Manholes	12,000.00	$12,000.00	8,500.00	$8,500.00	14,000.00	$14,000.00	8,700.00	$8,700.00
8	1	LS	Sealant Between Tank and Foundation	400.00	$400.00	1,600.00	$1,600.00	400.00	$400.00	28,000.00	$28,000.00
			TOTAL BASE BID		$55,[illegible]		$71,[illegible]		$1[illegible]		$1[illegible]
DEDUCTIVE ALTERNATE #1											
6	1	LS	Exterior Surface Preparation Including Pressure Washing, Spot Blasting, and Painting Per SSPC-SP11	4,000.00	$4,000.00	13,200.00	$13,200.00	15,000.00	$15,000.00	8,700.00	$8,700.00
7	1	LS	Exterior Overcoating, New Rubber Gaskets and Bolts for Manholes	12,000.00	$12,000.00	8,500.00	$8,500.00	14,000.00	$14,000.00	8,700.00	$8,700.00
			TOTAL DEDUCTIVE ALTERNATE #1		$16,000.00		$21,[illegible]		$[illegible]		$17,[illegible]

Prepared By:

THRASHER

KENNETH P. MORAN
REGISTERED
[illegible]
STATE OF WEST VIRGINIA
PROFESSIONAL ENGINEER

MARONEY, WILLIAMS, WEAVER & PANCAKE, PLLC

THOMAS P. MARONEY
GENERAL COUNSEL

ROBERT M. WILLIAMS, ATTORNEY
J. ROBERT WEAVER, ATTORNEY
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TELECOPIER TRANSMITTAL SHEET

DATE: January 5, 2005

TO: T.J. Obrokta, General Counsel FAX NO.: 304/926-5372
West Virginia Workers' Compensation Commission

FROM: J. Robert Weaver, Esquire
Maroney, Williams, Weaver & Pancake, PLLC

RE: Proposed Title 85 Series 1

TOTAL NUMBER OF PAGES, INCLUDING THIS SHEET: 4

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January 5, 2005

T. J. Obrokta, General Counsel
Executive Offices
WV Workers' Compensation Commission
4700 MacCorkle Avenue, SE
Charleston, West Virginia 25301

Re: Proposed Rule Title 85, Series 1
Exempt Legislative Rule Workers' Compensation Commission
Claims Management and Administration

Dear Mr. Obrokta:

This office had previously submitted comments regarding the above proposed legislative rule through correspondence of November 19, 2004. After further review and consideration, we have decided to elaborate on our comments as they relate to benefit calculations under Rule 85-1-3, §3.2 and Section 85-1-4, §4.2.

BACKGROUND

Historically, the former Workers' Compensation Fund, even prior to its inclusion in the Bureau of Employment Programs, allowed for the submission of wage information at any time, as long as the claim was still open, since they recognized that workers were not sophisticated in what constitutes a legitimate wage base and therefore a proper determination of their average weekly wage and subsequent benefits. Further, it must have been a concern of the Workers' Compensation Commission, since it sent notice to employers on March 31, 2004 regarding the calculation of the daily rate of pay for full-time employees and potential adjustment in benefit payments. The March 31st notice concluded by stating, "***We want to insure that injured workers receive benefits to which they are entitled but also want to share information with us so the appropriate level of benefit is paid.***"

By way of further illustration, in the report of the Board of Managers' Claims Committee on December 7, 2004, it was reported in the subsection titled "Quality Assurance File Reviews", that: *"In 62% of the claims the wages where entered correctly, which represents a decrease from the October report."* By our estimation, 62% is a failing grade and the prior month of October, would have been a D when we were in school.

We have taken an independent review of contracts filed by our office between January 2004 and June 30, 2004 with respect to the completeness of wage information. By complete wage information, we mean the daily rate of pay and at least three of the quarters in the four full quarters preceding the quarter in which the injury or last exposure occurred. We also picked this period of time since it was prior to the mandated conversion to self-administration for self-insured employers. During this period of time there were 195 contracts submitted; however, 37 of those were claims prior to July 1, 1994, which did not utilize quarterly earnings which were obtained by the Workers' Compensation Fund, (now Commission), through the use of wage printouts from the Division of Employment Security. This would have left a base of 158 claims. Of that number, 61 had complete wage information, which would be a compliance rate of 38.60%. Admittedly, some of those individuals would have received the maximum benefit even without the complete information, but all parties would rest easier if they were confident that the compliance rate was much higher.

In addition, recent experience with claims filed against self-insured, self-administrating employers has shown that many employers are not complying with the requirements to use quarterly wages in addition to the daily rate of pay to insure that their injured employees and the dependents of fatally injured workers are receiving proper compensation benefits.

Another complicating feature to the proposal that has become apparent is the fact that the personnel at the Workers' Compensation Commission (formally Division) have a particularly bad habit of intentionally not preparing the wage records properly if the claim is rejected. Obviously, a rejection causes a delay in the final adjudication of the claim, particularly so if it has to go through the appeal process which can take several years before a worker, or their representative, are aware that the wage record is incomplete, although that is not the case with our office. However, even our office sometimes does not become involved in a claim until several years after the initial ruling and only then is it discovered that the worker was not properly paid.

I am not suggesting that fairness and equality are not important to the Commission, but this rule certainly makes it appear that proper payment of benefits for some individuals is irrelevant when it is in opposition to the bottom line.

CONCLUSION

For all of these reasons, we feel that any shortened time-limits with respect to the submission of proper wage information are unfair, unjust and contrary to

statute, since a claimant now has the right to reopen their claim for further consideration at any time within five (5) years of the date of closure or the entry of a disability award.

RECOMMENDATIONS

§85-1-3 Injured Workers' Report of Injury and Application for Compensation

pg. 2 3.2 Beginning with the words "There shall" in line five, delete the entire sentence.

§85-1-4 Employer's Report of Injuries

pg. 3 4.2 Beginning with the words "There shall" in line five, delete the entire sentence.

This completes our supplemental comments to be considered in addition to comments previously filed on November 19, 2004.

Sincerely yours,

J. Robert Weaver

JRW/mec

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January 5, 2005

Mr. Thomas J. Obrokta, Jr.
Director of Operations
Workers' Compensation Commission
Office of Judges
PO Box 2233
Charleston WV 25328-2233

Re: **Comments on 85CSR1**

Dear Mr. Obrokta:

We appreciate the opportunity to comment on rule 85CSR1 dealing with Claims Management and Administration and want to acknowledge all the excellent work you have invested in the rewrite of this Rule. We would ask that you give consideration to the following suggested changes:

Section 2.5.1. We suggest adding the following at the end of this sentence: "acting as the employer's agent."

Section 2.7. The second paragraph reads as follows: "Receipt by the Commission" shall mean the day the document is scanned or otherwise entered into the Commission's computer system."

We suggest this paragraph be deleted. In the older Series 1 rule 1.5.(d) defined receipt of ....."notice" referencing receipt supplied the parties by the commission. It appears this language is needed to deal with receipt by outside parties. Further, the current language conflicts with Section 2.6. by moving from actual receipt date to the day a document is scanned or otherwise entered into the commission's computer system. We are concerned that either scanning or entry may create delay-related issues, moving us from a true "receipt" date. If all documents are date-stamped, then this could provide a solution.

Section 4.1. General
This section currently reads in part as follows: "The injured worker's employer shall report to the Commission every injury sustained by any person in its employ within five (5) days of the employer's receipt of the employee's notice of a desire to file a claim for injury...."

We suggest the last part of this section be changed as follows: **"...employee's written notice of a claim for injury."**

We fully support and applaud the efforts of the Commission to encourage the prompt filing of claims. This is totally consistent with the concept of early intervention and the effective claims management sought by the Commission.

We are, however, concerned about the imposition of a fine per occurrence of "late" filing by the employer. Dependent on the location of the accident and the employer's structure or hierarchy in filing claims, it is difficult for many employers to meet the five-day time frame. As an example, if you are dealing with a single plant site, it is certainly easier to have a claim filing brought to the attention of the individual who may be the single reporting source for all injuries. Where a company has multiple locations, it is common to have the injury flow through a supervisor, a superintendent or project manager and then to a central filing source—in may cases, through a regional or a corporate office. In either instance described above, if one party in the filing hierarchy is out on vacation, you are likely to experience a "late" filing. We are simply concerned with what may be interpreted as a rigid means of penalizing an employer who is generally very responsive in promptly filing claims.

Further, we are very concerned that, in an effort to avoid a potential financial penalty, we may trigger a large number of claim filings for minor incidents (see 85-1-20) which would never otherwise be filed as Workers' Compensation claims. For example, if the injury requires first-aid only, should the employer file the claim? If not, the employer may face a potential penalty. We hope that you will give serious consideration to removing this punitive language.

Section 4.2. Benefit Rate Information; Wage Information
We believe that the word "supplied" should be inserted following "based on inaccurate wage information" in the next to last line.

Section 85-1-5. Special Rules for Owner and Officer Claims
In all subsections dealing with this area, we urge that this language apply only in cases of default and not include delinquency. There are many cases in which delinquencies occur based on simple error whether on the part of the employer or the commission and are readily cured. To give the same weight to delinquency as default may create great harm to employers and individuals based on minor issues. Obviously, where delinquencies occur and are not cured, an employer moves to default and must rectify the problem or face legal action.

We strongly believe that in cases in which a default is cured, the proviso in Section 5.1.b.3.A. should apply in **all** cases of default without regard to the amount of premium tax involved. To do otherwise is to ignore the fact that the default has been cured. Cured indicates that premium and likely interest and penalties have been paid. Consequently, all benefits due and owing the injured should be considered valid.

The absence of such language is a deterrent to any employer locating a corporate office in the state of West Virginia. Any officer of a corporation would have to find the existing language extremely troubling.

Section 7.3. Payment of Permanent Partial Disability Award
We would like to raise a couple of issues. First, it has been the historical practice to establish the payment of permanent partial disability benefits from the last date on which either temporary total or permanent partial disability benefits were paid. In the 10% example given, if the employee had last received benefits more than forty weeks earlier than the date of the award, would the award be paid in lump sum or is it the intent to simply pay on a prospective basis from the date of the award? Further, we note that the example of a 10% award is to be paid over a ten-month period. We wonder whether this should specify that forty weeks are to be paid on a monthly basis. One could infer that a 1% award equates to one month as opposed to four weeks of benefits. We are sure this is not what was intended—and simply raise this as something you may wish to clarify.

Section 10.5.(a)
We ask that consideration be given to adding the following language to this paragraph: "Except in cases where, at the discretion of the commission, such examination is deemed inappropriate."

By way of explanation, we would simply note that there are cases in which there is no real need and in fact it may be an inconvenience at best for the employee to require such 120-day evaluation. Assume we are dealing with a back claim in which the individual undergoes surgery at the 110th day. Certainly, an evaluation is inappropriate. We are simply looking for a way to allow the commission to apply a reasoned approach in such cases. We also question whether such evaluations are even necessary in a managed care environment as contemplated elsewhere in both our law and in 85CSR21.

Section 12.2.1
Should the last sentence reference "or self insurer's" in addressing the Commission's subrogation rights?

We do want to acknowledge the many positive and well written changes in this Rule. Thank you for your consideration of the above suggested changes.

Sincerely,

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Edward G. Atkins, Esq.
Douglas V. Atkins, Esq.

December 2, 2004

T. J. Obrokta, General Counsel
Workers' Compensation Commission
PO Box 431
Charleston, WV 25322

RE: Title 85 Series 1

Dear Mr. Obrokta:

I understand public comment on proposed Title 85 Series 1 has been extended, and I enclose my comments on the proposed revision. Those comments, as you can see, are extensive.

It is not seen that Senate Bill 2013 requires a substantial change in administrative processing of claims. From the claimant's point of view, the existing process is satisfactory and the tenor of my remarks is to continue the past process. The new proposed regulations differ significantly from past practice, and the changes are all adverse to claimant's interests. It is still the purpose of the Workers' Compensation law to compensate those injured on the job, and the Commission's regulations should be balanced reflecting the interests of claimant, the employer and the Commission. The proposed regulations do not reflect this balance and, on the whole, reflect an anti-claimant bias. It is hoped that my comments produce changes to the proposed regulations which would more fairly take into consideration claimant's interests.

Sincerely yours,

Edward G. Atkins
EGA/pjm
cc: Steve White

§85-1-3. Injured Workers' Report of Injury and Application for Compensation.

3.1 General

Immediately after a work-place injury, an injured worker 1) should seek necessary medical care; 2) shall immediately on the occurrence of the injury or as soon as practicable give or cause to be given to the employer or any of the employer's agents a written notice of the occurrence of the injury; and 3) should file a workers' compensation claim or request that one be filed on his or her behalf. Failure to immediately give notice to the employer of the injury shall weigh against a finding of compensability in the weighing of the evidence mandated by West Virginia Code Section 23-4-1g and will dilute the credibility and reliability of the injured workers' claim. Notice provided to the employer within forty-eight (48) hours of the injury shall be deemed immediate notice. Enforcement of an employer's personnel policy requiring that an injured worker report an injury immediately shall not be deemed a discriminatory practice under Chapter 23 of the West Virginia Code.

Delete "Failure...claim." Delete "Enforcement... Code."

Rationale. From a legal standpoint, this commentator argues that there is no statutory basis for creating a presumption that a failure to report within 48 hours "shall weigh against a finding of compensability..." The Code allows an employee up to six months to file a claim. Creating such a presumption materially affects the right of the claimant to file within that time period. No statutory authority is cited for the creation of this presumption.

From a policy point-of-view, there are many employees who prefer not to file a claim if the injury appears minor. Despite a statutory presumption against discrimination by an employer against an employee for filing a Workers' Compensation claim, in fact, such discrimination does exist. A minor back injury may actually portend a major medical problem which does not come to light within 48 hours. A minor cut can turn into a full-blown infection. In fact, an employee may be so seriously injured, he may not be able to report the accident at all. While employers do need to have information as soon as possible to investigate an accident, the creation of a regulatory presumption is inappropriate from both a legal and policy point-of-view. Any delay in the reporting of an injury should be considered in compensability determinations along with all other relevant evidence.

The last sentence of the proposed regulation is particularly onerous and, in this commentator's opinion, void on its face. It is directly contrary to the provisions of W.Va. Code §23-5A and particularly W.Va. Code §23-5A-1. An employer's personnel policy may be to discharge an employee failing to report an injury. The last sentence of this regulation would appear to condone such a practice. Not only is this part of the regulation contrary to law, it is dangerous to an employer who may rely upon it. An employer relying upon this part of the regulation as a disciplinary tool might find itself embroiled in a lawsuit it cannot win.

3.2 Benefit rate calculation; wage information

It is the joint responsibility of the injured worker and the employer to ensure that the correct wage information is provided to the Commission so that the correct benefit rate can be paid the injured worker. If inaccurate wage information is received by the Commission, the Commission will, upon receipt of accurate wage information, adjusted prospectively the benefit rate. There shall be no retroactive adjustments to previous underpayments beyond two (2) years. The submission of inaccurate wage information submitted by the employer or the receipt of benefits based on accurate wage information by the injured worker may serve as evidence of abuse or fraud under the applicable provisions of the West Virginia Code.

Delete "There...Code."

Rationale. This sentence reflects an attempt to limit the law where no such limitation appears. This commentator has, on numerous instances, submitted evidence of income which resulted in an adjustment of an award with a higher benefit being paid. Many, if not most, claimants are unsophisticated and are never advised as to how their daily benefit rate is calculated. In any event, W.Va. Code §23-4-6(a) states that with respect to the award of temporary total disability benefits, benefits are based on "the average weekly wage earnings, wherever employed, of the injured employee, at the date of injury,..." (Emphasis applied.)

Similar language is found in §23-4-6(d) and §23-4-6(e)(1). There is no qualifying language in the Code that limits the period of time in which information regarding income cannot be submitted. If there is a policy reason to limit the period in which to report, that policy should be addressed by legislation and not regulation.

4.1 General

The injured worker's employer shall report to the Commission every injury sustained by any person in its employ within five (5) days of the employer's receipt of the employee's notice of a desire to file a claim for injury or within five (5) days after the employer has been notified by the Commission that a claim for benefits has been filed, whichever is sooner. Failure to comply with this reporting requirement may result in the employer being fined up to $250 per occurrence. Any employer that has five (5) or more occurrences within a rolling three hundred sixty-five (365) day period shall be fined up to $500 per occurrence as determined in the sole discretion of the Commission.

Delete "Failure...Commission."

Rationale. While this office is almost exclusively in the business of representing claimants in Workers' Compensation claims, it is also an employer. This commentator finds no statutory basis whatsoever for authority to issue penalties. The Commission's enforcement powers are limited to those provided in the Code, and the Commission has no authority to impose any additional penalties.

§85-1-4. Employer's Report of Injuries.

4.2 Benefit rate calculation; wage information

It is the joint responsibility of the injured worker and the employer to ensure that the correct wage information is provided to the Commission so that the correct benefit rate can be paid the injured worker. If inaccurate wage information is received by the Commission, the Commission will, upon receipt of accurate wage information, adjusted prospectively the benefit rate. There shall be no retroactive adjustments to previous underpayments beyond two (2) years. The submission of inaccurate wage information submitted by the employer or the receipt of benefits based on inaccurate wage information by the injured worker may serve as evidence of abuse or fraud under the applicable provisions of the West Virginia Code.

§85-1-6. Special Rules for TTD Claims.

6.1 To qualify for temporary total disability benefits, the injured worker must have missed more than three (3) consecutive, regularly scheduled work days due to the compensable injury before benefits become payable. To receipt temporary total disability benefits for the first three (3) days of regularly scheduled work days missed, the injured worker must have missed more than seven (7) consecutive, regularly scheduled days of work due to the compensable injury.

Delete "There... Code."

Rationale. See rationale expressed in comment on Rule 85-1-3.2.

Additionally, that sentence in the regulation providing that inaccurate wage information "may serve as evidence of abuse or fraud" has no place in the regulation. That the sentence is qualified by the term "may" does not matter. This language elevates inaccurate wage reporting to a position of importance greater than any other evidence which might be offered to support the charge of abuse or fraud.

Moreover, it is not seen how the Commission can enforce a responsibility assigned to another state agency, i.e. Department of Employment Security. The Workers' Compensation Commission relies upon information supplied by the Department of Employment Security, and this proposed regulation appears to regulate the Department of Employment Security.

Delete phrase "consecutive, regularly scheduled work"; delete "of regularly scheduled work days missed,"; delete phrases "consecutive, regularly scheduled" and "of work"

Rationale. This is another area where the regulations attempt to amend the statutory scheme. W.Va. Code §23-4-5 simply uses the word "day" or "days." It is not limited by any phrases, such as "regularly scheduled work days" or "consecutive, regularly scheduled days." A day is a day. If an employee is injured on a Friday and remains injured for seven days, that worker is eligible for benefits for the first three days, even though the first two, i.e. Saturday and Sunday, may not be a "scheduled" work days for such a worker.

6.2 If an individual retires, he or she is disqualified from receiving temporary total disability indemnity benefits as a result of an injury received from the place of employment from which he or she retired. Individuals who have retired also shall be barred from reopening for indemnity benefits an earlier claim filed in connection with an injury received at the place of employment from which he or she retired.

Delete 6.2 paragraph

Rationale. This commentator finds no statutory authority disqualifying a claimant from receiving temporary total disability benefits from a place of employment from which such claimant is retired. Presumably, such a claimant could receive temporary total disability from a place of employment from which he has not retired even though such employee was retired from another place of employment. There is no definition of "retired" in this regulation. The regulation does not require the claimant to be receiving retirement benefits of any kind. This commentator sees no reason to discriminate against a retired employee who might be brought back to his former place of employment for a limited period of time or for a particular project to be excluded from temporary total disability benefits simply on the basis of that status. It is this commentator's intention, health permitting, to work beyond the period required to attain full old-age Social Security retirement benefits. While this commentator may be entitled to receive full Social Security retirement benefits, he would not, in fact, be retired. If this commentator were injured in an automobile accident on a trip to the courthouse or falling down the steps at the office or straining his back lifting a box of old files, he should be entitled to a period of temporary total disability benefits as any other claimant would be.

6.3 If a period of disability includes a reasonably ascertainable period of time during which the injured worker would not have been compensated from his or her employer, then temporary total disability indemnity benefits shall not be paid during that period.

Delete 6.3 paragraph.

Rationale. There is no statutory basis for this regulation. The term "temporary total disability benefits" means a period of time for which a claimant can receive benefits if that person is: (a) not working; (b) under the regular care of a treating physician; (c) certified disabled by such treating physician; and (d) not reached his maximum medical improvement. This proposed regulation appears to add another requirement for the receipt of temporary total disability not heretofore existing. Not only is there no statutory basis for §85-1-6.3, it is unduly vague by using the term "reasonably ascertainable period of time."

§85-1-7. Special Rules for PPD Claims.

7.3 Payment of PPD award.
Permanent partial disability awards shall be paid in monthly installments equal to the impairment awarded. For instance, a 10% permanent partial disability award would be paid over a ten (10) month period with the first payment being made the month following the award.

Delete 7.3 paragraph. Substitute current §85-1-13.2

Rationale. The current policy is to pay permanent partial disability benefits from the date temporary total disability benefits cease or, in the case of reopening for an additional permanent partial disability award, from the date of the last payment on any previous award. Other than temporarily improving the Fund's cash flow, certain claimants will be subject to unfair discrimination in the payment of benefits. For example, a person deemed eligible for non-awarded partial benefits (NAP benefits) will get his benefits before, and possibly long before, an individual determined not eligible for NAP benefits. Indeed, the very existence of NAP benefits, i.e. W.Va. Code §23-4-7(a), recognizes and supports the existing payment process.

Moreover, making payments prospective discriminates against a claimant who may suffer delay in the evaluation process as opposed to one who is promptly evaluated. Also, such a regulation would tend to encourage a delay by the self-administered, self-insured employer in the evaluation process by postponing that employer's financial responsibility for as long as possible.

There may also be unintended adverse consequences to claimants if this regulation is adopted. As this commentator stated at the public hearing, the adoption of the practice of paying permanent partial disability benefits prospectively may have adverse consequences on those persons receiving benefits from other sources, such as Social Security Disability. Under present practice, a claimant, only recently determined eligible for Social Security Disability benefits, may be entitled to reopen a prior Workers' Compensation claim and receive an award for periods of time before the receipt by that claimant of Social Security Disability benefits and suffer no consequence. Presumably, §85-1-7.3 would transform payment for past periods into payment for future periods which, for some Social Security Disability recipients, may result in a loss by such claimants of Social Security Disability benefits. Similarly, payment of PPD benefits prospectively may reduce benefits to those individuals receiving awards from private disability policies which are affected by the payment of Workers' Compensation benefits.

This commentator perceives §85-1-7.3 as a mechanism to aid cash flow, for example, by paying a 5% award over the next 20 weeks rather than in a lump sum. While this might improve cash flow, no argument has been presented as to what extent the cash flow would be improved, and the consequences to a claimant in terms of the delay involved in receiving benefits seem to outweigh any potential cash flow benefit. Persons with a permanent disability need payment now, not next week or next month.

§85-1-9. Special Rules for Non-Awarded Partial Benefits.

9.2 If an injured workers' temporary total disability benefits have been exhausted in terms of reaching the 104 week maximum, or any other maximum set by the Legislature, he or she will only be eligible to receive non-awarded partial benefits if the authorized treating physician has recommended a fifteen percent (15%) or more permanent partial disability award and the recommendation is consistent with the extent of the injured worker's injuries and guidelines for impairment utilized by the Commission.

Delete 9.2. Insert present practice.

Rationale. No statutory basis exists for postponing the award of non-awarded permanent disability if the claimant has been paid the maximum temporary total disability benefits. See §23-4-7a(c).

Again, this proposed regulation attempts to add a restriction to the law where none exists. While a case could be made that this would be a sound practice, it is not authorized by statute. This regulation does not take into account the commonly accepted practice of treating physicians offering an opinion to the Commission that a permanent disability exists, but not offering an opinion as to the amount. The position of the treating physician is understandable in these situations. It is a function of the treating physician to get the best result possible, and there would be a natural bias to offer a low permanent disability opinion. A low disability opinion may put the patient, i.e., the claimant, in conflict with the patient-claimant. In any event, there is no statutory authority for distinguishing the payment of NAP benefits based upon how much TTD benefits have been awarded.

9.3 Non-awarded partial disability benefits shall not be payable in a claim that has been re-opened for temporary total disability benefits if a permanent partial disability award was previously made in the claim.

Delete 9.3. Insert present practice.

Rationale. This is yet again another attempt, by regulation, to add a condition to receiving benefits which is not in the statute. W.Va. Code §23-4-7a(c) contains no exception for the payment of NAP benefits based upon a prior award. While the obvious purpose of this regulation is to prevent over-compensation of permanent disability benefits, the appropriate process is by statutory amendment rather than regulatory action.

9.5 The Commission may cease paying non-awarded partial disability benefits if the Commission concludes that the amount of non-awarded partial disability benefits already paid will likely exceed the expected partial disability award.

Delete 9.5.

Rationale. This regulation is indefinite and, therefore, incapable of fair implementation because of the term "will likely exceed the expected partial disability award." The whole purpose of the evaluation process is to make an accurate determination of percentage of impairment. While it may be fairly simple to deduce an impairment of a simple back strain, the process becomes much more complicated in cases where the claimant may have sustained multiple injuries. The best deterrent to excess payment of NAP benefits is a prompt and fair IME. Proposed §85-1-9.5 should not serve as a substitute therefore.

9.7 Non-awarded partial disability benefits shall be immediately suspended if the injured worker fails, without good cause, to present for an examination or rating. Benefits can be reinstated, without back pay, once the injured worker presents for the examination or rating.

Third line delete "without back pay."

Rationale. One presumes that a claimant should not be penalized if, in fact, he could show good cause for not appearing at a scheduled IME.

§85-1-10. Time Standards

10.6. Permanent disability rulings.

a. Permanent disability evaluation reports received from physicians to whom claimants have been referred by the Commissioner in claims based upon injuries and occupational diseases other than occupational pneumoconiosis shall be acted upon in a timely manner.

Delete "in a timely manner" and substitute "within fifteen (15) working days from the date of receipt."

Rationale. Rule 85-1-10 in three separate places, i.e., 10.3, 10.4 and 10.6, uses the phrase "acted upon," which phrase is defined under §85-1-2.9. The term "acted upon," is to be distinguished from the phrase "ruled upon" which appears in other subsections of 85-1-10. While the Commission certainly should have adequate time to determine the correct payment of benefits, the Commission should not be able to indefinitely postpone a ruling by raising as a defense that it is "acting in a timely manner." The statutory admonition still exists, i.e. "It is the further intent of the Legislature that this chapter be interpreted so as to assure the quick and efficient delivery of indemnity and medical benefits to injured workers..." (W.Va. Code §23-1-1(b)) If the Commission requires self-insured and self-administered employers to "act upon" permanent disability evaluation reports within 15 working days of the date of receipt (see 85 CSR 18-15.5(d)(2)), the Commission's own staff should do likewise. Moreover, simply adopting the words "timely manner" does nothing but to increase litigation potential with the expected result that the phrase "timely manner" being

interpreted as meaning only days than for longer periods, such as weeks or months. Nowhere in 85-1-10 is more than 30 days stated for the accomplishment of any activity.

§85-1-12. Overpayments

12.2 Overpayments to injured workers may be collected by the Commission by withholding future disability benefits payable to the injured worker or the worker's dependents in the same or other claims. The overpayment specifically can be withheld from temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, dependents benefits, fatal (104 week) benefits, travel reimbursement, and any other monies awarded or paid by the Commission. Amounts due as a result of the Commission's subrogation rights or as a result of restitution or other related orders shall be deemed an overpayment for administrative purposes and subject to the provisions of this Rule.

Delete "Amounts... this Rule."

Rationale. No statutory authority exists for reducing a claimant's benefits based upon the Commission's subrogation rights. The statutory provision for recovery of overpayments is found in §23-4-1(c). There are no provisions for recovery of any overpayment because of some prior subrogation determination. W.Va. Code §23-2A creates a lien, but provides no mechanism of enforcement. Technically, the right to subrogation is not due to an overpayment. It is a reimbursement.

§85-1-13. Occupational Pneumoconiosis and Occupation Disease Center.

13.1 Occupational disease claims that involve disability or death resulting from occupational pneumoconiosis must be filed, processed, and litigated in accordance with statutory provisions proscribing the administration of occupational pneumoconiosis claims. Claims involving cancers caused by inhalation of minute particles of dust over a period of time in the course of and resulting from employment are occupational pneumoconiosis claims and must be filed, processed and litigated as such. Statutes of limitation of occupational pneumoconiosis cancer claims will begin to run on the date when the cancer was made known to the claimant by a physician or on the date when the claimant should reasonably have known of the cancer, whichever shall last occur.

Suggested amendment: In all places where the word "cancer" appears, insert the word "occupational."

Rationale. The proposed amendment makes it clear that the time begins to run from the discovery that cancer was caused by occupational exposure and not simply from the date of the first diagnosis of cancer. A potential claimant diagnosed with cancer may not know that his cancer is related to his occupation until long after the diagnosis is made. Time should begin to run from that point.

13.3 An occupational disease claim filed based on the opinion of a psychologist shall be denied. Psychologists are not treating physicians and are not permitted to certify occupational disease disability.

Delete 13.3.

Rationale. This commentator sees no reason why a qualified psychologist, usually a master's level or Ph.D. level psychologist, familiar with Workers' Compensation guidelines should not be entitled to treat or to offer opinions on emotional disorders related to occupational injury claims. The pool of psychologists familiar with or willing to treat Workers' Compensation claimants is very small. There are many instances in which treatment provided by psychologists are as useful as treatment provided by M.D.'s. Indeed, in many instances, the only difference between a treating psychologist and a treating psychiatrist is the ability to prescribe medication. In most such instances, treating psychologists are associated with physicians who can prescribe appropriate medication.

§85-1-15. Procedures for Suspension for Claimant Abuse.

Add new subsection 15.4 as follows:

Suggested amendment. Include 15.4:

"Abuse will only be found if a pattern of conduct supports a conclusion that a claimant is willfully failing to comply with the Commission's orders or willfully engaging in an activity or activities for the purpose of drawing Workers' Compensation benefits to which he may otherwise not be entitled."

Rationale. A charge of abuse carries more with it than simply ineligibility for benefits. Abuse carries with it the stigma of illegal activity and, if charged, should be supported by specific charges and by provable facts. This regulation in itself is ripe for abuse, including unsubstantiated reports from disgruntled neighbors to angry ex-wives. The regulation is not clear as to whether a single failure to undergo examination would support a finding of abuse. An innocent, though inaccurate, statement made without intent to illegally obtain Workers' Compensation benefits should not be the basis for termination of benefits. Termination of benefits by reason of abuse should only be resorted to in cases where a pattern of conduct support a conclusion of abuse. The suggested addition to Rule 85-1-18 makes it clear that abuse will only be found in certain situations.

In any case, in which benefits are terminated due

§85-1-17. Litigated Claims.

17.1 A treating physician appearing at a hearing to give testimony regarding an examination of an injured worker will be paid a fee commensurate with the service rendered for such appearance and testimony: Provided, That the examination was made at the request of the Commission. If the treating physician or other medical vendor appear to give testimony on behalf of the injured worker or employer regarding an examination made at the instance of such injured worker or employer, except as provided in 93 C.S.R. 1, payments must be made by the party requesting the testimony.

to abuse under this regulation and a protestable order entered, an expedited hearing process should be available.

Delete 17.1. Replace:

"An authorized treating physician appearing at a hearing to offer testimony regarding a diagnosis of a medical disorder, its relationship to the compensable event, care and treatment, and periods of temporary total disability will be paid a fee by the Commission or by the self-administered employer or its third-party administrator commensurate with the service rendered for such appearance and testimony. The appearance fee of an authorized treating physician offering an opinion of permanent disability in accordance with the provisions of W.Va. Code §23-4-7a(c) or a physician offering an opinion on behalf of the Commission or on behalf of a self-administered employer or its third-party administrator instead of the Commission shall be paid by the Commission or by the self-administered employer or its third-party administrator commensurate with the service rendered for such appearance and testimony. The appearance fee of all other physicians or medical vendors shall be paid by the party offering that physician's or vendor's evidence."

Rationale. Rule 85-1-17.1 is represented as adopting current practice. This commentator does not believe this to be the case and prefers the proposed substitute. Usually, the purpose of examining or cross-examining the treating physician is to determine what conditions are compensable, medical treatment issues and periods of temporary total disability. Disputes tend to arise over these matters. If the treating physician's testimony at a hearing is necessary, it should be paid by the Commission or by the self-administered, self-insured employer. Such issues are not readily reducible to written report which is often the reason for taking a treating physician's testimony at a hearing.

Rule 17.1, as proposed by the Commission staff, appears only to authorize the Commission to pay the appearance fee if there was an examination by the treating physician made at the request of the Commission. Presumably, any party requesting the testimony of a treating physician in any other circumstance, including the party

claimant, must pay for the physician's appearance. Depending upon the claimant's financial circumstances, necessary medical treatment may be delayed or not undertaken at all under this interpretation of presently proposed 85-1-17.1.

Moreover, W.Va. Code §23-4-3(a) can be interpreted as requiring that the appearance fee be paid by the Commission or self-insured, self-administered employer. W.Va. Code §23-4-3(a) requires that the Commission establish a reasonable fee schedule for health care providers providing treatment "...or services to injured employees under this chapter." "Services" can be interpreted as the testimony of a treating physician at a hearing.

The second sentence of the regulation proposed by this commentator adopts the present practice of the Commission or as the case may be the self-insured, self-administered employer paying the appearance fee of a physician examining on behalf of the Commission or of the treating physician offering an opinion of disability within the NAP process.

The third sentence maintains the present practice requiring that the party offering evidence by an examining physician pay for the appearance fee. This would include a treating physician offering opinion of permanent disability outside the NAP process. Section 85-1-17.1 as proposed by the Commission staff reverses that practice, requiring that payments "must be made by the party requesting the testimony."

On this point, the proposal made by the Commission staff presents serious procedural due process problems. Why should a claimant be required to pay to cross-examine an examining physician who says nasty things about the claimant? Conversely, why should the employer have to pay to examine the claimant's evaluating physician who may offer an opinion of impairment substantially in excess of what the totality of the other evidence suggests.

There is no discovery in Workers' Compensation cases. In civil matters, if a party wishes to offer an expert's opinion into evidence at trial, that party is required to pay the appearance fee of that expert. So too should the rule be in Workers' Compensation hearings. Finally, the

17.3 Stay Pending Appeal. Pursuant to West Virginia Code Section 23-5-9(g), the Commission shall not be required to implement an Order from the Office of Judges until either 1) the time period to appeal the Order has expired without appeal; or 2) the matter has been resolved by the Board of Review, whichever is later.

rule as proposed by this commentator defines the obligations of the self-insured, self-administered employer which are not found elsewhere in the regulations.

Delete 17.3.

Rationale. This proposed regulation, of all the regulations proposed in this series, may be the most objectionable by claimants. While innocuous on its face, the consequences to claimants would be far-reaching.

This proposed regulation, as understood, permits the suspension of the effect of an ALJ award until appeal periods have expired. The proposed regulation opens the door to substantial employer abuse by retaliating against an employee with an avalanche of frivolous appeals. While most responsible employers do not engage in frivolous activities, some do and in some cases, employer retaliation can be expected.

The main beneficiary of this regulation appears to be the Commission itself which is responsible for the payment of benefits where there is no responsible employer to which to charge the claim. That an ALJ decision may be reversed on appeal and the claimant determined not to be eligible for benefits as awarded by an ALJ can and does occur. Also, it is true that present practice allows the payment of benefits during the appeal process with the result that an overpayment may occur. While overpayment can occur, it is unfair for the entire claimant population to suffer the delay in the processing of their claims. It is to be observed that this regulation applies to <u>all</u> orders of the Office of Judges, including orders related to medical treatment.

Aside from the policy reasons above-stated, no statutory authority appears to exist for its implementation. The regulation refers to W.Va. Code §23-5-9(g) which provides that the decision of the Office of Judges "...is final and benefits shall be paid or denied in accordance with the decision, unless the decision is subsequently appealed and reversed..." The statute says that the decision of the administrative law judge is final – not interlocutory. It is effective until subsequent repeal and reversal; that benefits have been paid

during appeal is not contemplated as a reason for denying the effect of the award. There is no provision in Workers' Compensation law regarding stays of appeal as exists in civil practice matters.

Other Comments:
It is understood that former Rule W.Va. 85 CSR 1 is to be abolished. Presently, 85-1-13.3 provides for lump sum payments of PPD benefits under particular circumstances as outlined in that particular regulation. No counterpart is found in the proposed new Series 1. Whether this is intentional or due to oversight is not known. While rarely used in this commentator's experience, there are good reasons for the commutation of a permanent partial disability award as outlined in §85-1-13.3. It is recommended that this regulation be adopted into the new proposed regulations. This process is so rarely used, that it is unlikely to have any impact on cash flow.

This entire series should be reviewed and compared with Series 18 relating to self insurance, self administration and third-party administration with respect to procedural consistencies. It is understood that the Commission and self-administered employers are to be treated on an equal basis procedurally. As noted above, there is one circumstance in which does not occur, and that is the difference between §85-18-15.5(d)(1) and §85-1-10.6(a), i.e., 15 days versus a "timely manner."

RESPONSE TO COMMENTS TO 85 C.S.R. §1

1. Comments From Union Group, Ltd.

- Comment regarding Section 1.a. is rejected because $5,000 is an appropriate mechanism to encourage prompt reporting of injuries.

2. Comments From Maroney, Williams, Weaver & Pancake

- The recommendations for modification of Sections 3.2. and 4.2. are rejected because these provisions are reasonable enticements to encourage prompt reporting of injuries.

3. Comments From Atkins & Atkins

- Comments regarding Section 3.3. are partially accepted as reflected in the final version of Rule 1.
- Comment regarding Section 3.2. is rejected because it allows for an unreasonable amount of back pay to be paid.
- Comment regarding Section 4.1. is rejected because the language proposed to be eliminated is a reasonable incentive to encourage prompt claim reporting.
- Comment regarding Section 4.2. is rejected because it allows for an unreasonable amount of back pay to be paid.
- The proposed comment regarding Section 6.1. is accepted and is reflected in the final version of Rule 1.
- Comment regarding Section 6.2. is partially accepted as reflected in the final version of Rule 1.
- Comment regarding Section 6.3. is partially accepted as reflected in the final version of Rule 1.
- Comment regarding Section 7.3. is rejected as the current language is a reasonable method of paying permanent partial disability awards.
- Comment regarding Section 9.2. is accepted.
- Comment regarding Section 9.3. is rejected as the current language is a reasonable regulation of non-awarded partial disability benefits.
- Comment regarding Section 9.5. is rejected as the current language is a reasonable regulation of non-awarded partial disability benefits.
- Comment regarding Section 9.7. is accepted.
- Comment regarding Section 10.6. is accepted as reflected in the final version of Rule 1.
- Comment regarding Section 12.2. is accepted.
- Comment regarding Section 13. is accepted as reflected in the final version of Rule 1.
- Comment regarding Section 13.3. is rejected because a psychologist is not a treating physician.

- Comment regarding Section 15. is rejected as it is inconsistent with the intent of Chapter 23.
- Comment regarding Section 17.1. is accepted as reflected in the final version of Rule 1.
- Comment regarding Section 17.3. is rejected as being inconsistent with the West Virginia Code.

All other comments received at the public hearing or through written comment are rejected or are partially accepted as represented in the final version of Rule 1.

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
JOE MANCHIN III
Governor
JANE L. CLINE
Insurance Commissioner

FILED

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

October 11, 2006

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

RE: 85CSR20 - Repeal Language

Dear Judy:

The above subject rule, which became effective on January 20, 2006, contains repeal language which is incorrect. The repeal language under subsection 1.5 states that "This exempt legislative rule repeals and replaces ... 5) 85 C.S.R. 1, 'Administration of the Workers' Compensation Fund,' Sections 11, 14, and 20." This repeal language refers to an earlier version of the Series 1 rule and does not apply to the current Series 1 rule which became effective on June 1, 2005. Therefore, Sections 11, 14 and 20 should not be removed from the current Series 1 rule. The incorrect repeal language will be removed as part of a Series 20 rule amendment currently being drafted by our office.

Please contact our office if you have any questions regarding the above.

Sincerely,

Mary Jane Pickens
General Counsel

MJP/jz
Enclosures

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