WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION

Form #2

Do Not Mark In This Box

FILED

2003 NOV -7 P 3:53

OFFICE WEST VIRGINIA SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Workers' Compensation Commission TITLE NUMBER: 85

RULE TYPE: Exempt Legislative CITE AUTHORITY: W. Va. Code 23-1-1a(j); 23-4-7a

AMENDMENT TO AN EXISTING RULE: YES X NO ___

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 1

TITLE OF RULE BEING AMENDED: Administration of the Workers' Compensation Fund

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ___

TITLE OF RULE BEING PROPOSED: ___

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON December 12, 2003 AT 5:00 p.m. ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

T.J. Obrokta, General Counsel
Workers' Compensation Commission
4700 MacCorkle Avenue, S.E.
Charleston, WV 25304
Fax # 304-926-5372

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

$8.60

WCC Insuring a Working West Virginia
Workers' Compensation Commission
Gregory A. Burton, Executive Director

4700 MacCorkle Avenue, S. E.
Charleston, West Virginia 25304
Phone: (304) 926-1710

November 6, 2003

The Honorable Joe Manchin III
Secretary of State
State Capitol Complex
Building 1, Room W-157
Charleston, West Virginia 25305

Re: Proposed Rule
Title 85, Series 1
"Administration of the Workers' Compensation Fund"

Dear Secretary Manchin:

Please consider this letter to be my written approval for the filing of the above-noted proposed Rule.

Pursuant to Senate Bill 2013, Second Extraordinary Session, 2003, the Workers' Compensation Commission is established as a government entity separate from the Bureau of Employment Programs. Pursuant to that same bill, the Board of Managers of the Workers' Compensation Commission have approved the enclosed 85 C.S.R. 1 for filing as a proposed rule of the Workers' Compensation Commission.

Thank you very much for your assistance in this matter.

Very truly yours,

Gregory A. Burton
Executive Director

Enclosure

FISCAL NOTE FOR PROPOSED LEGISLATIVE RULES

Rule Title: Title 85 Series 1: Administration of the Workers' Compensation Fund

Type of Rule: ___ Legislative Exempt ___Interpretive _X_ Procedural

Agency: Workers' Compensation Commission

Address: 4700 MacCorkle Ave. S.E.

Charleston, WV 25304

1. Effect of Proposed Rule

	Annual		Fiscal Year		
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
ESTIMATED TOTAL COST	$0	Unknown	Unknown	Unknown	Unknown
PERSONAL SERVICES	0	0	0	0	0
CURRENT EXPENSE	0	0	0	0	0
REPAIRS & ALTERNATIONS	0	0	0	0	0
EQUIPMENT	0	0	0	0	0
OTHER:					
Benefit payments	0	Unknown	Unknown	Unknown	Unknown
Benefit related payments	0	6,000,000	6,000,000	6,000,000	6,000,000

2. Explanation of above estimates:

Implementation of this rule should result in a reduction in benefit payments that are temporarily suspended by the Commission as a result of any claimant, without good cause, missing two (2) or more scheduled examinations or necessary treatments. Because this rule establishes the criteria for determining if a period of non-compensability exists, it is expected to save an undetermined amount in benefits that may have been paid without the defining guidance of this rule. There would also be a reduction of approximately $6,000,000 in benefit related payments made to claimants per fiscal year due to the rule defining what the requirements are for reimbursing mileage to a claimant. This is based on an estimate that about 75% of the approximately $8,000,000 in mileage reimbursement payments that were paid in fiscal year 2003 do not meet the revised requirements for reimbursable mileage, according to the rule's guidance.

Rule Title: Title 85 Series 1: Administration of the Workers' Compensation Fund

3. Objectives of this rule:

This rule establishes and defines the policy and procedure for the administration of the Workers' Compensation Fund, including specific criteria and requirements related to suspension of claims benefits and required mileage reimbursement payments in certain defined situations.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

It is expected that this rule will contribute toward more efficient and thorough claims management by the Workers' Compensation Commission, and will result in savings in claims and claim related costs.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

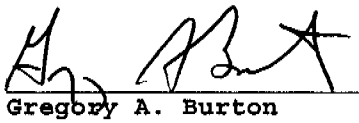
It is expected that, with lower claims costs, employers will incur lower premium rates. Also, it is expected that the rules guidelines will contribute toward better and more effective treatment of injured workers.

C. Economic Impact on Citizens/Public at Large.

This proposed rule would not have a direct economic impact on the citizens of West Virginia.

Date: November 6, 2003

Signature of Agency Head or Authorized Representative



Gregory A. Burton
Executive Director, Workers' Com
Compensation Commission

SUMMARY OF PROPOSED RULE
STATEMENT OF CIRCUMSTANCES

TITLE 85, SERIES 1
WORKERS' COMPENSATION COMMISSION
ADMINISTRATION OF THE WORKERS' COMPENSATION FUND

Effective July 1, 2003, Senate Bill 2013 significantly changed the provisions of the Workers' Compensation Act. Certain stylistic changes reflecting new terminology consistent with statutory changes, i.e. commission, executive director, are reflected in this rule change. Other more significant changes center on the provisions of §11 and §15 of 85 C.S.R. 1.

Section 11 of this rule was changed to comply with the new law changes effective July 1, 2003. W. Va. Code §23-4-7a requires the Commission to develop a rule to allow for the suspension of benefits if the claimant refuses, without good cause, to undergo examinations or needed treatment. The rule defines "good cause."

Section 15 of this rule was changed in large part to eliminate mileage reimbursement for claimants' medical treatment, except where the travel results from required Commission or employer examinations. This provision is calculated to save a number of millions of dollars in reimbursement expenses.

TITLE 85
EXEMPT LEGISLATIVE RULE
WORKERS' COMPENSATION COMMISSIONER

SERIES 1
ADMINISTRATION OF THE WORKERS' COMPENSATION FUND

'85-1-1. General.

1.1. Scope. -- ~~These Legislative Rules provide~~This exempt legislative rule provides for the general administration of the West Virginia Workers' Compensation Fund.

1.2. Authority. -- W. Va. Code ~~§§23-1-13,~~§§23-1-13, 23-2-9 and ~~23-3-1.~~
23-3-1. Pursuant to W. Va. Code, §23-1-1a(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, § 29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed.

1.3. Filing Date. -- ~~April 15, 1986.~~

1.4. Effective Date. -- ~~July 1, 1986.~~

1.5. Definitions. -- As used in ~~these regulations:~~this Rule:

(a) "Claimant" shall mean any individual who files an application for Workers' Compensation benefits.

(b) "Filing" shall mean actual receipt in the office of the ~~Commissioner.~~Executive Director.

(c) "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.

(d) "Receipt of . . . Notice" shall be presumed to have occurred on the third day following the date of the notice. The next day (or the fourth day following the date of the notice) will be treated as the first day of the period during which a protest or appeal may be filed. Should the final day of such period be a Saturday, Sunday or legal holiday (State or Federal), the period shall expire on the next business day immediately following such Saturday, Sunday or legal holiday.

(e) "Subscriber" shall mean an employer for whom Workers' Compensation coverage has been effected.

(f) "Within fifteen (15) days of the mailing of such copy" shall mean within a fifteen (15) day period beginning with the day immediately following the date of such copy. Should the fifteenth (15th) day be a Saturday, Sunday or legal holiday (State or Federal), the fifteen (15) day period shall expire on the next business day immediately following such Saturday, Sunday or legal holiday.

(g) "Medical Vendor" ~~shall mean a person or persons within the medical field as defined in the W. Va. Code '30-1 et seq.,~~refers to health care vendors including providers of rehabilitation services within the meaning of W. Va. Code Section 23-4-9 as amended, and shall include any hospital licensed under ~~W. Va. Code '16-5B et seq.~~the West Virginia Code.

'85-1-2. Reserv~~r~~ed.

'85-1-3. Reserved.

'85-1-4. Reserved.

'85-1-5. Reserved.

'85-1-6. Reserved.

'85-1-7. Reserved.

'85-1-8. Reserved.

'85-1-9. Employer's Report of Injuries; Wage Information.

9.1. Wage information.

Failure to report wage information may result in payment of maximum benefits for temporary total disability if the injury results in lost time. Upon receipt of proper information, the benefit rate will be adjusted prospectively, but there shall be no adjustments to previous overpayments caused by the employer's failure to provide proper wage information.

9.2. Temporary total disability benefits.

If the claimant is injured during the first half of the working day, the date of injury will be considered the first day of disability. If the claimant is injured during the second half of the working day, the following day will be considered the first day of disability.

9.3. Permanent disability awards.

In any claim, including claims for occupational pneumoconiosis or other occupational diseases, where the file contains insufficient wage information, the Commissioner shall, before granting an award of permanent disability, request additional wage information from the employer. If such information is not received within ten (10) days from request, benefits shall be payable at the maximum rate provided by law, including any adjustments to the maximum rate which occur through operation of law.

In the event that claimant, while receiving payments under an award of permanent disability, becomes temporarily disabled as a result of another compensable injury and is entitled to receive temporary total disability payments therefore, payments under the permanent partial disability award shall cease until such time as claimant has returned to work. Upon returning to work claimant shall be entitled to a lump sum payment of accrued permanent partial disability benefits which were suspended.

9.4. Information required of claimant.

Where the employer is no long a subscriber in good standing, the Commissioner may require the claimant to supply proof of earnings. In the absence of proof to the contrary, permanent disability benefits shall be payable at the minimum rate, but nothing in these Rules shall be construed as limiting the claimant's right to file information to show that he is entitled to the higher rate.

'85-1-10. Employee's Report of Injury and Application for Compensation.

10.1. General.

The injured employee should immediately give notice to his employer, in writing, that he has suffered an injury.

This requirement may be satisfied by giving the employer a copy of the application for benefits or by giving him any other writing which gives the name and address of the employer, the name and address of the employee, the time, place, nature and cause of the injury, and whether or not the employee is, at the time of writing, unable to return to work as a result of the injury. A copy of the application or other writing must also be filed with the Commissioner.

Failure to give written notice will relieve the employer of the responsibility of filing the report of injury until such time as the employer is notified in writing that an injury has occurred and may result in delaying benefits to the injured employee.

'85-1-11. Injured Employee's Responsibilities Concerning Medical Examination and Treatment.

11.1. Examination and treatment.

The Commissioner may order an injured employee to report for examination and may further order him to undergo such treatment or hospitalization as is indicated in the particular case. It shall be the duty of the injured employee to comply fully and promptly with any such order issued by the Commissioner.

11.2. Violation of rule.

a. If violation of any provision of this rule, or refusal to comply with any order of the Commissioner issued as provided herein, should result in an increase in the duration of temporary disability or in the degree of permanent disability, such violation or refusal will be considered in determining the compensation, if any, to be awarded and no compensation will be awarded for extension or increase of disability caused thereby.

~~11.3. Injured employee's right to choice of medical vendor.~~

~~An injured employee has a legal right to select a medical vendor of his own choice and an employer cannot interfere in any way with this right.~~ b. The Commission may suspend benefits being paid to a claimant if the claimant refuses, without good cause, to undergo the examinations or needed treatments provided for in West Virginia Code Section 23-4-7a. Good cause shall consist of the following:

1. Compelling evidence that the examination or treatment would have little, if any, positive effect on the claimant's injury;
2. Compelling evidence that no ordinarily prudent and reasonable person would have submitted to the examination or needed treatment;
3. Compelling evidence that the examination or treatment would pose a danger to the life or health of the claimant or require extraordinary suffering;
4. A consensus of medical opinions establishing that the examination or treatment would not effect a cure or would not at least improve the likelihood that the claimant could return to gainful employment; and
5. Compelling evidence that the prognosis for success and recovery were unreasonably low.

c. Failure to attend a single scheduled examination or treatment shall not be grounds to suspend benefits. However, failure to attend two (2) or more consecutively scheduled examinations or treatments without clear justification, regardless if the examinations or treatments were scheduled for a related purpose, may, in the Commission's sole discretion, constitute grounds to suspend benefits. Also, a pattern of failing to attend scheduled examinations or treatments shall constitute grounds for the suspension of benefits.

d. A claimant whose benefits are suspended under this rule shall have not be entitled to benefits from the date the relevant examination or treatment was not undergone until such time

as the examination or treatment is undergone and notice of such is provided to the Commission. If benefits are re-instated, any overpayment will be deducted from the re-instated benefits at a reasonable rate until the overpayment is recouped. The unpaid balance of the overpayment, if any, will be recovered from any future award to the claimant.

e. The Commission shall enter a protestable order notifying the claimant of the suspension of benefits and shall serve the order on all of the parties to the claim.

'85-1-12. Investigation of Claims.

12.1. General.

The Commissioner shall consider all information and proof properly submitted in connection with each claim. Whenever he is of the opinion that a claim has not been adequately or properly developed for his consideration, he may require the parties to produce additional evidence. In his investigation and consideration of a claim the Commissioner shall accept ex parte statements at any time prior to the filing by an interested party of such protest as will entitle him to a formal hearing. After the filing of a protest, ex parte statements will be accepted only by agreement of all interested parties.

12.2. Investigation of claim by Commissioner.

The Commissioner may independently investigate any claim prior to making initial decision. Parties must cooperate with ~~Commissioner's investigators.~~the Commission's investigation.

'85-1-13. Awards.

13.1. Notice.

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

13.2. Computation of awards.

When a claimant is found to have a permanent disability, his award shall be computed from the date of injury, excluding all periods for which the claimant receives other Workers' Compensation. Accrued benefits shall be computed in accordance with the benefit rate or rates in effect during the period or periods for which they are payable. Where nonaccrued benefits are

commuted to a lump sum, the same shall be computed on the basis of the benefit rate as of the date of delivery of said benefits.

13.3. Lump sum payment of permanent partial disability award.

(a) The Commissioner may, in his discretion, commute a permanent partial disability award to one or more lump sum payments. Beneficiaries of a permanent partial disability award who desire commutation of the award to a lump sum payment must petition the Commissioner on forms provided by the Commissioner. The forms will be made available. Such forms will include a form to be completed by the employer. The petition must set forth reasons for the petitioner's request and, when appropriate, must be accompanied by the following documents:

(1) When the reason for the request is to purchase real property,

(i) A brief opinion from a licensed attorney regarding the legal and equitable title to the property sought to be purchased.

(ii) The opinion of two (2) or more disinterested persons having a knowledge of real estate values in the locality of the petitioner's prospective purchase regarding the advisability of the purchase.

(2) When the reason for the request is to liquidate pressing debts,

(i) Statements from the petitioner's creditors regarding petitioner's debts,

(ii) A recapitulation by petitioner of his total indebtedness.

(3) The Commissioner may require such other documentation as deemed necessary.

(b) The Commissioner, after determining that the claimant has a means of support and the nonaccrued benefits are for a period not exceeding one hundred (100) weeks, may commute an award of permanent partial disability benefits.

(c) Any lump sum payment shall be subject to discount at the rate of four percent (4%): Provided, however, That the first one hundred (100) weeks of benefits shall not be discounted. The charge to the employer's account shall not be discounted.

'85-1-14. Reports of Examination, Treatment and Payment of Bills.

14.1. Obligation for submitting reports.

All medical vendors, upon accepting a claimant as a patient, assume an obligation to submit a report of such case to the Commissioner immediately and to make continuing reports.

The preliminary report must be made by the medical vendor on a form prescribed by the Commissioner and completed in its entirety. Inasmuch as an attending physician's reports (Form WC-219) of disability are an essential part of each claim, it is extremely important that they be submitted to the Commissioner promptly in order that the claimant may receive his compensation payments regularly during the period of disability. Failure to make reports promptly may result in the delay of payments of benefits to the claimant and payment to the medical vendors for services rendered.

14.2. Periodic reports.

In case of any medical or similar service being rendered during a period longer than a month, the attending medical vendor must file with the Commissioner a narrative report upon request indicating the progress of the injured employee. Completion of Form WC-219 (Attending Physician's Report) will not satisfy the requirement of a narrative report. If such reports are not made when requested by the Commissioner, payment for services may be withheld until such report is submitted.

14.3. Signature of medical vendor is required.

Medical reports and fee bills must be signed by the medical vendor rendering the services or his authorized representative with the name in legible printing or typing beneath the signature.

14.4. Payment for appearance at hearings.

A medical vendor appearing at a hearing to give testimony regarding an examination of a claimant 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 Commissioner. If the medical vendor appears to give testimony on behalf of the claimant or employer regarding an examination made at the instance of such claimant or employer, payments must be made by the party requesting the testimony.

14.5. Change of medical vendors.

A claimant will not be permitted to change medical vendors without obtaining written consent of the Commissioner for such change. This rule does not apply to cases transferred after emergency or first aid treatment, cases transferred to a specialist by the original attending physician or cases where an unforeseen emergency develops which requires special facilities and skills not available to the attending physician or hospital.

Any removal or transfer made without proper authorization must be explained in detail for the Commissioner's consideration and disposition of fee bills submitted. When a change of physicians is authorized, the original attending physician will file a final report of the claimant's physical status on the effective date of change. It is the responsibility of every doctor to make a reasonable effort to ascertain whether he is the first attending physician.

14.6. Treatment by more than one medical vendor.

Except in cases where a consultant, anesthetist or surgical assistant is required, or the necessity for treatment by a specialist is clearly shown, fees will not be approved for treatment by more than one medical vendor for the same condition over the same period of time.

14.7. Unusual treatment.

In cases requiring unusual treatment not contemplated under ordinary circumstances, the medical vendor must inform the Commissioner immediately of the condition or complications present. If the necessity for additional treatment is clearly indicated, authorization for such treatment shall be granted by the Commissioner and additional professional fees shall be paid at a rate commensurate with the services rendered in addition to the fee specified by the Commissioner.

14.8. Treatment of unrelated conditions.

The Commissioner will pay for treatment of a condition which was not caused by the injury: provided That, it is clearly evident that the unrelated condition is aggravating the occupational injury by preventing recovery from said occupational injury. Any unrelated condition must be reported to the Commissioner before payment is considered.

14.9. Surgical procedures.

Except in emergencies or where the condition of the patient, in the opinion of the medical vendor, is likely to be endangered by delay, written authorization must be obtained from the Commissioner in advance for all surgical procedures. Failure to comply with this rule may result in disapproval of the medical vendor's bill. This rule does not apply in cases involving initial treatment.

14.10. Hernia.

The Commissioner shall not approve payment for conservative treatment of a hernia, except for the initial examination for diagnostic purposes, and except where it is shown that the employee has some chronic disease or is otherwise in such physical condition that it is considered unsafe for him to undergo such operation. Payment for surgical repair of a hernia cannot be considered until all required forms have been filed and the claim determined compensable.

14.11. Amputation of upper or lower extremities.

In cases involving amputation of either upper or lower extremities, the attending medical vendor must file a report of the claimant's physical status when he is of the opinion that the

stump is ready for fitting of a prosthesis. Upon receipt of the attending medical vendor's report, the Commissioner may refer the claimant to a medical vendor or a Rehabilitation Center for evaluation to determine the type of prosthesis most beneficial for the particular claimant involved and whether the claimant is in need of training in use of the prosthesis.

Upon receipt of the medical recommendations, the Commissioner shall authorize the fitting of the recommended prosthesis. Payment shall not be approved until the prosthesis is determined to be serviceable and satisfactory. The requirement for prior approval for prosthesis shall not apply when the attending medical vendor utilizes the procedure of immediate amputation prosthetic application.

14.12. Braces and appliances.

The Commissioner will not approve payment for braces and appliances unless the necessity for their use is clearly indicated by the medical vendor and authorization is granted prior to fitting the brace or appliance. The request must specify the exact type of brace or appliance and the name and address of the supplier.

This rule does not apply in cases where back supports, crutches and minor appliances are necessary in order that a claimant may be released from a hospital following initial or authorized treatment, nor shall it apply when the medical vendor utilizes the procedure of immediate amputation prosthetic application. In such cases, the medical vendor must inform the Commissioner immediately of the device obtained and the name and address of the supplier.

14.13. Editor's Note: Repealed and Replaced by 85 CSR 15, "Vocational and Physical Regabilitation", effective July 1, 1994.

14.14. Necessity for X-ray examination must be apparent.

An X-ray examination may be made in any case where it is clearly shown that such an examination is necessary in the diagnosis or treatment of the industrial injury.

14.15. To whom payments are approved.

The Commissioner will approve payment for X ray examinations to medical vendors who take such X rays or refer claimants for X ray examination. Medical vendors and hospitals must bill separately when the hospital furnishes the X ray facilities and the medical vendor charges a separate fee for review and interpretation of the film with the report.

14.16. Filing and mailing X ray films.

All X ray films made in or out of the hospital by medical vendors in connection with the treatment or examination of industrial injuries must be labeled with the date the film was made,

the claim number, if available, and the name of the claimant. All films must be retained so that they may be forwarded to the Commissioner upon written request. If X ray films for which previous interpretative reports have been filed and paid for by the Commissioner are not furnished upon request, the physician, hospital or dentist will be required to reimburse the Fund for the amount originally paid.

14.17. Interpretations of X ray films must be submitted with fee bill.

A written report, signed by the medical vendor who interpreted the film and bearing the date the film was made, claim number and name of the claimant must accompany the fee bill on which X ray charges are submitted. Reports must contain interpretations of each study. Fee bills must be fully itemized including the portion of the body studied and the exact number of complete X ray examinations made. This bill should also contain the coded number of the medical vendor who interprets the film.

14.18. X ray therapy.

The Commissioner will approve payment for X ray therapy treatment when administered by a qualified roentgenologist or dermatologist when such services have been duly authorized.

14.19. Requirements for payment of fees.

Fees for examination or treatment are approved only when made by the medical vendor duly licensed to make such examination or to render such treatment, and then only when the medical vendor actually sees and examines the patient and actually renders or directly supervises such treatment.

14.20. Payment of bills.

Bills for medical services rendered in cases involving minor injuries should be submitted immediately upon cessation of treatment. In the case of medical or similar services extending over a period longer than one (1) month, medical vendors should submit fee bills monthly.

In contested cases consideration of fee bills will be deferred until the compensability of the claim is determined; however, bills should be filed promptly in expectation of payment at a later date and in order to comply with the statute of limitations on payment of medical, hospital and dental treatment, crutches, artificial limbs and other such devices. In those cases requiring medical or similar services over a period longer than one (1) month, medical vendors shall submit reports monthly or at other required intervals, stating the treatment rendered and the progress of the injured claimant. If such reports are not submitted, the Commissioner may refuse payment for such services.

14.21. Additional charges to claimant, failure to submit fee bills.

Additional services and accommodations not reasonably required for treatment of the compensable injury but requested by the claimant shall be the responsibility of the claimant.

Failure on the part of the medical vendor or other person, firm or corporation to submit fee bills to the Commissioner for services rendered within the statutory period prohibits collection thereof from the injured employee, the employer or the Fund.

14.22. Provisions for separate billing.

Medical vendor services must be filed on a separate billing form. Fee bills for medical vendor services, other than hospital services, must be signed by the medical vendor rendering the service or his representative. The bills for hospital services must be signed by the hospital administrator or his qualified representative.

14.23. Payment for drugs or medicine.

The Commissioner may approve payment for drugs or medicines furnished to the injured claimant as part of routine treatment rendered by the medical vendor. If unusual treatment is necessary, or if drugs or medicines are to be used by the injured claimant at his home in the absence of the medical vendor, payment of a reasonable amount of such drugs or medicines may be approved. Application for such payment must be accompanied by a statement of the medical vendor setting forth the necessity and purpose of the use of such drugs or medicines.

14.24. Available funds for treatment.

The law presently provides that the Commissioner may charge to an employer's account medical expenses not to exceed a statutory limit applicable at the date of injury. If medical expenses exceeding the statutory limit are authorized, payments are made from an unlimited medical expense reserve and are not charged to the individual employer's account.

14.25. Rules for physicians and nurses.

(a) Amputation reports.

In cases involving amputations, the physician must mark the exact line of amputation on the prescribed form (Amputation Chart). To avoid error, the exact point of amputation must also be described in the written report and the Amputation Chart and report must be carefully checked to be certain that they agree.

(b) Nomenclature to be used in describing amputations of digits.

Inasmuch as different nomenclature is often used in describing the amputation of digits of the hand or foot and the involved phalanx (distal, proximal or metacarpal, for example),

it is necessary for the purpose of conformity the terminology given on the Amputation Chart be used in describing the member injured resulting in an amputation.

(c) Payment to two (2) physicians when claimant transferred.

In cases when a change of physicians is authorized in accordance with these Rules and Regulations, the Commissioner will pay a fee commensurate with reasonable and customary charges for the services rendered. In all such cases it is incumbent upon the referring physician to set forth the services rendered, including the name and address of the physician to whom the claimant is referred. The Commissioner shall be notified in writing at the time the referral is made.

(d) Physiotherapy (authorization and payment).

The first twenty (20) physiotherapy treatments may be administered without prior authorization if the nature of the injury clearly indicates the necessity. The Commissioner will not approve payment for additional physiotherapy treatments unless prior authorization is granted. The physician must accompany his request for such authorization with a report and recommendation showing the necessity for the additional treatments and the type of physiotherapy contemplated. Such treatment must be rendered by a registered physical therapist or by a licensed physician who is equipped for and uses physiotherapy as an integral part of his practice or medicine.

(e) Payment for nursing service.

Fee bills for nursing services must be filed on the form prescribed by the Commissioner as soon as practical. The fee bill should show the number of nurses engaged in the treatment and the number of hours worked by each.

(f) Transfer to another hospital must be authorized.

A claimant is not permitted, upon his own initiative, to transfer from one hospital to another without submitting the reason for such transfer in writing and obtaining authorization from the Commissioner prior to the transfer. No hospital will be paid unless the authorization is made in advance.

(g) Use of the operating room.

Before the Commissioner will allow a fee for the use of the operating room, a detailed narrative operative report, must be submitted with the fee bill and must clearly show that the nature of the injury and the procedure performed warranted the use of the operating room.

(h) Emergency room service.

The Commissioner will approve payment for initial use of emergency room facilities and services such as routine dressings, routine medications and routine local anesthesia. Subsequent use of the emergency room will not be approved without a statement from the physician explaining the necessity for the services rendered.

(i) Inpatient hospital stay.

The Commissioner shall approve payment for inpatient hospitalization of a claimant at the prevailing semiprivate room rate; however, the Commissioner will approve payment for a private room if the claimant's attending physician deems it medically necessary. If the claimant's condition warrants treatment in an intensive care unit, the Commissioner will approve payment at the usual and customary rates until the claimant can be transferred to a private or semiprivate room. The Commissioner shall have the right to exclude any charges from the hospital bill that do not specifically relate to the treatment of the occupational injury or occupational disease.

14.26. Physiotherapy.

The following rules will govern the authorization of the payment of physiotherapy administered in hospitals:

(a) Fees for physiotherapy administered in a hospital on an outpatient basis will be approved for twenty (20) treatments without prior authorization if the nature of the injury indicates the necessity for such treatment.

(b) If the nature of the injury clearly indicates that more than twenty (20) physiotherapy treatments are necessary, authorization must be obtained from the Commissioner prior to additional treatment.

(c) Such treatment must be rendered by a registered physical therapist or by a licensed physician who is equipped for and uses physiotherapy as an integral part of his practice.

14.27. Subsequent periods of hospitalization.

Following the initial period of hospitalization, all subsequent periods of hospitalization must be authorized by the Commissioner prior to the time the claimant is admitted. However, in cases of emergencies requiring hospitalization, the Commissioner should be notified promptly of such admission and provided with a complete medical report of the claimant's condition.

14.28. Fee bills and reports.

All fee bills must be itemized and completed in full. Failure to do so may result in the delay of payment to the hospital. Reports covering X rays and operative procedures must be filed with the fee bill containing the charges.

14.29. Reporting.

When a dentist renders treatment for injuries involving the teeth and gums, he must complete the physician's preliminary report form provided by the Commissioner.

14.30. Payment for Dental Treatment.

In addition to standard dental treatment in industrial accidents, the Commissioner will approve payment for repair and/or replacement of partial or complete dentures or crowns or bridges broken or destroyed in a compensable accident. Except in case of an emergency or where the condition of the patient may be endangered by delay, the dentist must obtain prior authorization from the Commissioner for all treatment involving crown and bridge work or partial or full dentures. Such request must fully describe the appliance or procedure to be used and the cost thereof. Also accompanying such request should be a dental chart designating the natural teeth and/or artificial teeth which were injured and/or damaged in the accident and also listing missing and/or diseased teeth that could be a factor in determining proper course of treatment.

14.31. Treatment of a preexisting dental deficiency or disease.

The Commissioner will not approve payment for treatment of a preexisting dental deficiency or disease, unless it is clearly established that such preexisting condition is prohibiting treatment of or recovery from an industrial injury. In such cases the Commissioner must be provided with a complete report of the preexisting condition and authorization granted prior to rendering treatment.

14.32. Chiropractors, number of treatments and authorizations.

Number of treatments shall be limited to twenty (20) treatments without authorization. Treatments and X rays thereafter will be authorized by the Commissioner upon receipt of such request or report from the chiropractor setting forth the condition of the claimant and the number of additional treatments or X rays required. Each subsequent request for treatments must be accompanied by a progress report.

After a reasonable period of treatment, the case will be reviewed by the Commissioner to determine whether a consultation examination is desired. Chiropractors will be considered in selecting the consultants. If the particular case indicates a herniated disc or severe deformity of the spine which may require operative treatment, then an orthopedic and/or neurological diagnosis and evaluation may be secured.

14.33. Ambulance service.

The Commissioner will approve payment for ambulance service from the scene of the accident to the hospital or in the event an emergency situation develops. Payment for other ambulance service will not be approved without a letter from the attending physician explaining the medical reasons for such services.

14.34. Filing of ambulance service bills.

Fee bills must be completed in full, listing the name and address of the claimant and the employer, claim identification number, as well as vendor's identification number. The fee bill must show the loading fee, round trip mileage and the total amount of charges.

'85-1-15. Travel Expenses - Medical Examination and Treatment.

15.1. General.

Claimants are entitled to reasonable traveling, meals and lodging expenses actually incurred in connection with medical examinations or treatment, if the examination or treatment is such a distance from the claimant's home to reasonably require the claimant to seek lodging. In making a determination on the "Reasonableness" of such expenses, the Commissioner shall utilize the "Travel Regulations for State Employees" as a guide, unless specific provisions to the contrary are otherwise contained herein.

As set forth in West Virginia Code Section 23-4-8, claimants are entitled to be reimbursed for the mileage actually traveled to and from a medical exam when the Commission requires the claimant to undergo the medical exam and has selected the physician. Otherwise, claimants are not entitled to mileage reimbursement from the Commission.

This rule is not intended to limit in any way the responsibility of an employer to pay a claimant reasonable travel and other expenses as provided for in West Virginia Code Section 23-4-8.

15.2. 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.

15.3. Claimant's residence.

~~The parties to a claim shall be bound by the claim ant's residence on the date of injury, and the claim ant shall be reimbursed for reasonable expenses from the residence to the situs of examination, whether the claimant be a resident or a nonresident of this state.~~ It shall be the policy of the Commissioner to arrange for examination as near as practicable to the claimant's residence.

~~However, nothing here in shall be taken as limiting the rights of the parties to have examinations performed by physicians of their choice.~~

If the claimant changes his residence after ~~the~~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, upon a proper showing of such reasons the Commissione~~r~~ shall, in writing, endorse the change of residence and direct payment of ~~travel~~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, ~~travel~~meal and lodging expenses shall be payable as provided in Subsections 15.1 and 15.2 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;~~
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.

15.4. Occupational pneumoconiosis claims.

Notwithstanding any other provisions of these rules, the employer must avail itself of the opportunity to participate in the examination scheduled before the Occupational Pneumoconiosis Board, or, pay the entire expense of any reexamination conducted on its behalf, including out-of-state travel, if any, to the extent provided under these Rules.

'85-1-16. Reserved.

'85-1-17. Reserved.

'85-1-18. Access to records.

18.1. General.

All proceedings, orders and awards of the Commissioner are public records and subject to inspection by all who have a legitimate interest therein.

All other records of the Commissioner which are kept not as a memorial of official transactions but as evidence of internal operations, and information necessary to the proper administration of the Workers' Compensation Fund are private except as to parties in interest and their duly authorized representatives. The Commissioner or his duly authorized representative may require any person to produce satisfactory evidence of his authority before such person will be permitted to file any papers or examine claim records of the Commissioner.

The Commissioner may require satisfactory evidence of one's interest in the records of the Workers' Compensation Fund, and such interest must be a legitimate interest before such records will be produced for inspection.

'85-1-19. Transcripts and Other Papers.

19.1. Copies of transcripts and other papers.

Copies of transcripts of hearings or other like proceedings taken and had on a claim and any other paper pertinent to a claim will be furnished on request to either party to a claim or to any third person that can satisfy the Commissioner that it has a legitimate interest in the claim. The Commissioner may charge a fee for such copies. However, each party will be entitled to one copy of all proceedings in which he is involved free of charge.

'85-1-20. Procedure in Occupational Pneumoconosis Cases.

20.1. General.

In addition to the applicable provisions of other rules, the following shall apply to the determination of claims in occupational pneumoconiosis cases:

20.2. Nonmedical hearing.

Upon receipt of a proper application, employer's reports and investigation (if requested by the Commissioner shall determine the nonmedical questions, and shall notify all interested parties of his decision. After the Commissioner makes or has made a determination, any dissatisfied party may, within fifteen (15) days after receipt of written notice of the Commissioner's decision, file objection thereto in writing, whereupon the Commissioner will set a time and place for a hearing thereon. The procedure in nonmedical hearings shall be subject to the provisions of Section 16 of these Rules.

Upon completion of the nonmedical hearing, the Commissioner will enter a final nonmedical ruling and shall notify the claimant and employer of this decision. The

Commissioner's final nonmedical ruling will be subject to appeal to the Workers' Compensation Appeal Board.

20.3. Occupational pneumoconiosis board hearing.

Subject to and upon the completion of, the protest and/or appellate review of the Commissioner's initial nonmedical order, the Commissioner shall refer this claim to the Occupational Pneumoconiosis Board: Provided That, , that the requirements of West Virginia Code section fifteen-b, article four, chapter twenty-three have been satisfied. In the case of such reference, the Commissioner will notify the claimant and the interested employer or employers to appear before the Board at the time and place stated in the notice. A quorum of the Board will then proceed to hear and determine all medical questions relating to the claim.

At such hearing the claimant and each employer must produce as evidence all reports of medical and X ray examinations that may be in their respective possession or control showing the past or present condition of the employee.

20.4. Report of Occupational Pneumoconiosis Board.

Upon completion of the hearing the participating members of the Occupational Pneumoconiosis Board shall prepare a written report to the Commissioner setting forth their findings and decision, and shall prepare a sufficient number of signed copies of report so that the Commissioner may file one in his office, send one to the claimant and one to each employer interested in the claim.

20.5. Objections.

Any interested party who objects, in whole or in part, to the findings and conclusions of the Board may, within the statutory period after the mailing to him of the copy of the report, or within such additional time as may be allowed by the Commissioner for good cause shown, file with the Commissioner his written objections, specifying the particular statements of the Board's findings and conclusions to which he objects. Upon receipt of such objection, the Commissioner shall set a time and place for a hearing thereon and shall notify each interested party and each member of the Board of the time and place of the hearing.

20.6. Hearings on protest.

Hearings held upon protest to the findings of the Occupational Pneumoconiosis Board will be held at the offices of the Commissioner in Charleston unless the Commissioner shall otherwise direct. The procedure in protest hearings shall be governed by the provisions of Section 16 of these Rules, except that evidence shall be limited to medical testimony and other competent medical evidence, unless the Board has passed upon non-medical aspects under the Commissioner's referral. Cross-examination of the Board shall be limited to those members who

examined the claimant. However, if the Commissioner, or his duly authorized representative, decides that testimony of other members of the Board is necessary or desirable, he may permit such testimony at the protest hearing.

20.7. Employer's Request For Medical Examination.

An employer's request for medical examination of the claimant by a physician of its choice, shall be rejected if filed before the findings of the Occupational Pneumoconiosis Board have been transmitted to the claimant and the employer. Such requests shall be entertained only when filed subsequent to the transmittal of the Occupational Pneumoconiosis Board findings.

20.8. Standards for medical examination.

20.8.1. The following standards specify examination and evaluation criteria to guide the Occupational Pneumoconiosis Board in its examination and evaluation of claimants, and to guide other physicians and medical technicians who conduct examinations and evaluations of claimants on behalf of such claimants and their employers. These standards are established for the further purpose of ensuring that uniform procedures are used in administering and interpreting ventilatory function tests and arterial blood gas studies and that the best available medical evidence will be obtained in support of a claim for occupational pneumoconiosis benefits. The physician supervising any such testing and/or the technician administering any such testing will so indicate by signing the reports. Any report of test results submitted to the Occupational Pneumoconiosis Board must affirmatively state, as to each of the standards individually, the fact that the particular test or study was performed in compliance with that standard. In the event that any such report fails to affirmatively show compliance with these standards, the Occupational Pneumoconiosis Board may disregard all or any part of such test or study or give such test or study such weight as the Board believes it deserves.

20.8.2. When two (2) or more ventilatory function tests performed in reasonably close proximity in time produce differing but acceptable results, the Commissioner, at the request of the Occupational Pneumoconiosis Board, may direct the parties to furnish additional evidence and/or order additional testing at the laboratory utilized by the Occupational Pneumoconiosis Board or other laboratories, all for the purpose of determining whether any of the results are unreliable or incorrect or are clearly attributable to some identifiable disease or illness other than occupational pneumoconiosis.

20.8.3. When blood gas studies are performed and abnormal values are obtained and thereafter new blood gas studies are performed and normal or significantly higher values are further obtained, the Commissioner, at the request of the Occupational Pneumoconiosis Board, may direct the parties to furnish additional evidence and/or order additional studies at the laboratory utilized by the Occupational Pneumoconiosis Board or other laboratories, all for the purpose of determining whether any of the values are unreliable or incorrect or are clearly attributable to some identifiable disease or illness other than occupational pneumoconiosis.

20.8.4. As used herein, the following terms shall have the meanings indicated:

(a) FVC -forced vital capacity -- Volume of air that can be forcefully exhaled from the lungs after a maximal inspiration.

(b) FEV -forced expiratory volume -- Same as FVC.

(c) FEV_1 -forced expiratory volume in one (1) second -- Volume of air that can be exhaled forcefully from the lungs in one (1) second after a maximal inspiration.

(d) FEV_3 -forced expiratory volume in three seconds -- Volume of air that can be exhaled forcefully from the lungs in three (3) seconds after a maximal inspiration.

(e) FEV_1FEV -forced expiratory volume (timed) to forced expiratory volume. -- A ratio expressed as a percentage.

(f) MVV -maximal voluntary ventilation -- The volume of air that can be exchanged over a unit period of time, usually twelve (12) to fifteen (15) seconds.

(g) BTPS -- Body temperature, ambient pressure, saturated with water.

(h) Kpm -kilopond meter -- The amount of work required to lift one (1) kilogram one (1) meter.

(i) NIOSH -- National Institute for Occupational Safety and Health.

(j) BOARD -- West Virginia Occupational Pneumoconiosis Board.

20.8.5 Ventilatory function tests.

(a) Instruments to be used for the administration of ventilatory function tests should conform to the following criteria:

(1) The instrument must be accurate within plus (+) fifty (50) ml or within plus (+) three percent (3%) of reading, whichever is greater.

(2) The instrument must be capable of measuring vital capacity from zero (0) to seven (7) liters BTPS.

(3) The instrument must have a low inertia and offer low resistance to airflow such that the resistance to airflow at twelve (12) liters per second must be less than 1.5 cm H20/liter/second.

(4) The zero time point for the purpose of timing the FEV_1 must be determined by extrapolating the steepest portion of volume-time curve back to the maximal inspiration volume or by an equivalent method.

(5) Instruments incorporating measurements of airflow to determine volume must conform to the same volume accuracy stated in Subdivision 20.8(e)(1)(A) of this regulation when present with flow rates from at least zero (0) to twelve (12) liters per second.

(6) The instrument or user of the instrument must correct volumes to body temperature saturated with water vapor (BTPS) under conditions of varying ambient spirometer temperatures and barometric pressures.

(7) The instrument used must provide attracing of either flow versus volume or volume versus time during the entire forced expiration and volume versus time during the MVV Maneuver. Such tracing must be furnished to the Board with the test results. No results will be considered by the Board unless they are accompanied by the corresponding tracings. A tracing is necessary to determine whether the subject has performed the test properly. The tracing must be of sufficient size that hand measurements may be made within the requirement of Subdivision 20.8(e)(1)(A) of this regulation.

(8) The instrument must be capable of accumulating volume for a minimum of ten (10) seconds after the onset of exhalation.

(9) The forced expiratory volume in one (1) second (FEV_1 measurement must comply with the accuracy requirements stated in Subdivision 20.8(e)(1) of these Regulations; that is, the FEV_1 must be accurately measured to within plus (+) fifty (50) ml or within plus (+) three percent (3%) of reading, whichever is greater.

(10) The instrument must be capable of being calibrated in the field with respect to the FEV_1. This calibration of the FEV_1 may be done either directly or indirectly through volume and time base measurements. The volume calibration source must provide a volume displacement of at least three (3) liters and must be accurate to within plus (+) thirty (30) ml.

(11) For measuring maximum voluntary ventilation (MVV), the instrument must have a response which is flat within plus (+) ten percent (10%) at flow rates up to twelve (12) liters per second over the volume range. The time for exhaled volume integration or recording must be no less than twelve (12) seconds and no more than fifteen (15) seconds. The in dicated time must be accurate to within plus (+) three percent (3%). A recording of the spirometer tracing is required, and the volume sensitivity must be such than ten (10) mm or more deflection corresponds to one (1) liter volume.

(b) The administration of ventilatory function tests must conform to the following criteria: For ascertainment of the FEV_1 and FVC, a nose clip or alternative should be used. The procedures must be explained in simple terms to the subject who shall be instructed to loosen any tight clothing and sit or stand in front of the apparatus. Although the subject may sit or stand, care should be taken on repeat testing that the same position is used. Particular attention must be given to insure that the subject's chin is slightly elevated with the neck slightly extended. The subject must be instructed to make a full inspiration, either from the spirometer or the open atmosphere, and then blow into the apparatus, without interruption, as hard, fast, and completely as possible.

At least three (3) forced expirations must be carried out. During the maneuvers, the subject must be observed for compliance with instructions. The expirations must be checked visually for reproducibility by examining the flow-volume or volume-time tracings. The effort shall be judged unacceptable and cannot be considered in evaluating pulmonary functional impairment when the subject:

(1) Has not reached full inspiration preceding the forced expiration; or

(2) Has not used maximal effort during the entire forced expiration; or

(3) Has not continued the expiration for at least five (5) seconds or until an obvious plateau in the volume-time curve has occurred; or

(4) Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

(5) Has coughed or closed his glottis; or

(6) Has an unsatisfactory start of expiration, one characterized by excessive hesitation (or false starts), and therefore did not allow back extrapolation of time zero (0) (extrapolated volume on the volume-time tracing must be less than ten percent (10%) of the FVC); or

(7) Has an excessive variability between the three (3) satisfactory curves. The variation between the two (2) largest FEV_1's of the three (3) satisfactory tracings should not exceed seven percent (7%) of the largest FEV1 or one hundred (100) ml, whichever is greater.

(8) Predicted values are derived from Kory's Nomogram.

(c) For ascertainment of the MVV, the subject must be instructed before beginning the test that he or she will be asked to breathe as deeply and as rapidly as possible for approximately fifteen (15) seconds. The test may be performed with the subject in either a

sitting or standing position. Care shall be taken on repeat testing that the same position is used. The subject should breathe normally into the mouthpiece of the apparatus for ten (10) to fifteen (15) seconds to become accustomed to the system. The subject should then be instructed to breathe as deeply and as rapidly as possible and shall be continually encouraged during the remainder of the maneuver. The subject shall continue the maneuver for twelve (12) seconds. The subject should be allowed to rest between maneuvers. At least three (3) MVV's must be observed to determine if there was compliance with instructions. The effort must be judged unacceptable and cannot be considered in evaluating pulmonary functional impairment when the patient:

Has not maintained consistent effort for at least twelve (12) to fifteen (15) seconds; or

Has coughed or closed his glottis; or

Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

Has an excessive variability between the three (3) satisfactory curves. The variation between the three (3) satisfactory tracings must not exceed ten percent (10%) and should approximate forty (40) times the greatest FEV{11{s volume.

(d) A calibration check must be performed on the instrument each day before use, using a volume source of at least three (3) liters, accurate to within +one percent (1%) of full scale. The room air in the syringe must be introduced into the spirometer once with a flow rate of approximately five tenths (5/10) liters per second (six (6) seconds emptying time with a three (3) liter syringe) and once with a higher flow rate of approximately three (3) liters per second (one (1) second emptying time with a three (3) liter syringe). The volume measured by the spirometer must be between two and nine tenths (2.90) and three and one tenth (3.10) liters for both trials. Accuracy of the time measurement used in determining the FEV1 must be checked using the manufacturer's stated procedure and must be within +three percent (3%) of actual. The procedure described herein must be performed as well as any other procedures suggested by the manufacturer of the spirometer being used.

(e) The first step in evaluating a spirogram for the FEV and FEV_1 shall be to determine whether or not the subject has performed the test properly or as described in Subdivision 20.8.5.(b)(FEV) of this regulation and the forced expiratory volume, Subdivision 20.8.5.(a)(1) of this regulation. From the three (3) satisfactory tracings, the forced expiratory volume in one (1) second (FEV_1 must be measured and recorded. The largest observed FEV_1 must be used in the analysis, corrected to BTPS.

(f) Only MVV maneuvers which demonstrate consistent effort for at least twelve (12) seconds shall be considered acceptable. The largest accumulated volume for a twelve (12) second period corrected to BTPS and multiplied by five (5) shall be reported as the MVV.

20.8.6. Arterial blood gas studies.

(a) In order to ensure comparability of data obtained in arterial blood studies, the following guidelines should be observed:

(1) The puncture site should be infiltrated with a local anesthetic to minimize pain and arterial spasm.

(2) The barrel of the syringe used to draw the blood sample should be wetted with heparin and the excess heparin must be expelled just prior to obtaining the blood sample.

(3) The subject should be allowed to rest for fifteen (15) minutes prior to beginning the study.

(4) Resting blood samples should be drawn with the subject in the sitting position.

(5) On occasions when the subject is unable to be exercised due to physical impairments; i.e., heart disease, artificial leg, etc., a resting sample of arterial blood may be drawn by direct puncture with a twenty -twenty-five (20-25) gauge needle and a heparinized syringe.

(6) Blood samples must be discarded if contaminated by an air bubble.

(7) All blood samples should be analyzed immediately (less than ten (10) minutes). If not, the sample should be iced in water. If the analysis is not performed within ten (10) minutes, the metabolic activity of the cells in the blood will cause the $p0_2$ to fall and the $pC0_2$ to rise.

(8) If an exercise sample is to be obtained, a plastic catheter must be inserted into the radial or brachial artery for both the resting as well as the exercise sample.

(9) Exercise must be accomplished by having the subject pedal the bicycle ergometer at a rate of fifty (50) -sixty (60) revolutions per minute against a resistance of seventy-five (75) Watts or four hundred fifty (450) Kilopond Meters (Kpm) per minute for a period of five (5) minutes. A treadmill may be used, and when used, exercise must be done at two (2) mph and ten percent (10%) grade. During the last twenty (20) seconds of the fifth minute of exercise, the exercise sample must be drawn into a heparinized syringe and the pulse and respiration rates noted. If an added level of exercise is performed, this must be done at one hundred twenty (120) Watts on the bicycle, or on the treadmill at two and five tenths (2 5/10) mph and twelve percent

(12%) grade. Exercise testing beyond the level set forth herein shall be considered to be measurements of physical conditioning rather than of blood gas transfer abnormalities due to occupational pneumoconiosis. The EKG leads are then removed and the subject allowed to sit on a chair while the catheter is removed. Pressure must be held at the site of arterial cannulation for five (5) minutes, and if there is no bleeding or hematoma present, a compression bandage must be placed on the radial artery. This bandage must be left in place for four (4) hours. After about fifteen (15) minutes of observation, the subject will be allowed to leave. The arterial blood sample should be drawn while exercise continues, not following cessation of exercise.

(10) EKG monitoring with a single lead should take place during exercise to determine the heart rate. It should be noted that this is not an EKG Stress Test.

(11) The report should indicate the place, date and time of the study, altitude of the testing site and barometric pressure at the testing site on the day of the testing, name and claim number of the subject, name of any assisting personnel, name and signature of the supervising physician, duration and type of exercise (if performed), pulse rate at the time the blood sample was drawn, and whether analysis equipment was calibrated before each test.

(b) It is recognized that arterial blood gas studies done in laboratories throughout this state are obtained at different altitudes. Only by "Standardizing" for altitude can an equitable assessment be made of impairment when values of arterial oxygen are being measured at remarkably different altitudes. Therefore, the results reported from laboratories should include the name of the laboratory and the date and time of the testing, altitude of the laboratory and barometric pressure at the laboratory on the day the samples were collected. The Occupational Pneumoconiosis Board will evaluate the arterial blood gas values by converting those values to the average altitude of Charleston, West Virginia. For this purpose, it shall be sufficient to add one (1) mmHg to each arterial oxygen tension for each three hundred (300) feet or fraction thereof that the testing laboratory is located above the average altitude of Charleston, because the relationship of barometric pressure (altitude) and alveolar oxygen is approximately linear up to four thousand (4,000) feet as long as the subject breathes room air.

As an example, Bluefield is located approximately two thousand six hundred (2,600) feet above sea level. Charleston is approximately six hundred (600) feet above sea level. Thus, arterial oxygen values obtained in Bluefield should have 6.67 mmHg added to them before applying the table to them to obtain "percent impairment". The calculations are as follows:

"Bluefield (2,600') minus Charleston (600') equals 2,000' differential

2,000' divided by 300' altitude equals 6.67

6.67 multiplied by 1 mmHg per 300' altitude equals 6.67 mmHg"

TABLE 85-1A

20.8.7. Table for impairment of pulmonary function.

(a) The following table will be used as an indicator of impairment of pulmonary function if any of the acceptable values appear in the percentage of impairment column:

% IMPAIRMENT	0	10	15	20	25	30	40	50	60	TOTAL	
FVC % PRED.		80	75	70	67	64	61	58	55	52	50
FEV_1.0% PRED.	75	73	70	67	64	61	58	55	52	50	
FEV_1.0/FVC	75	73	70	67	64	61	56	51	48	45	
MVV 1% PRED.	80	75	70	67	64	61	58	55	52	50	
$PaCO_2$			$Pa0_2$ Values Equal to or Less Than								
30 or below		85	81	78	75	73	70	68	67	66	65
31	84	80	77	74	72	69	67	66	65	64	
32	83	79	76	73	71	68	66	65	64	63	
33	82	78	75	72	70	67	65	64	63	62	
34	81	77	74	71	69	66	64	63	62	61	
35	80	76	73	70	68	65	63	62	61	60	
36	79	75	72	69	67	64	62	61	60	59	
37	78	74	71	68	66	63	61	60	59	58	
38	77	73	70	67	65	62	60	59	58	57	
39	76	72	69	66	64	61	59	58	57	56	
40 or above		75	71	68	65	63	60	58	57	56	55

(b) Exercise $p0_2$ values that rise above the resting $p0_2$ values will indicate a lesser degree of impairment of pulmonary function, and if they are less than the resting values will indicate a greater degree of impairment of pulmonary function.

(c) The results of any medically acceptable tests or procedures reported by a physician which are not addressed in this table but which tend to demonstrate the presence or absence of pneumoconiosis or sequela of pneumoconiosis or the presence or absence of a respiratory pulmonary impairment may be submitted and given appropriate consideration (Airway Resistance, Ear Oximetry, DLCO and A-a gradient, etc.). It is also important that the Occupational Pneumoconiosis Board use all clinical history and physical findings that would enhance or detract from any percentage of impairment in the above table.