WEST VIRGINIA
SECRETARY OF STATE
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ADMINISTRATIVE LAW DIVISION

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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: Insurance Commissioner (Workers' Compensation Rules) TITLE NUMBER: 85

CITE AUTHORITY W.Va. Code §§ 23-2C-5(c)(2), 23-2C-22, 33-2-10(b) and 33-2-21(a)

RULE TYPE: PROCEDURAL _____ INTERPRETIVE _____

EXEMPT LEGISLATIVE RULE X

CITE STATUTE (s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW

W.Va. Code § 23-2C-5(c)(2)

AMENDMENT TO AN EXISTING RULE: YES X NO _____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 1

TITLE OF RULE BEING AMENDED: Claims Management and Administration

IF NO, SERIES NUMBER OF NEW RULE BEING ADOPTED: _____

TITLE OF RULE BEING ADOPTED: _____

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS August 17, 2008

Virgil T. Helton
Cabinet Secretary
West Virginia Department of Revenue

TITLE 85
EXEMPT LEGISLATIVE RULE
WORKERS' COMPENSATION RULES OF THE WEST VIRGINIA INSURANCE COMMISSIONER

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 Insurance Commissioner, private carriers, self-insured employers, third-party administrators, claimants, health care providers, vocational professionals, and others involved in the administration of claims.

1.2. Authority. -- W. Va. Code §§23-2C-22; 33-2-10(b); and 33-2-21(a). Pursuant to W. Va. Code §§23-2C-5(c)(2) and 33-2-10(b), workers' compensation rules proposed by the Insurance Commissioner and approved by the Industrial Council 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. -- July 18, 2008.

1.4. Effective Date. -- August 17, 2008.

§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. "Acted upon" means, but is not limited to, any one of the following: 1) received and processed; 2) contacted a claimant, employer, or medical provider in any fashion requesting more information; 3) reviewed and examined by medical personnel; 4) conducted a potential overpayment analysis; 5) cross-checked 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.

2.2. "Board of Review" means the workers' compensation board of review created pursuant to W. Va. Code §23-5-1 et seq.

2.3. "Decision" means any determination by a responsible party regarding the compensability of a claim, the award or denial of any type of benefit in a claim, or any other substantive request by a claimant in a claim.

2.4. "File" means:

a. If mailed, the date on which document being postmarked;

b. If faxed, the date on which fax is sent;

c. If emailed, the date on which email is sent to the email address for the recipient; and

d. If hand delivered, the date on which the document is delivered.

2.5. "Employer" means an employer within the meaning of W. Va. Code §23-2-1, et seq.

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

2.7. "Commissioner" means the Insurance Commissioner of West Virginia or any designated third-party administrator of the Insurance Commissioner.

2.8. "Office of Judges" means the workers' compensation office of administrative law judges pursuant to W. Va. Code §23-5-1 et seq.

2.9. "Paid" means the time a check is deposited in the mail or presented in person to the claimant, claimant's attorney or anyone acting in his or her behalf.

2.10. "Private carrier" means an insurer authorized by the Insurance Commissioner to provide workers' compensation insurance pursuant to chapters twenty-three and thirty-three of the West Virginia Code and any third-party administrator designated by the private carrier to adjust West Virginia workers' compensation claims.

2.11. "Receipt" means:

a. If mailed or hand delivered, the date on which the document is delivered into the possession of the responsible party;

b. If emailed, the date on which the document is received in the email inbox of the responsible party; or

c. If faxed, the date on which the document is received in the fax machine of the responsible party.

2.12. "Responsible party" means the Insurance Commissioner, private carrier or self-insured employer, whichever is applicable.

2.13. "Self-insured employer" means an employer who is eligible and has been granted self-insured status pursuant to the provisions of W. Va. Code §23-2-9 and the rules promulgated thereunder, and any third-party administrator designated by the self-insured employer to adjust West Virginia workers' compensation claims.

2.14. "West Virginia workers' compensation coverage" means workers' compensation coverage which provides the employees of an insured employer workers' compensation benefits consistent with chapter twenty-three of the West Virginia Code and the rules promulgated thereunder.

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

3.1. General.

Immediately after sustaining an occupational injury, a claimant should 1) seek necessary medical care; 2) immediately on the occurrence of the injury or as soon as practicable thereafter 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) 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 weighs against a finding of compensability in the weighing of the evidence mandated by W. Va. Code §23-4-1g and dilutes the credibility and reliability of the claim. Notice provided to the employer within two (2) working days of the injury shall be deemed immediate notice: *Provided*, That under no circumstances shall the fact that notice of an occupational injury was provided by the claimant later than two (2) working days from the time of the injury be the sole basis for denial of a claim. Enforcement of an employer's personnel policy requiring that a claimant report an injury immediately is not a discriminatory practice under chapter twenty-three of the West Virginia Code.

3.2. Benefit rate calculation; wage information.

It is the joint responsibility of the claimant and the employer to ensure that the correct wage information is provided to the Insurance Commissioner or private carrier so that the correct benefit rate can be paid the claimant. If the responsible party receives inaccurate wage information, the responsible party will, upon receipt of accurate wage information, adjust prospectively the benefit rate. The submission of inaccurate wage information by the employer or the receipt of benefits based on inaccurate wage information by the claimant 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.

The claimant's employer shall report to the private carrier every injury sustained by any person in its employ within five (5) days of the employer's receipt of the notice of an employee's desire to file a claim.

§85-1-5. Special Rules for Temporary Total Disability Claims.

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

5.2. If an individual retires, as long as the individual remains retired, 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. An individual who has retired is also barred from reopening for temporary total disability 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 does not preclude payments of benefits otherwise due a claimant if the retiree has returned to employment and suffers a compensable injury or payment of benefits if the compensable injury causes the individual to retire.

5.3. If a period of disability includes a reasonably ascertainable period of time during which the claimant would not have been performing work for any employer, then temporary total disability indemnity benefits shall not be paid during that period. This section does not apply to periods of time caused by a reduction in force, lay-off, or time-off provided in connection with an employee benefit.

§85-1-6. Special Rules for Permanent Partial Disability Claims.

[RESERVED]

§85-1-7. Notice and Litigation.

7.1. In all workers' compensation claims, the parties shall be limited to: (1) the claimant or the claimant's dependants; (2) the employer; and (3), in claims involving funds created by article two-c, chapter twenty-three of the West Virginia Code, the Insurance Commissioner.

7.2. Upon the making of any decision, the responsible party shall send all parties a written notice of the decision, setting forth the decision and the basis thereof, and informing the claimant or claimant's dependants of the right to protest the decision by filing a protest with the Office of Judges within sixty (60) days of the receipt of the decision.

7.3. In claims in which there was insurance coverage on the date of injury or last exposure, the private carrier providing coverage has sole authority to act on behalf of the employer in the claim, including, but not limited to, the ability to make claims decisions, appoint counsel for defense of the claim and make determinations regarding litigation strategy. An insured employer generally may not independently protest a decision issued by its carrier. However, in order to place certain issues into litigation, the employer's right to protest a decision issued by its carrier exists in the following limited circumstances:

a. Decisions incorporating findings made by the Occupational Pneumoconiosis Board; and

b. Decisions entered pursuant to W. Va. Code §23-4-7a(c)(1).

In the circumstances set forth in subdivisions a. and b. of this subsection, the employer's protest shall be subject to the carrier's sole authority to act on the employer's behalf in the litigation of the claim.

§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 pursuant to W. Va. Code §23-4-7a are payable only if the preponderance of the evidence indicates that a permanent impairment exists.

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

9.3. 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 claimant is not entitled to any further benefits from the award. The excess is considered to be an overpayment and may be collected by the responsible party pursuant to section 12. of this rule.

9.4. The responsible party may cease paying non-awarded partial disability benefits if the responsible party 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 W. Va. Code St. R. §85-20-1 et seq., if applicable.

9.5. If the claimant begins to receive rehabilitation benefits, non-awarded partial disability benefits shall not be paid until the rehabilitation process is completed.

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

9.7. 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. -- The responsible party shall rule on claims based upon injuries and occupational diseases other than occupational pneumoconiosis that are properly executed and filed on prescribed forms with the responsible party within fifteen (15) working days from the receipt of all required information by the responsible party. The responsible party shall consider all information and proof properly submitted in connection with each claim. Whenever a claim has not been adequately or properly developed for consideration, the responsible party may require the production of 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. -- The responsible party shall enter non-medical decisions in occupational pneumoconiosis claims within ninety (90) days from the date the responsible party receives properly executed, prescribed forms. The responsible party shall consider all information and proof properly submitted in connection with each claim. Whenever the responsible party is of the opinion that a claim has not been adequately or properly developed for consideration, it may require the production of additional evidence. The ninety (90) days shall be tolled for no more than thirty (30) additional days during this evidence gathering process.

10.3. Medical treatment, medications, appliances, devices and supplies. -- The responsible party shall act upon an injured worker's request for authorization of medical treatment, medications, appliances, devices and supplies within fifteen (15) working days from the date the request was received by the responsible party.

10.4. Medical evaluations.

a. The responsible party shall refer claimants to physicians for examinations and evaluations as required by W. Va. Code §23-4-7a within twenty (20) days of the end of the one hundred twenty (120) day period of temporary total disability: *Provided*, That if the period of expected temporary total disability exceeds one hundred twenty (120) days, the responsible party shall make the referral within twenty (20) days of the end of the expected period of 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 after issuance of a non-medical decision directing referral to the Board.

10.5. Permanent disability decisions.

a. The responsible party shall act on a permanent disability evaluation report received from a physician to whom the responsible party referred a claimant in a claim for injuries and occupational diseases other than occupational pneumoconiosis within thirty (30) working days of receipt by the responsible party of the report.

b. The responsible party shall make a referral of a claimant to a physician for examination and evaluation in response to a request by or on behalf of the claimant for consideration of a permanent disability award in a claim for injuries and occupational diseases other than occupational pneumoconiosis within thirty (30) working days from the date the request was received by the responsible party.

c. Permanent partial disability awards may be paid, at the discretion of the responsible party, either by lump sum or in installments consistent with applicable law. Payment of permanent partial awards shall commence within fifteen (15) working days of the decision granting the award.

d. Findings of the Occupational Pneumoconiosis Board shall be transmitted to the parties within thirty (30) working days after the date of examination by the Board.

10.6. Application for reopening.

Applications for reopening of claims for temporary or permanent disability benefits shall be ruled upon by the responsible party within thirty (30) days from the date of receipt of the application by the responsible party. The responsible party shall consider all information and proof properly submitted in connection with the application. Whenever a claim has not been adequately or properly developed for consideration, the responsible party may require the production of additional evidence. The thirty (30) days to rule on the claim shall be tolled during this evidence gathering process.

10.7. Orders.

A responsible party shall comply with all orders of the Office of Judges and the Board of Review and all mandates of the West Virginia Supreme Court of Appeals within thirty (30) days after the date of receipt, unless the responsible party is required to act sooner under the terms of the order or mandate or the order or mandate is subject to a lawfully ordered stay.

§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 a claimant'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 by the responsible party from a claimant's compensation are the amounts 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 responsible party shall 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 responsible party 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 any monies received from, or paid on a claimant's behalf by, the responsible party to which it is subsequently determined by the responsible party that the injured worker was not entitled. Overpayment may 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. The responsible party may collect overpayments to claimants by withholding future disability benefits payable to the claimant or the worker's dependents in the same claim or other claims which are pending with the same responsible party to whom the overpayment is due. 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, and travel reimbursement.

12.3. Collection of overpayments from temporary total disability benefits, permanent total disability benefits, temporary total rehabilitation benefits and temporary partial rehabilitation benefits is 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 claimant 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 are not limited and may be withheld in full until the overpayment is satisfied.

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

13.1. In any claim involving an occupational disease, other than occupational pneumoconiosis, resulting from inhalation of minute particles of dust over a period of time in the course of and resulting from employment: (1) which is filed as an occupational disease claim (as opposed to being filed as an occupational pneumoconiosis claim); and (2) in which a permanent disability determination is required, the claim shall be referred by the responsible party to the Occupational Pneumoconiosis Board for a determination of whole body medical impairment: *Provided*, That this subsection in no event affects the applicability of benefits or any other procedures available under the West Virginia Code for occupational disease claims other than occupational pneumoconiosis claims. In the claims described in this subsection, the Occupational Pneumoconiosis Board's findings and conclusions regarding whole body medical impairment have the same legal force and effect as any other findings and conclusions issued by the Board: *Provided*, That in such claims, the jurisdiction of the Occupational Pneumoconiosis Board is limited solely to the determination of whole body medical impairment.

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. The responsible party shall deny an occupational disease claim 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. Procedures for Suspension for Claimant Abuse.

14.1. When evidence is obtained justifying a finding that a claimant 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, the responsible party will suspend the claimant's temporary total disability benefits.

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

14.3. 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 is not protestable. The claimant has thirty (30) days to submit evidence justifying the reinstatement of benefits. If justification is not established, then the claimant will receive notice that the claim has been closed for temporary total disability payments. This notice is protestable. If justification is established, benefits will be reinstated with back benefits awarded.

14.4. In claims pending prior to approval of a managed health care plan, the claimant's 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 the claimant's selection is made, unless the claimant is eligible to opt out of the managed care plan network.

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

15.1. General.

Claimants are entitled to reasonable travel, meals and lodging expenses actually incurred in connection with an authorized medical examination or treatment. In determining the reasonableness of such expenses, the responsible party shall utilize the travel regulations for State employees as a guide, unless specific provisions to the contrary are otherwise contained herein. A claimant may be reimbursed for mileage in connection with medical examination or treatment at a rate of 15 cents ($0.15) per mile. This rate does not apply to mileage reimbursement requests involving treatment provided when the responsible party 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.

15.2. Physical limitations.

Where a medical vendor certifies that a claimant, because of the state of his or her 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 responsible party shall 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 by the responsible party upon a proper showing of such reasons, the responsible party shall, in writing, endorse the change of residence and direct payment of meal and lodging expenses in the following manner:

1. Where the distance between the residence and the situs of the examination is less than four hundred (400) miles, meal and lodging expenses are payable as provided in subsections 15.1. and 15.2. of this section;

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, up to the cost of round trip air fare, economy class, between the closest airports offering scheduled commercial passenger service, as of the date the examination was scheduled;

3. Where the claimant objects to any decision 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 is 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 are payable only from point of entry into West Virginia.

§85-1-16. Complaints.

Upon receiving any inquiry from the Insurance Commissioner regarding a complaint filed with the Commissioner, a private carrier or self-insured employer shall, within fifteen (15) working days of the date appearing on the inquiry, furnish the Commissioner with a complete written response. A "complete written response" addresses all issues raised by the complainant or the Commissioner and includes copies of any documentation requested. This subsection is not intended to permit delay in responding to inquiries by the Commissioner or the Commissioner's staff in conjunction with a scheduled examination.

§85-1-17. Expert Witness Appearances.

17.1. An authorized treating physician, or an authorized consulting physician acting upon referral from an authorized treating physician, appearing at a hearing to give testimony regarding

an examination of a claimant will be paid a fee by the responsible party commensurate with the service rendered for such appearance and testimony, not to exceed $100 per quarter hour.

17.2. All other expert witness appearance fees, including, but not limited to, any physician other than those physicians mentioned in subsection 17.1. of this section, medical vendors, rehabilitation providers, physical therapists or vocational specialists, shall be paid for by the party wishing to examine or cross-examine the expert witness at an amount agreed to by the parties based upon usual and customary rate for the profession involved, not to exceed $100 per quarter hour. If the expert witness demands an amount in excess of $100 per quarter hour to appear, it is the sole responsibility of the party who has retained the services of the expert or submitted a report or records of the expert as evidence in the case to pay for the difference.

§85-1-18. Implementation and Stay of Orders from the Office of Judges.

18.1. The responsible party may move for stay of any order entered by the Office of Judges for the payment of indemnity benefits, or which will necessarily require or result in the payment of such benefits, including, but not limited to, an order which finds a claim to be compensable, by filing a motion with either the Administrative Law Judge who entered the order or with the Board of Review.

18.2. A motion as described in subsection 18.1. of this section filed with the Office of Judges must be filed within ten (10) days of the date of entry of such order. A motion as described in subsection 18.1. of this section filed with the Board of Review must be filed contemporaneously with the notice for appeal. Any motion that is not timely filed in accordance with this subsection shall be dismissed with prejudice. In either case, the claimant may file a response to the motion within ten (10) days of the date on which the motion was filed, and the Office of Judges or Board of Review, whichever is applicable, shall enter an order granting or denying the motion within the ten (10) days from the end of the response period.

18.3. Any motion as described in subsection 18.1. of this section must include the following minimum content: (1) A statement of the reasons the stay is being sought; and (2) a statement of the grounds for the underlying appeal. Failure to include the minimum content described in this section is grounds for summary denial of the motion.

18.4. Any order granting a motion described in subsection 18.1. of this section shall expressly limit the stay to temporary total or permanent partial indemnity benefits to be paid in the claim as a result of the underlying Office of Judges order. No order granting a motion as described in subsection 18.1. of this section shall stay any medical, rehabilitation or permanent total disability benefits.

18.5. Any order granting a motion described in subsection 18.1. of this section by the Office of Judges shall expressly limit the duration of the stay to the expiration of the jurisdictional time limit for the filing of an appeal of the underlying order, or to the entry of a decision by the Board of Review if an appeal is filed. Any order granting a motion described in subsection 18.1. of this section by the Board of Review shall expressly limit the duration of the stay to the entry of a decision by the Board of Review of the underlying appeal: *Provided*, That if the Board of Review

enters a decision remanding a case to the Office of Judges for further proceedings, any stay granted by the Office of Judges or Board of Review shall remain in effect until the Office of Judges enters a new order on the issue which was remanded, at which time the stay will be lifted.

§85-1-19. Miscellaneous Administrative Matters.

If mail sent by the responsible party to a claimant, 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 responsible party shall cease mailing correspondence to the party until such time as a correct address is provided.

§85-1-20. Preferred Drug List.

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, the responsible party may 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 health care services by determining what is reasonably required; and

c. Optimizing pharmaceutical care and cost effectiveness.

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%

PUBLIC HEARING

MAY 29, 2008

OFFICES OF THE WEST VIRGINIA INSURANCE COMMISSIONER
WORKERS' COMPENSATION INDUSTRIAL COUNCIL

"CLAIMS MANAGEMENT AND ADMINISTRATION"
TITLE 85, SERIES 1

Transcript of the Public Hearing held on Thursday, May 29, 2008, at 3:00 p.m., Offices of the West Virginia Insurance Commissioner, 1124 Smith Street, Room 400, Charleston, West Virginia.

Industrial Council Members Present:
Charles Bayless, Chairman
Bill Dean
Senator Don Caruth
Delegate Nancy Guthrie
Kent Hartsog
Dan Marshall (via telephone)
Senator Brooks McCabe
Walter Pellish (via telephone)

Henry Bowen (West Virginia Self-Insurers Association): Mr. Chairman, members of the Industrial Council, I'm Henry Bowen and I appear this afternoon on behalf of the West Virginia Self-Insurers Association.

I did file this afternoon with Mr. Sims written comments on behalf of the Self-Insured Association. Our Board did ask me to make a public comment with respect to one area it was particularly concerned about, and also they wanted me to make an acknowledgement. So I'll start with the latter of those first, if I may.

Our Board wanted me to express publicly its sincere appreciation to the Commissioner and to the General Counsel for the work they have done in making a comprehensive claims management rule. Early on in our meetings with this agency we had urged that there be one claims management rule and not the confusion that was frankly there as to whether or not Rule 1 did apply to self-insured employers. In fact when Rule 18 was promulgated by the prior Workers' Compensation Board of Managers there were sections in the two rules that actually conflicted with regard to

claims management issues. So we do appreciate the fact that this issue is now being addressed so comprehensively by the agency.

There are many, many sections in the claims management rule that are important, as this rule is the key claims management document that really was required as a result of the 2003 reforms to implement many of the legislative changes at that time that dramatically redefined the workers' compensation system in West Virginia.

Today the only oral comment I wish to make about one staff of the proposal on Rule 1 is found at Section 1-13.1 on page 10 of your rule. I've gone through I think a detailed explanation of our concern and I wanted to make sure and hopefully succinctly address what our Association's concern is.

Over the years the occupational pneumoconiosis system developed to where it is now. I think objectively anybody would agree. It's one of the real showcases or real crown jewels of the West Virginia workers' compensation system. There are many jurisdictions that compensate injured workers for development of an occupational pneumoconiosis, but no coal state, like Virginia or Kentucky, has a system that mirrors the West Virginia system. We have had for years a medical board that is appointed by the Commissioner that over the years has perfected an expertise that's really unique in our area in their understanding, study and assessment of lung diseases that are related to workplace exposures and environmental exposures that men and women working in West Virginia may encounter in their work.

When Rule 1 was promulgated by the Workers' Compensation Board of Managers our Association joined with other business associations to urge clarity with respect to a policy of the former Workers' Compensation Commission that allowed motions to be brought before the Office of Judges to have a referral made to the Occupational Pneumoconiosis Board any time there was a claim involving lung cancers. And in fact as the practice evolved, claims involving diseases of ordinary life that men and women have such as emphysema, chronic bronchitis, asthma – those types of issues were handled at the election of the claimant either as a straight occupational disease issue or at the request of the parties on referral to the Occupational Pneumoconiosis Board.

The staff recommendation is that Rule 1, with respect to this section, be changed so that the only inquiry that can be brought to the Board is the matter of whether or not there is whole man impairment, which would be compensable on a permanent partial

disability basis. This is perhaps an understandable response to what I think happened in the application of Rule 1. I think it has been mishandled by some parties, and I certainly don't direct this to the representatives of BrickStreet, but I do the self-insured. I know some self-insured, self-administration decisions with respect to the interpretation of this system incorrectly denied claims for cancer on the basis that they didn't comply with the forms filed, didn't comply with the occupational pneumoconiosis of claim filings. So the most obvious example that we could all identify with is if a case were presented in an occupational pneumoconiosis claim involving someone who had a history of exposure to asbestos disease developed the subsequent cancer. And if that cancer were particularly the type of cancer that is almost universally recognized medically to be related to asbestos exposure, then the whole intent of the rule was to have the claim processed by referral to the Occupational Pneumoconiosis Board. It didn't become an OP claim. That was never the intent of the rule. But the language of the rule that was adopted said, "filed as and processed as." It's the filing as an OP claim that has created a lot of problems.

The staff response to the complaints is legitimate, except if you adopt the language they propose then we will not be able to legally take the issue of causation before the Occupational Pneumoconiosis Board. And the reason I think this is so extraordinarily important is that it's the one area of law that is so uniquely limited to a medical expertise that's embodied within this agency. There are five doctors appointed to this Board – two radiologists, three who specialize in internal medicine. These doctors have had – in the case of two Board members – over 10 years of experience I believe. I know one of the doctors has been there at least 10 years. I think two of three have been there 10 years, and the newest member appointed by the Commissioner is a Board Certified pulmonary specialist who has had years of experience in the Charleston area; and in fact has done significant work with the chemical industry. So, he brings a unique qualification. Of course they serve an important function because of their independence. They aren't there to advocate on behalf of any party, and they do an extraordinary excellent job. I say that recognizing that in some other practices that occur create confusion as to whether or not there can be apportionment of impairment between multiple causes and things of that nature. But in this particular case the issue of cancer or emphysema or chronic bronchitis, in its relationship to an alleged workplace exposure, makes it almost paramount since these are diseases that men and women have in the general population where there is no industrial exposure to any carcinogen or any type of dust hazard.

It makes it absolutely essential that a mechanism be available to bring the issue of causation in front of the Board. And, frankly, because there are so many causes of cancer, including use of tobacco that has been recognized universally as the number one risk factor for heart and lung disease, we think that there would be serious harm done to the employer community if its sole limitation is to be limited to the inquiry of whether or not this person is impaired and to what degree; and not whether or not the Board believes that the type of exposure that the record reflects is reasonable to have a relationship to the type of diseases diagnosed.

Because of the importance of this to our extraction clients, coal members, chemical members, utility members, they felt that in addition to the written comments that they wanted me to bring this as an oral comment as well, and to ask the consideration of amending the current rule to make it clear that such an occupational disease claim involving alleged diseases of the lung be processed as occupational pneumoconiosis claims merely to get the matters in front of the Board. I readily agree it makes no sense to require additional exposure. It certainly makes no sense to require an ILO form be completed when someone is alleging a workplace cancer. Thank you very much, and I would be happy to answer any questions.

Senator Don Caruth: Just so I'm sure where you're at. Your offending language to use in the proviso. . .at the very end of the rule. You have it there. The last sentence, the last two lines of the proviso.

Mr. Bowen: Senator, your question was am I. . .

Senator Caruth: Offending language. . .

Mr. Bowen: Oh, offending. . .I'm sorry. I thought you said, "Am I defending the proviso." I thought not. Yes, that is the offending language.

Senator Caruth: In your written comments did you propose some resolution of that?

Mr. Bowen: I simply proposed retaining the current rule with the addition of striking the "filed as" so as to make it clear it's only "processed as." Apparently there have been some good faith interpretations by some self-administrators that if you receive a subsequent cancer case and the time for reopening of OP has passed, then you had to have additional exposure to a hazard in order to have a new claim. And

that's not what Rule 1 was ever intended to do. It was simply done by the prior Board of Managers to facilitate referral to the Occupational Pneumoconiosis Board so it would have jurisdiction to evaluate and diagnose the condition and the person's impairment.

Chairman Bayless: Any other questions? Does the staff have any questions? Would you consider these comments?

Edward G. Atkins (Atkins & Atkins): My name is Edward Atkins. I generally represent the claims community. I've been through these and for clarification perhaps somebody from the staff could help me – Rule 10.6, Application for Reopening. It goes over to page nine where it says, "Petitions for reopening of claims upon a permanent disability basis shall be ruled upon. . ." That language is stricken I presume. Is there any timeframe for ruling on those petitions for reopening? Does anybody have a comment why that was stricken?

Kent Hartsog: Could you quote again to where you're at?

Mr. Atkins: Page 9 (b.) near the top of the page.

Mr. Hartsog: Okay.

Mr. Atkins: The first part talks about, "applications for reopening of claims for temporary or permanent total disability benefits shall be ruled upon within 30 days." That's up from 10. And you keep on reading it and then it goes to (b.) where you reopen. For example, you feel that there is an aggravation or progression of your injury and you want an additional reopening for an increase in PPD for example. It's stricken. Why is that?

Mary Jane Pickens (General Counsel OIC): Again, just so everybody will know. I would like to keep this really focused on the comments, and there is probably going to be a lot of comments. There are a lot of written comments that I haven't read. I want to make sure before we respond to specific things that we're careful, we read everything, and we can come up with a response after we've had the benefit of reading the comments.

Mr. Atkins: Right.

Ms. Pickens: On this one I think it just may be a matter of just putting everything together. Petitions are in 10.6. . .

Mr. Atkins: Yes.

Ms. Pickens: "Applications for reopening of claims for temporary or permanent total disability benefits shall be ruled upon. . ."

Mr. Atkins: Right.

Ms. Pickens: And I think (b.) is just talking about reopening of claims for permanent total disability benefits must be ruled upon. I think we took it out of (b.) because we thought it was covered it the preceding paragraph.

Ryan Sims (Associate Counsel, OIC): With the addition of the word "permanent," which we added to the preceding paragraph.

Mr. Atkins: Well this says "permanent total disability benefits." So it gives you the impression that reopening for a permanent partial award is sort of left out there hanging, if you understand what I'm saying.

Ms. Pickens: Well, if that's a comment, we'll take that into consideration.

Mr. Atkins: All right. That may be a particular problem here. You could just do that and add a claim for temporary or permanent partial or permanent total. Just add that in there. The second question is I don't understand 5.3. I think I understand 5.2, but 5.3 on page five. . ."If a period of disability includes a reasonably ascertainable period of time during which the injured worker would not have been performing work for any 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." What other ascertainable period of time would exist during which the injured worker would not have been compensated or performing work?

Mr. Sims: I can tell you that. This is Ryan Sims. This section I think is primarily intended to address situations where there is a seasonal period where no work is being performed, such as a bus driver or school teacher or something like that where they have a three-month period where they're not performing work and not receiving wages

for that period. I think that is actually different than what that last sentence says. I don't think when a teacher or a school bus driver has a summer off that would be considered a time caused by a reduction of force lay-off or time-off provided in connection with the benefit. I think they are just actually not working nor being paid for that three-month summer period and that would be the primary example. And I think that is why this section was originally placed in this rule.

Mr. Atkins: My concern is some issues that have been raised with respect to some of my clients who during the period of time of their injury apply for and receive Social Security disability benefits. Then it turns out. . .and in some instances because a person is receiving Social Security disability benefits there is a ruling that "well since he's receiving Social Security disability benefits he's not going to be in the workforce, therefore he's not entitled to temporary total disability benefits." I've seen that argument made. I don't agree with the argument. But I want to make sure that this isn't what that was intended for.

Mr. Sims: The comment will be considered.

Mr. Atkins: Thank you.

Chairman Bayless: Thank you, sir. Are there any other public comments on Title 85, Series 1? Are there any comments from members of the Council?

PUBLIC HEARING

TITLE 85, SERIES 1, "CLAIMS MANAGEMENT AND ADMINISTRATION"

Industrial Council Meeting
Offices of the West Virginia Insurance Commissioner
1124 Smith Street, Room 400, Charleston, WV 25301
May 29, 2008

Name	Address	Telephone Number	Group Affiliation	Do you desire to address the Council?	Agenda item to which you desire to speak
Henry Bowman			WVSIT		

AVIZENT™
Frank Gates Service Co / Attenta

Mailing Address:
405 Capitol Street
Suite 905
Charleston, WV 25301

Tel: 304.346.2683
Fax: 304.346.2687
Web: AVIZENTRISK.co

May 28, 2008

Mary Jane Pickens
Office of the Insurance Commissioner
P O Box 50540
Charleston, WV 25301-0540

Via email at mj.pickens@wvinsurance.gov

Re: **Issues and Comments - On Initial Draft of Amendments:**
85 C.S.R. § 1
85 C.S.R. § 2

Dear Ms. Pickens:

Please accept this correspondence as our public comments regarding the Offices of Insurance Commissioner's Proposed Rules 85 C. S. R. §§ 1 and 2. We are submitting these comments on behalf of our clients who are affected by these proposed rules.

Series 1 Claims Management and Administration

85 C.S.R. § 1-2. Definitions.

- ***Issue*** – § 2.14. "Retire" means an individual has permanently ceased working due to age or years of service and has no intent to return to work.

- ***Comment –*** We suggest the language referring to "has no intent to return to work" be removed or rephrased since it is very subjective. This could provide a "loop hole" for the claimant once he or she learns no temporary total disability benefits will be paid because he "retired" but wants to argue with the responsible party or employer that he may want to work at a later date but is merely retiring from his pre-injury employment. This leaves the responsible party or employer in a position to be unable to defend the denial of benefits or impossible to contradict the claimant's statement of his/her intent.

85 C.S.R. §1-5 - This section relates to "special rules of temporary total disability claims."

- ***Issue*** – §1-5-2 has been amended to reflect that when an individual retires "as long as the individual remains retired", the individual 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 is retired.

- ***Comment-*** As with the definition of retire discussed above, the inclusion of the language as long as the individual remains retired is subjective to the claimant. Please consider that the use of this phrase in the amendments to this rule regarding the eligibility to receive benefits, in some instances, would encourage or suggest to a retired claimant to state that they do not have an intent to remain retired in order to receive benefits. The responsible party or employer would be unable to rebut such a statement since it would be impossible to contradict the individual's statement of his/her intent.

85 C.S.R. § 1-10. Time Standards

- ***Issue*** - §10.1 After each time frame the word "working" has been removed.

- ***Comment*** - Although this may be the Industry Standard the employer or carrier should be allowed a minimum of five (5) additional days similar to the allowance in the changes to 85 C.S.R. § 6 and 85 C.S.R. § 8.
  By using calendar days rather than business days there will be times that the pending ruling or action could fall during the Holidays and this could hinder the employer or carrier's ability to render the appropriate decision due to the limited time for investigation.
  Also, in certain instances the time frame change could require payments to be issued prior to the determination of "stay" by the Office of Judges

85 C.S.R. § 1-10.5

- ***Issue*** - §10.5.c. The added language, "Permanent partial disability awards "may" be paid either by lump sum or in installments"

- ***Comment*** – The language should clarify that this is at the responsible party or employers' discretion or upon receipt of documentation of hardship.

85 C.S.R. § 1-16. Complaints

- ***Issue*** – Upon receipt of any inquiry from the Insurance Commissioner regarding a complaint filed with the Commissioner, all private carriers and self-insured employers shall, within fifteen (15) days of the date appearing on the inquiry, furnish the Commissioner with a complete written response. A "complete written response" addresses all issues raised by the complainant or the Commissioner and includes copies of any documentation requested. This subsection is not intended to permit delay in responding to inquiries by the Commissioner or the Commissioner's staff in conjunction with a scheduled examination.

- ***Comment*** –
  - There should be language which includes the exception of response by the Commissioner or the Commissioner's staff, private carriers and self-insured employers on issues currently in litigation.
  - We believe the private carrier and self-insured employers have the right to be provided copies of **all** responses to the complainant by the Insurance Commissioner or the Commissioner's staff.

Series 2 Workers' Compensation Claims Index

85 C.S.R. § 2-4. Claims Index.

- ***Issue*** – § 4.2.f. Body part that is the subject of the claim. And Section 4.2.g. the percentage of permanent partial disability award granted in the claim.

- ***Comment*** - Request permanent partial disability award percentage contain break down for the specific accepted body parts in the claim. The lack of this information is not only detrimental to employer/carrier, but claimant as well.
  - Example:
    Index shows low back claim, 17% PPD (break down of impairment is 10% lumbar, 5% cervical, 2% shoulder).
    - An injured worker suffers a new injury to the same shoulder and he is evaluated for permanent partial disability. The recommendation is 3% for the shoulder, with the information listed in the current language the injured worker would be granted a 3% award for the shoulder which would actually be over compensating since he was previously granted a 2% in the prior claim.

- Another scenario would be if the claimant was evaluated for a newer low back injury and the physician recommends a 12% for the low back the claimant would not be granted any award since the index states he was already granted 17% award for a low back in a prior claim.

- To avoid this inaccuracy the proper procedure is to request the complete record for any related body part that has a percentage of impairment from the responsible party as soon as a new injury has occurred. However if the break down of the awarded body parts is not listed there would be inaccurate awards short changing the claimant and causing over payments by the responsible party that may not be possible to recover.
- Rule 18 had a time standard for supplying requested records but this was not included in the drafted version of Rule 1.
- Since there is reluctance to provide the records by responsible parties and they are refusing to release the records with out a separate signed release by the claimant. We suggest that the rule refer to WV Code 23-4-7 to reinforce the acceptance of the claimant's signed Report of Occupational Injury that states that by signing the application he/she authorizes the release of medical records pertaining to the occupational injury or illness for which he/she is claiming benefits and any prior injury to or disease to the portion of his/her body for which he/she is alleging a medical impairment.
- Furthermore now that the carrier and employer have less time to issue decisions and payments because the "working" day has been removed from Rule 1 it is very important to be able to timely gather the necessary records to make the accurate claim decision and to avoid unnecessary litigation.

Thank you for your consideration of these comments. If you have any questions, please feel free to contact me at 304-346-2683 ext. 23302.

Respectfully,

Karen Burgess

Karen Burgess
WV Operations Manager
kburgess@avizentrisk.com

Brickstreet INSURANCE
Legal Department

May 29, 2007

Members of the Industrial Council
c/o Ryan Sims, Associate Counsel
West Virginia Insurance Commission
P.O. Box 50540
Charleston, WV 25305-0540

Re: Comments on Proposed 85 CSR 1, "Claims Management and Administration"

Members of the Industrial Council:

BrickStreet Insurance appreciates the opportunity to participate in this public process and offer comments regarding the proposed rule.

Proposed Rule Sections Followed by Comments

2.14. "Retire" means an individual has permanently ceased working due to age or years of service and has no intent to return to work.

§2.14. Comment: The reasons for retirement vary. This definition appears to limit the definition of "retire" to circumstances involving age or years of service. This definition does not account for other reasons to retire, such as medical retirement. Also, the provision creates ambiguity as the individual can be considered to be retired only if they have no intent to return to work.

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

§5.1. Comment: The change in this provision may be difficult to administer. Does this mean 3 days that the employee was scheduled to work or 3 days that the employer was open for business? This can lead to unintended consequences. For example, a nurse who works Friday, Saturday and Sunday is injured on Sunday and admitted to the hospital. Following this language, the claimant's first day of lost time is the next Friday with Saturday and Sunday being the first three days off work. They claimant would not hit day 4 until the following Friday, or two full weeks from the injury. In order to be off 7 days, the claimant would have to miss the equivalent of two and 1/3

400 Quarrier Street
P.O. Box 3922 Charleston, West Virginia 25339-3922
304.941.1000 Ext. 1023-phone ■ 304.941.1207-fax ■ 866.45.BRICK
www.brickstreet.com

full weeks of pay. The statute at §23-4-5 does not mention working days and concentrates on three and seven days from the last day worked.

5.3. 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~~ performing work for any employer, then temporary total disability indemnity benefits shall not be paid during that period. This ~~Section~~ 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.

§5.3. Comment: This provision was meant to apply to "seasonal employment," i.e. a worker, who as part of their normal work schedule, does not engage in work activities for a reasonable ascertainable portion of the year or who is hired for only a portion of the year, such as retail jobs for the months leading up to holidays. This should be clearly stated in the rule.

~~6.2. 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.~~

§6.2. Comment: The elimination of this provision leads to confusion about how a PPD award is calculated. Will the award be calculated based on the law at the date of injury, on the date when the claim was filed, etc.?

~~6.3. 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.~~

§6.3. Comment: See 10.5.c. that says that workers' compensation payments may be paid by lump sum or in installments. There is no definition of "installments." The current provision provides the ability to make equal payments on a monthly basis over the course of time. 10.5.c provides no guidance as to the type of installment payment that can be made. It also does not indicate who determines how it is paid. Is the payment stream at the discretion of the carrier or the claimant?

7.2. Upon the making of any decision, the responsible party shall send the parties a written notice of the decision setting forth the decision and the basis thereof, and informing the claimant or claimant's dependants of the right to protest the decision by

filing a protest with the Office of Judges within sixty (60) days of the receipt of the decision.

§7.2. Comment: Statutory awards based on OP Board findings are required by statute to be protested within 30 days. These specific provisions control the newer, general, provisions under the rules of statutory construction. The statute is at odds with the rule.

~~9.5~~ 10.4. Medical evaluations.

a. Referral of claimants to physicians for examinations and evaluations as required by W. Va. Code §23-4-7a~~(d)~~, shall be made within twenty (20) ~~working~~ days of the end of the one hundred twenty (120) day period of temporary total disability: *Provided*, That if the period of expected temporary total disability exceeds one hundred twenty (120) days, the referral shall be made within twenty (20) days of the end of the expected period of disability.

§10.4. Comment: The purpose of the 120 day exam is to determine whether a claimant should continue on TTD. Under this proposal, you can't make this determination until the claimant is off TTD. The provision becomes a "Catch 22." You can't tell if a claimant should be off TTD, until they are off TTD. A better choice is to require the carrier to determine whether or not an exam is needed and reflect it in the file after 120 days of lost time. The extent of the claimant's disability may be well known to the carrier and an examination may be very disruptive to the claimant and/or a significant unnecessary expense to the carrier.

~~11~~ 12.2. Overpayments to injured workers may be collected by the ~~Insurance Commissioner or private carrier~~ responsible party by withholding future disability benefits payable to the injured worker or the worker's dependents in the same claimor other claims which are pending with the same responsible party to whom the overpayment is due. 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 ~~Insurance Commissioner or private carrier~~ responsible party .

§12.2. Comment: On its face, this removes the ability of a carrier to collect overpayments from future claims that may be filed. Future claims are a primary source for the collection of overpayments. This limitation on collections appears to be arbitrary. The OIC's comment was that one carrier could not be required to collect for another. Recovery would still be limited to claims against the same carrier. However, the carrier should be able to collect overpayments from future claims filed with it.

~~12~~ 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 prescribing 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.~~ In any claim involving an occupational disease, other than occupational pneumoconiosis, resulting from inhalation of minute particles of dust over a period of time in the course of and resulting from employment: (1) which is filed as an occupational disease claim (as opposed to being filed as an occupational pneumoconiosis claim); and (2) in which a permanent disability determination is required, the claim shall be referred to the Occupational Pneumoconiosis Board for a determination of whole body medical impairment: *Provided*, That this subsection shall in no event affect the applicability of benefits or any other procedures available under the West Virginia Code for occupational disease claims other than occupational pneumoconiosis claims. In the claims described in this subsection, the Occupational Pneumoconiosis Board's findings and conclusions regarding whole body medical impairment shall have the same legal force and effect as any other findings and conclusions issued by the Board: *Provided*, That in such claims, the jurisdiction of the Occupational Pneumoconiosis Board is limited solely to the determination of whole body medical impairment.

§13.1. Comment: The removal of this provision seems to eliminate the need to file an OP induced cancer claim as an OP claim. If a dust cancer claim is filed as an OD claim, then there is no need to demonstrate statutory exposure as a prerequisite to pursuing the claim. In other words, a claimant could work for an employer for a week and claim that their dust cancer was caused by the employer, regardless of their previous dust-exposure history. Changes to this provision circumvent the OP Board's diagnostic expertise and limits their function to a determination of PPD in claims filed as OD claims. As written, the provisions would not allow the OP Board to offer its opinion as to whether the cancer was caused by dust exposure or the claimant's smoking history, for instance. The amendments to these provisions are patently unfair.

§15 Concerning Travel Reimbursement --Comment . No changes were made to this section, although comments were solicited regarding changes. The history concerning the current reimbursement rate is valuable in discussions regarding the reimbursement rate.

During the spring of 2004, the Workers' Compensation Commission made a proposal to the Board of Managers to eliminate mileage reimbursement in its entirety. In the previous fiscal year July 1, 2002 through June 30, 2003 (FYE 2003), the Workers' Compensation Commission had 3 full time employees processing travel reimbursements. Claims for travel reimbursement for service dates in FYE 2003 totaled in excess of 19 million miles at a cost in excess of $6.8 million. The reimbursement rate during this time was 36 cents per mile.

Mileage submitted for Dates of Service during the period July 1, 2002 through June 30, 2003 (FYE 2003):
19,164, 390.79 miles
Paid at 36 cents per mile = $6,899,180.68

After much discussion, instead of eliminating mileage reimbursement, a compromise was reached whereby the Board adopted a reimbursement rate of 15 cents/mile for general medical travel by the claimant. The reimbursement rate for other types of medical travel including when the employer required the claimant to travel for a medical examination continued to be reimbursed at the higher State travel rate. The amount determined under this compromise was the amount allowed as a deductible for medical travel expense under the rules of the Internal Revenue Service.

For service dates during the period July 1, 2004 through June 30, 2005 (FYE 2005), total mileage reimbursement requests dropped to about 7.55 million miles. This amount included about 7.3 million miles at 15 cents/mile. The balance of the mileage (about 267,000 miles) was paid at 39.4 cents/mile and 41.55 cents/mile, which were the State travel reimbursement rates.

Mileage submitted for Dates of Service during the period July 1, 2004 through June 30, 2005:

	7,287,529.82 miles at 15 cents/mile	**= $1,093,129.47**
	143,748.4 miles at 41.5596208 cents/mile	**= 59,741.29**
	122,969.39 miles at 39.4056 cents/mile	**= 48,456.86**
Total	**7,554,247.61 miles**	**= $1,201,327.62**

If the mileage for FYE 2005 had been paid at the current State employee reimbursement rate of 50.5 cents/mile, the cost would have been $3,814,895.04 instead of $1,201,327.62, an increase greater than **$2.61 million** to private carriers and the Insurance Commissioner's Old Fund using FYE 2005 mileage numbers. This scenario assumes that mileage remains somewhat constant. This may be a faulty assumption.

In FYE 2003, when reimbursement rates were higher, more than 19 million miles were turned in for reimbursement. In FYE 2005, around 7.55 million miles were turned in for reimbursement. While a number of factors may play into the reduction in mileage

reimbursement requests for FYE 2005, the stimulating effect of the higher reimbursement figure for the earlier period should not be discounted.

If mileage reimbursement numbers are stimulated sufficiently to return to FY 2003 mileage levels, then:

19,164, 390.79 miles at 50.5 cents/mile = $9,678,017.35

The **increased cost to the system would almost $8.48 million per year** to be absorbed by BrickStreet, the Old Fund and new carriers.

NCCI loss costs filings for July 1, 2008, do not contain provisions for increased mileage reimbursement. Mileage reimbursement changes should be implemented in such a manner so that any increase can be fairly spread to all policyholders and not be borne by carriers and the Old Fund alone.

At the time, 15 cent/mile reimbursement rate for general medical travel was a reasonable compromise.

Since the 15 cents/mile had its genesis in the amount allowed as deductions from federal taxes for medical travel expenses, this amount could be revisited. For 2008, this number is 19 cents/mile. At the same time, it is important to remember that higher rates are allowed when the employer or carrier requires the claimant to make medical visits.

§85-1-16. Complaints.

Upon receipt of any inquiry from the Insurance Commissioner regarding a complaint filed with the Commissioner, all private carriers and self-insured employers shall, within fifteen (15) days of the date appearing on the inquiry, furnish the Commissioner with a complete written response. A "complete written response" addresses all issues raised by the complainant or the Commissioner and includes copies of any documentation requested. This subsection is not intended to permit delay in responding to inquiries by the Commissioner or the Commissioner's staff in conjunction with a scheduled examination.

§16 Comment: This provision appears to track the provisions of administrative rule 114 CSR 14 concerning "Unfair Trade Practices." There is one very important distinction. The time for response required by the "Unfair Trade Practices" rule is 15 working days. Matters subject to the complaint process are often complex. In addition, the implementation of this section would result in the treatment of workers' compensation carriers in a different manner than other carriers and require the OIC to have two tracking systems. Hopefully, this was not the intent of this section. Another matter of

importance is that the time calculation is made from the date that appears on the letter from the OIC. While this is by no means a common occurrence, on occasion, complaints are received 4 or 5 days after the date on the OIC letter. The date of "receipt" by the carrier should be used to calculate the response date.

~~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 Insurance Commissioner or private carrier by the worker or the employer.~~

§18.1. Comment: This provision was designed so that some discretion could be exercised by the parties in whether a claim should be filed. An employee should not be required to report a strain or a bruise or a cut or a blister, if no medical treatment is involved or anticipated.

Again, thank you for the opportunity to offer comment of this rule. If I can provide any other assistance, please do not hesitate to contact me.

Very truly yours,

Randall B. Suter

Randall B. Suter

JACKSONKELLY
ATTORNEYS AT LAW PLLC
1600 LAIDLEY TOWER • P.O. BOX 553 • CHARLESTON, WEST VIRGINIA 25322 • TELEPHONE: 304-340-1000 • TELECOPIER: 304-340-1130
www.jacksonkelly.com

Writer's Direct Dial (304) 340-1301
Writer's Fax No. (304) 340-1044
Writer's E-Mail Address: tehuffman@jacksonkelly.com

May 30, 2008

Mary Jane V. Pickens, Esquire
West Virginia Insurance Commission, Legal Division
Post Office Box 50540
Charleston, West Virginia 25305-0540

Re: *Comments to Proposed Rule Amendments*

Dear Ms. Pickens:

Please find enclosed herewith comments which I wish to file on behalf of the Workers' Compensation Committee of the West Virginia Chamber of Commerce to the proposed amendments presently being considered to Rule 1, Rule 2, Rule 6 and Rule 18.

Very truly yours,

TIMOTHY E. HUFFMAN

TEH/nkl

cc: Ms. Brenda Nichols Harper

COMMENTS TO:
SERIES 1
CLAIMS MANAGEMENT AND ADMINISTRATION RULE

- **Section 2.14**

This definition is too restrictive and does not include medical, disability or voluntary retirements.

- **Section 2.4.c**

The amended rule defines filing to include a document that is e-mailed and deems the date of filing to be the date upon which the e-mail was sent to the e-mail address for the recipient. A filing should only be completed upon proof of receipt, however filed. Additionally, specific standards should be developed regarding the use of e-mail transmissions under these and other rules.

- **Section 5.1**

This Section needs further amendment to be consistent with *W. Va. Code* § 23-4-5. Specifically, that Code Section requires that temporary total disability benefits are not paid unless the period of disability lasts longer than three days from the date the employee leaves work as a result of the injury. This Section, as written, does not specifically require three days of consecutive disability from scheduled work before temporary total disability benefits are payable.

- **Section 5.3**

This Section should be further amended to apply specifically to seasonal reductions in work force and seasonal layoffs.

- **Section 6.2**

The proposed rule would delete Section 6.2 as written. Section 6.2 should not be deleted or amended.

- **Section 7.2**

This Section needs further amendment to provide for the statutory requirement of a 30-day protest period for decisions of the Occupational Pneumonoconiosis Board.

- **Section 9.3**

See comments under Section 12.2.

- **Section 10.1**

The proposed amendments to this Section shorten the time period for ruling on claims from 15 working days to 15 days. This Rule should continue to permit 15 working days for the responsible party to rule on a claim.

- **Section 10.4.a**

This Section should be deleted entirely. Notwithstanding the fact that, the statute continues to require 120-day evaluations, neither self-insured employers nor insurance carriers wait 120 days before referring a claimant out for an evaluation.

- **Section 10.5.b**

The word "working" should not be deleted from this section.

- **Section 10.5.c**

This Section should be amended to provide that the payment of permanent partial disability awards in either monthly installments or in a lump sum amount, should be at the discretion of the responsible party.

- **Section 10.5.d**

This Section should not be amended from 30 working days to 30 days.

- **Section 10.6**

This Section should be further amended by striking "total" from line 2, so that it is applicable only to applications for the reopening for temporary or permanent disability benefits and does not include permanent total disability benefits.

- **Section 12.2**

This Section as amended limits the collection of overpayments contrary to the provisions of *W. Va. Code* § 23-4-1C(h) and 23-4-1D(d). The statute permits the collection of overpayments from future claims that the claimant may file. The limitation proposed in the amendment leads to the unintended financial enrichment of claimants. Additionally, a system should be developed to track and manage intercarrier reimbursements for such overpayments.

- **Section 13.1**

This Section should not be amended as proposed. The amendments will allow a claimant to file an OP cancer claim as an occupational disease claim and thus avoid having to satisfy statutory exposure requirements as a prerequisite to establishing a valid OP claim.

- **Section 16**

This new Section should be further amended to require that a responsible party receives a copy of any response made by the Office of the Insurance Commissioner to a complaint.

- **Section 18.1**

The proposed amendments would delete this Section entirely. Section 18.1 as exists in the current Rule should remain intact.

COMMENTS TO:
SERIES 2
WORKERS' COMPENSATION CLAIMS INDEX

- **Section 4.2**

This Section should be further amended to provide that the data collected in this Rule must be sortable by the claimant's full name and must include all of the claims filed by each claimant.

A system to manage and report intercarrier reimbursements for overpayments should be created under this rule.

COMMENTS FOR:
A SERIES 6
WORKERS' COMPENSATION DEBT REDUCTION FUND ASSESSMENTS AND REGULATORY SURCHARGES

- **Section 4.1**

This Section should be further amended to provide that a detailed accounting of all sums collected and expended by the Commissioner are to be reported to the Industrial Council on a semiannual basis within sixty (60) days of January 31st and June 30th of each year.

- **Section 5.1.b**

This Section should be further amended to provide that the Insurance Commissioner may only change the percentage as needed to meet the funding requirements of *W. Va. Code* § 23-2C-3(f) on an annual basis.

COMMENTS TO SERIES 18 SELF INSURANCE, SELF ADMINISTRATION AND THIRD-PARTY ADMINISTRATORS

Section 3.1

What other "recognized accounting body" is contemplated by this proposed change in the definition of audited statements?

Section 3.8

This definition is in conflict with the provisions of *W. Va. Code* § 23-2-9(f). That Section specifically defines the period of inactivity as four or more consecutive quarters without payroll.

Section 3.11

The use of the term "payroll" should be consistent throughout this rule and should utilize the definition of "payroll" incorporated from Rule 6. The use of the term "gross wages" in this rule should be replaced with the term "payroll".

Section 5.1

This last line of that Section should be amended to read "The required parental guarantee must be received and accepted by the Commissioner before the applicant's self insured status may become effective."

Section 5.2

The current provisions of this rule provide that failure to disclose certain information may result in termination of a self insured account as determined at the "sole discretion" of the Commission and is contrary to the provisions of Section 15 regarding the involuntary revocation of self insured status, which requires approval by the Industrial Council.

The rule provisions should be amended to require only the signature of an individual with authority to act on behalf of the entity seeking self insurance.

Section 5.5

Self insurance should become effective on the first day of the month following approval by the Industrial Council or on a later date as determined by the self insured employer.

Section 5.5.a

The Commission should be required to make a recommendation to the Industrial Council within sixty (60) days of receipt of the completed application and additional requested information.

Section 6.1

This section should be deleted from this rule as the subject matter is covered by Rule 32.

Section 6.2

This section should be deleted from this rule as the subject matter is covered by Rule 32.

Section 7

This section should be deleted as unnecessary.

Section 8

All the provisions of this section should be covered under Rule 19 and should not be part of this particular rule.

Section 8.3

Because future self insured liability is secured through the Guaranty Pool, it is unnecessary to continue requiring employers to post minimum security of any level.

Section 8.3.b

This section should be amended to require that a self insured's failure to obtain additional bond or security may result in a revocation.

Section 9

The proposed language with regard to employer's modification of business constitutes an unreasonable expansion of this section. There should be no reporting requirement by the employer unless the modification impacts on the employer's claim liability. An employer should be required to provide such financial information only if the modification of the employer's business results in a substantial change in the financial ability of the company that provides the surety or parental guarantee.

Section 9.4

This section should be amended to provide that a processing fee may be assessed rather than shall be assessed.

Section 10.1.a

The word "forever" should be deleted as it is unnecessary.

Section 10.1.b

This section should be amended to provide that termination of a self insured account should occur on the first day of the month or on a date agreed upon between the Commission and the self insured employer.

Section 10.1.c

This section should be amended to provide that if surety is posted by the employer upon termination of the account, no further contribution to the Guaranty Pool will be required.

Section 10.2

This section should be amended to provide simply that without prior approval, the OIC is not bound by the terms of any such agreement.

This section should be amended to permit approved risk portfolio transfers of a self insured employer's past liability.

Section 11.1

This section should be amended to delete the following language "as those afforded to injured workers whose claims are paid and administered by the Workers' Compensation Commission private workers' compensation insurance carriers. These same benefits include the proper and timely payment of medical bills and compensation".

Section 12

"Payroll" as defined herein should be substituted for "gross wages and earnings".

Section 12.2

This section should be amended to replace "gross wages and earnings" with "payroll" as defined earlier in this rule.

Section 12.4

This section should be numbered 12.3.

Section 13.1

"Payroll" as defined herein, should be substituted for "gross wages".

Section 13.2

"Payroll" as defined herein, should be substituted for "gross wages".

Section 13.4.b

The word "shall" should be replaced with "may".

Section 13.5

"Payroll" as defined herein, should be substituted for "gross wages".

Section 13.9

The words "and conduct" should be deleted from the end of this section.

Section 13.9.a

This section should be amended to provide a penalty of $500.00 per review and not per occurrence.

Section 14.2

This section should be amended to provide that the Commissioner shall perform a financial review on an annual basis and may perform a comprehensive claims review on a less frequent basis.

Section 14.2.b

This section should be amended to provide that the Commissioner may recommend revocation of the employer's self insured status consistent with the involuntary revocation provisions of this rule.

Section 14.2.c

This section should be amended to read "The Commissioner shall notify the employer of the results of any review."

Section 14.3.a.5

This section should be amended to read "The auditor's opinion on the financial statements for the most recent fiscal year must not express a going concern qualification."

Section 14.4

The amendments to this section are unnecessary.

Section 14.5

These amendments are unnecessary and currently covered under the provisions of Rule 19. Additionally, catastrophic surety is not required by statute.

Section 14.8

The proposed language to be added to this section should be amended to read "The Commissioner shall report to the Industrial Council any acts of noncompliance by the self insured employer which the Commissioner deems to be major violations."

MARONEY, WILLIAMS, WEAVER & PANCAKE, PLLC
ATTORNEYS AT LAW
608 VIRGINIA STREET, EAST
CHARLESTON, WEST VIRGINIA 25301

THOMAS P. MARONEY
ROBERT M. WILLIAMS
J. ROBERT WEAVER
EDWIN H. PANCAKE
PATRICK K. MARONEY

TELEPHONE
(304) 346-9629

TELECOPIER
(304) 346-3325

May 28, 2008

VIA FACSIMILE ONLY 304-558-1362

Ryan Sims, Esquire
Associate Counsel
WV Office of the Insurance Commissioner
Post Office Box 50541
Charleston, West Virginia 25305

Re: Comments to Proposed Rules 1, 2, 8 and 18

Dear Mr. Sims:

This letter contains responses to the above-proposed rules filed with the Secretary of State. On behalf of the West Virginia AFL-CIO and its affiliated members, including the United Mine Workers of America, the following changes are suggested:

RULE 85 CSR 1, CLAIMS MANAGEMENT AND ADMINISTRATION

85-1-2 Definitions

Pg. 2 2.10 Delete the word "deposited" and replace it with the word "received."

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

Pg. 3 3.1 Delete sentence beginning with "Failure to immediately..." and the remaining two sentences of Section 3.1

Pg. 4 3.2 Line 6, delete sentence beginning with "There shall be no retroactive adjustments..."

85-1-4 Employers' Report of Injuries

Line 3, Keep in the two deleted sentences beginning with "Failure to comply..."

85-1-5 Special Rules for Temporary Total Disability Claims

Pg. 5 5.2 Line 4, insert the words "temporary total disability" immediately prior to the word "indemnity."

Pg. 5 5.3 Delete Section 5.3 in it's entirety.

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

Pg. 6 9.2 Delete this Section in it's entirety.

85-1-10 Time Standards

Pg. 7 10.2 Line 2, reinsert the word "fifteen (15)" and delete the word "ninety (90)."

Line 9, reinsert the word "fifteen (15)" and delete the word "ninety (90)."

Pg. 7 10.3 Line 1, insert the word "prescriptions" after the word "Treatment."

Line 2, insert the word "prescriptions" after the word "treatment."

Pg. 8 10.6 Lines 2 and 3, reinsert the word "ten (10)" and delete the word "thirty (30)."

Line 9, reinsert the word "ten (10)" and delete the word "thirty (30)."

85-1-12 Overpayments

Pg. 10 12.1 Lines 7 and 8, delete the words "dependents benefits, fatal (104 week) benefits."

The following new Section needs to be added:

"85-1-14A Procedure for Abuse by Employer and Responsible Party

Misrepresentation of any statement and information by Employer or Responsible Party shall be considered fraudulent and subject to a $1,000.00 fine for each occurrence for failure by Employer and/or Responsible Party to timely file information, provide information and act

on information shall result in a $1,000.00 fine for each occurrence, and after five occurrences fines shall be increased to $2,500.00."

"Coercing and discouraging a worker not to report an injury is an offense that will result in a fine of $2,500.00 and result in a ruling in an automatic ruling for the claimant."

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

Pg. 12 15.1 Line 6, delete the number (15) and insert the number (54.5) and insert "($54.50) and delete ($0.15)."

85-1-16 Complaints

Pg. 13 Add "failure to respond within 15 days will result in a $1,500.00 fine for each occurrence."

85-1-17 Expert Witness Appearances

Pg. 13 17.1 Line 1, insert the words "authorized independent medical examiner" after the words "treating physician."

RULE 85 CSR 2, WORKERS' COMPENSATION CLAIMS INDEX

85-2-4 Claims Index

Pg. 3 4.2 Add the following:

"h. All wage information"

"i. Any other fields of information as the Commissioner deems necessary."

RULE 85 CSR 8, WORKERS' COMPENSATION POLICIES, COVERAGE ISSUES AND RELATED TOPICS

85-8-3 Definitions

Pg. 3 3.8 Add the following:

"e. Any business involving first responders including, but not limited to, policeman, fireman, EMTs, and other emergency personnel."

85-8-6 Employees Covered; Independent Contractors; Coverage Elections; Assignment

Pg. 7 6.2a.3 Line 7, delete the entire sentence beginning with the word "Provided."

6.2.a.5 Line 1, delete the first thirteen sentences of this Section through the words "legal right to use the same."

RULE 85 CSR 18, SELF INSURANCE, SELF ADMINISTRATION, AND THIRD PARTY ADMINISTRATORS

85-18-3 Definitions

Pg. 2 3.4 Line 1, delete the words "without good cause."

Line 15, delete the remainder of this Section beginning with the words "For purposes of."

In closing, I would be happy to meet with the members of the Industrial Council, Commissioner Cline or any members of her staff to discuss our thoughts on these issues.

Respectfully submitted,

Thomas P. Maroney

TPM/clw

PULLIN, FOWLER FLANAGAN, BROWN & POE PLLC
ATTORNEYS AT LAW

JAMESMARK BUILDING
901 QUARRIER STREET
CHARLESTON, WV 25301
PHONE: (304) 344-0100
FAX: (304) 342-1545

600 NEVILLE STREET
SUITE 201
BECKLEY, WV 25801
PHONE: (304) 254-9300
FAX: (304) 255-5519

CRANBERRY SQUARE
2414 CRANBERRY SQUARE
MORGANTOWN, WV 26508
PHONE: (304) 225-2200
FAX: (304) 225-2214

REPLY TO: CHARLESTON

SENDER'S E-MAIL: jbrannon@pffwv.com
www.pffwv.com

Date: May 29, 2008

Re: Comments regarding Proposed Rules:
85 C.S.R. § 1
85 C.S.R. § 2
85 C.S.R. § 6
85 C.S.R. § 8
85 C.S.R. § 18
Public Comment period expires 5/29/2008
Public Hearing to be held on 5/29/2008 at 3:00 p.m. at OIC Office in Charleston, West Virginia

Please accept this correspondence as our public comments regarding the Offices of Insurance Commissioner's Proposed Rules 85 C.S.R. §§ 1, 2, 6, 8, and 18, which has been submitted for public comment.

85 C.S.R. § 1 et seq.: "Claims Management and Administration"

General Comment: We applaud the OIC's determination to modify Rules 1 and 18 to provide one consistent claims management and administration standard for all "responsible parties" as a beneficial change that now standardizes all claims management and claims administration requirements.

85 C.S.R.§ 1-2

This section has been amended to provide a definition for "retire" which means "an individual has permanently ceased working due to age or years of service and has no intent to return to work."

Comment:

The phrase "has no intent to return to work" is subjective to the individual seeking benefits. Please consider that the use of this phrase in the amendments to this rule regarding the eligibility to receive benefits, in some instances, would incentivize a "retired" claimant to state that they do have an "intent to return to work" in order to receive benefits. The "responsible party" or employer would be unable to refute such a statement as it would be impossible to contradict the individual's statement of his/her intent.

85 C.S.R. § 1-3

The changes in this section provide specifically that the fact that an injury was reported more than 2 days after the injury cannot, by itself, be a reason to deny the claim. Retained in the draft is the language that enforcement of an employer's personnel policy requiring immediate reporting of a work-place injury is not a discriminatory practice.

No Comment.

85 C.S.R. § 1-4

The section was amended to delete the $250 dollar fine for failure by an employer to report injuries to the "responsible party" within 5 days. However, the reporting requirement itself was retained and still requires the employer to notify the "responsible party" within five (5) days of receipt of notice of the employees desire to file a claim.

Comment:

It is recommended that the OIC define "receipt of notice of the employees desire to file a claim". Some workers' who sustain a work related injury may report the injury to the employer but never file an application for benefits. Some "responsible parties" have interpreted this section to require the employer to report the injury to them within five (5) days of the occurrence of an injury and then, based on the employer's report, have taken the position that the employer's report under this section is sufficient to issue a ruling on the claim. This interpretation is contrary to West Virginia Code § 23-4-1a and 23-4-15(a) which requires the injured worker to complete and file an application for benefits with the responsible party. Any interpretation that does not require an application for benefits to be filed prejudices the employer's rights under the applicable statute of limitations. Further, without a completed application for benefits, as required by the statute, the "responsible party" does not have the injured workers' allegation regarding the injury, does not have medical evidence indicating that an injured worker sustained an injury, and does not have a valid release to obtain medical records related to the alleged claim.

85 C.S.R. §1-5

This section relates to "special rules of temporary total disability claims." § 1-5-2 has been amended to reflect that when an individual retires "as long as the individual remains retired", the individual 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 is retired.

Comment:

As with the definition of retire discussed above, the inclusion of the language "as long as the individual remains retired" is subjective to the claimant. Please consider that the use of this phrase in the amendments to this rule regarding the eligibility to receive benefits, in some instances, would incentivize a "retired" claimant to state that they do not have an intent to "remain retired" in order to receive benefits. The "responsible party" or employer would be unable to refute such a statement as it would be impossible to contradict the individual's statement of his/her intent.

Further, **§1-5.3** was amended regarding the closure of temporary total disability benefits when the claimant would not have been working for the employer. Previously, this section said a reasonably ascertainable period of time during which the injured worker would not have been compensated from his or her employer and now says a reasonable ascertainable period of time during which the claimant would not have been "performing work for any employer."

Comment:

The previous language in this section had been interpreted to relate to seasonal employees or temporary employees who did not work year-round of full-time for an employer. Under the previous language and employer of seasonal or temporary employees was not charged for temporary total disability benefits and the worker was not entitled to temporary total disability benefits during periods in which they would not have been compensated by the employer, i.e., during the off-season or after the termination of the temporary employment. The proposed amendment to this section now permits the worker to receive, and the employer to be charged, temporary total disability benefits even when the employee would not have been working for the employer. Further, even if the employee would not have been working for another employer during the off-season or after the conclusion of the temporary employment, this section incentivizes the worker to state that but for the injury he/she would/could have been working for another employer. If this is the intent of the amendment to this section, then the section should be deleted as it is superfluous. However, the previous language provided a significant benefits to employers of seasonal or temporary employees, who would naturally only be operating a portion of the year, to minimize the impact of claims on their premiums and to properly charge their policies with benefits during periods only when they would be working. This employer's are most likely smaller employer's who can not easily absorb additional workers' compensation premiums based on the amount of benefits which could be authorized under this section. It must be remembered that temporary total disability benefits are granted to compensate an injured worker for wages lost due to the injury. Clearly, the previous language in this section was consistent with the purpose of these benefits as the employee received benefits during

periods he/she would have been working for the employer, and not for periods when the worker would not have been receiving wages from the employer.

85 C.S.R. §1-7

§1-7: This section is completely new and relates to "Notice and Litigation." Language has been included which again re-states that there are only two (2) parties to a claim, the claimant or the claimant's dependents and the employer, with the exception of funds created by article two-c of Chapter 23, the Insurance Commissioner is also a party.

Comment:

While it is clear that the Insurance Commissioner is a party in all "Old Fund" claims created in article two-c of Chapter 23, it does not appear that the Insurance Commissioner is a party to "Uninsured Fund Claims" created in West Virginia Code § 23-2C-8. While the Insurance Commissioner, or its designee, is the claims administrator, the statute does not provide that he Insurance Commissioner is a party to the actual claim. If it is the intent of the Insurance Commissioner not to be a party to these Uninsured Fund Claims then this language should be amended to specify that the Insurance Commissioner is a party only in "Old Fund" claims.

§ 1-7.2: This section requires that upon the making of any decision, the responsible party is required to send written notice of the decision to all parties which sets forth the basis of the decision and "informing the claimant or claimant's dependents of the right to protest the decision by filing a protest with the Office of Judges within sixty days of the receipt of the decision."

Comment:

The language in this section purports to require notice of only the claimant's right to protest a decision and thus preclude the employer's right to protest a decision. This section should be amended to require notice "informing **the parties** of the right to protest the decision by filing a protest with the Office of Judges within sixty days of receipt of the decision."

The language which purports to provide only the claimant or the claimant's dependent's a right to protest a decision, and preclude the employer from filing a protest, is contrary to the plain language of West Virginia Code § 23-5-1(b)(1) as amended, and is inconsistent with numerous other sections of Chapter 23 which specifically provide the employer the right to protest decisions of the claims administrator.

Initially, West Virginia Code § 23-5-1(b)(1), as amended states "An employer may protest decisions incorporating findings made by the Occupational Pneumoconiosis Board, decision made by the Insurance Commissioner acting as administrator of claims involving funds created in article two-c of this chapter, or decisions entered pursuant to subdivision (1), subsection (c), section seven-a, article four of this chapter." There is no language contained

in this statute which eliminates or abolishes the employer's right to protest a decision by the claims administrator. In State ex rel McKenzie v. Smith, 212 W.Va. 288, 569 S.E.2d 809 (2002), the West Virginia Supreme Court of Appeals stated that "[a] statute, or an administrative rule, may not, under the guise of 'interpretation,' be modified, revised, amended or rewritten." Syllabus Point 1, *Consumer Advocate Div'n v. Public Service Comm'n*, 182 W.Va. 152, 386 S.E.2d 650 (1989)." Syl. pt. 11, State ex rel McKenzie v. Smith, 212 W.Va. 288, 569 S.E.2d 809 (2002). Further, the West Virginia Supreme Court of Appeals has stated that "[a]ny rules or regulations drafted by an agency must faithfully reflect the intention of the Legislature, as expressed in the controlling legislation. Where a statute contains clear and unambiguous language, an agency's rules or regulations must give that language the same clear and unambiguous force and effect that the language commands in the statute." Syl. pt. 4, *Maikotter v. University of West Virginia Bd. of Trustees/West Virginia Univ.*, 206 W.Va. 691, 527 S.E.2d 802 (1999)". Syl. Pt. 4, Repass v. Workers' Compensation Division, 212 W.Va. 86, 569 S.E.2d 162 (2002).

Further, an "interpretation" of this language which serves to administratively abolish the employer's right to protest decisions by the claims administrator does not reflect the "Legislatures" intent and is inconsistent with the remainder of Chapter 23. It must be remembered that "[s]tatutes which relate to the same persons or things, or to the same class of persons or things, or statutes which have a common purpose will be regarded in *pari materia* to assure recognition and implementation of the legislative intent. Accordingly, a court should not limit its consideration to any single part, provision, section, sentence, phrase or word, but rather review the act or statute in its entirety to ascertain legislative intent properly." Syl. Pt. 5, *Fruehauf Corp. v. Huntington Moving & Storage Co.*, 159 W.Va. 14, 217 S.E.2d 907 (1975)." Syl. pt. 7, Verizon v. West Virginia Bureau of Employment Programs, 214 W.Va. 95, 586 S.E. 2d 170 (2003).

When Chapter 23 is reviewed *in toto*, it is clear that the Legislature did not abolish the employer's right to protest a decision by a claims administrator. Had the Legislature intended to abolish the employer's right to protest such decisions, the Legislature could have done so clearly with language to effectuate that purpose. At Syllabus Point 5, the Verizon Court stated that "Where a particular construction of a statute would result in an absurdity, some other reasonable construction, which will not produce such absurdity, will be made." Syl. pt. 2, *Newhart v. Pennybacker*, 120 W.Va. 774, 200 S.E. 350 (1938)." Id. at Syl. Pt. 5. Additionally, in Syllabus Point 4 of Kessel v. Monongalia County General Hospital, 220 W.Va. 602, 648 S.E.2d 366 (2007) the West Virginia Supreme Court of Appeals stated that "[a] statute should be so read and applied as to make it accord with the spirit, purposes and objects of the general system of law of which it was intended to form a part; it being presumed that the legislators who drafted and passed it were familiar with all existing law, applicable to the subject matter, whether constitutional, statutory or common, and intended the statute to harmonize completely with the same and aid in the effectuation of the general purpose and design thereof, if its terms are consistent therewith." Syllabus Point 5, *State v. Snyder*, 64 W.Va. 659, 63 S.E. 385 (1908)." Id. Bearing this in mind, it can not be asserted that the Legislature "intended" to abolish the employer's right to protest when the Legislature is presumed to have been familiar with the remaining sections of Chapter 23, such as West Virginia Code §§ 23-5-2, 23-5-4, 23-5-5, 23-4-1b, 23-4-1c(a)(3), 23-4-1c(h), 23-4-1d, 23-4-

6(j)(6), 23-4-7a(g), and 23-4-16a, all of which reference the rights of either both parties to protest a decision or the employer specifically.

Further, as the employer and the claimant are the only parties to a workers' compensation claim, it is fundamentally unfair, and potentially a violation of the employer's constitutional equal protection rights (Article III, § 10 of the West Virginia Constitution) and the certain remedy provision of the West Virginia Constitution (Article III, § 17 of the West Virginia Constitution) to allow the claimant to protest any order entered by the claims administrator while denying, or attempting to severally limit, the employer's right to do the same.

§1-7.3: This section re-states the language from House Bill 4636 relating to the private carrier who is providing coverage to the employer, has full authority to act on behalf of the employer in the claim, including but no limited to, the ability to make claims decisions, appoint counsel for defense of the claim and make determinations regarding litigation strategy. Further, this section states that an insured employer generally may not independently protest the decision by its carrier and then lists the two (2) circumstances in which, according to the OIC, an employer may still protest a decision by its carrier. These two (2) exceptions are decisions incorporating findings made by the OP Board and decisions entered pursuant to West Virginia Code § 23-4-7a(c)(1). However, the proposed rule goes on to state that even in these circumstances the carrier has the sole authority to act on the employer's behalf in the litigation of the claim.

No Comment:

85 C.S.R. §1-10

This section deals with time standards related to actions and claims. The major change, obviously, is that these standards are now applicable to both private carriers and self insured employers.

Regarding injury and occupational disease claims under §1-10.1, this section has been amended to state that the responsible party is required to rule on a properly executed and filed application within fifteen (15) days from the date of the receipt of all required information. However, the section also provides that whenever a claim has not been adequately or properly developed for consideration, the responsible party may require the production of additional evidence and the fifteen (15) days to rule on the claim is tolled during that evidence gathering process.

Regarding occupational pneumoconiosis claims, in §1-10.2, the amendment requires that a non-medical ruling be issued within ninety (90) days and that this ninety (90) day period can be extended for up to an additional thirty (30) days to develop further evidence.

§1-10.3 relates to medical treatment, appliances, devices and supplies and requires that a request for authorization for the same be acted upon within fifteen (15) days from the date of the receipt of the request.

§1-10.4 relates to medical evaluations and requires that a referral for a one-hundred twenty (120) day exam be made within twenty (20) days of the end of the one-hundred twenty (120) day period. However, an amendment was added to allow that the expected period of temporary total disability exceeds one-hundred twenty (120) days, the referral can be made within twenty (20) days of the expected day of the end of the temporary total disability.

§1-10.5 has been amended to require that the responsible party act upon a permanent partial disability evaluation report within thirty (30) days of the receipt of that report. Furthermore, a section was added to permit the permanent partial disability awards to be paid either in a lump sum or in installments and requires that temporary total disability awards commence within thirty days of the decision granting the award.

§1-10.6 relates to applications for re-opening and requires that an application for re-opening for "temporary or permanent total disability benefits" be ruled on within thirty (30) days from the date of the receipt by the responsible party. However, this section also provides an additional thirty (30) days to rule if additional evidence is required. It should be noted that this section mentions temporary and permanent total disability benefits and the language regarding permanent total disability is contrary to West Virginia Code §23-4-6 requirements for ruling on a permanent total disability applications. It appears that the OIC meant to include re-opening requests for temporary total disability and permanent partial disability, not permanent total disability.

Further, §1-10.7 requires that a responsible party comply with orders of the Office of Judges Board of Review or the West Virginia Supreme Court of Appeals within thirty (30) days of the date of receipt, unless required to act sooner or unless the order issued is subject to a lawfully ordered stay.

No Comment.

85 C.S.R. §1-12

This section relates to overpayments and the definition of an overpayment includes any money received from or paid on an injured workers behalf by the responsible party which is subsequently determined that the injured worker was not entitled. Further, overpayments may include TTD, PPD, PTD, NAP TTR, TPR, dependent's benefits, fatal benefits, travel or medical benefits. The section also permits a responsible party to withhold the overpayment from future disability benefits payable to the worker or the dependents in the same claim or other claims which are pending with the same responsible party to whom the overpayment is due.

Comment:

This section should be amended to allow for the responsible party to collect the overpayment from a prior or subsequent responsible party. Additional changes may have to

be made in Rule 2 to provide a mechanism to place prior and subsequent responsible parties on notice that a claimant has an overpayment in a claim and to whom the withheld overpayment should be forwarded.

85 C.S.R. §1-17

This section relates to expert witness appearance fees and requires a responsible party to reimburse a treating physician or authorized consulting physician who appears at a hearing to give testimony at a rate of $100.00 per quarter hour. Additionally, all other expert witness appearance fees are also paid at the rate of $100.00 per quarter hour; however, if the expert demands an amount in excess of that, it is the responsibility of the party who has retained the services of the expert or submitted a report or record to pay the additional monies.

Comment:

The net effect of this is to put in a requirement that allows expert witnesses to charge in excess of the rate set by the Office of the Insurance Commissioner and the Office of Judges and essentially costs the carrier, or the claimant, additional money for the deposition as the deponent is now allowed to charge the additional sum to the parties who submitted the report. This was not the case previously and may prove to have a negative impact on employers, carriers and even claimants depending on the evaluating physician that they use.

85 C.S.R. §2-1, *et seq.* "Workers' Compensation Claims Index"

Comment:

As noted in the Comment to 85 C.S.R. § 1-12 above, it is recommended that this Rule be amended to include a field in the Claims Index for overpayments made by a responsible party in a claim. Further, each responsible party should be required to confirm by review of the Claims Index that no overpayments have been made to a claimant before paying benefits. Similar to the requirement to confirm no outstanding child or spousal support debts. This would serve as notice to the responsible party preparing to make an indemnity benefit payment in a claim to withhold any prior or subsequent overpayment in a claim for another responsible party.

85 C.S.R. §6-1 et seq. "Debt Reduction Fund Assessment and Regulatory Surcharges"

No Comment.

85 C.S.R. §8-1 "Workers' Compensation Policies, Coverage Issues and Related Topics"

No Comment.

85 C.S.R. §18-1, et seq. "Self Insurance, Self Administration and Third Party Administrators"

§ 18-14.4. was amended to prohibit self-insured employers from operating in an "illegal, improper or unjust manner" with regard to claims handling. This is similar to language found in chapter 33 pertaining to carriers. According to the OIC, the concept is to create a "catchall" provision for self-insured employers similar to that which applies to insurance companies.

Comment:

The language contained in this amendment, "illegal, improper or unjust" is vague and ambiguous, does not provide a consistent standard which will be applied, and presents an opportunity for misinterpretation of claims handling decisions. There is a potential for severe penalties based on the subjective interpretation of a claims handling reviewer. This section should be deleted.

Thank you for your consideration of these comments. If you have any additional questions, please feel free to contact me.

Sincerely yours,

Jeffrey B. Brannon

PYLES HAVILAND TURNER & MICK, LLP

ATTORNEYS AT LAW

408 MAIN STREET / P.O. BOX 596
LOGAN, WEST VIRGINIA 25601
TELEPHONE (304) 752-6000 / FAX (304) 756-3123

BRADLEY J. PYLES
JAMES M. HAVILAND
WILLIAM D. TURNER
REBECCA E. MICK

CHARLESTON OFFICE
TEL. (304) 345-3080
FAX. (304) 345-3083

LEWISBURG OFFICE
TEL. (304) 645-6400
FAX. (304) 645-6419

May 27, 2008

Workers Compensation Industrial Council
Office of the Insurance Commissioner
1124 Smith Street Room 400
P.O. Box 50540
Charleston, WV 25301-0540

Re: United Mine Workers of America
Comments on Proposed Workers' Compensation Rules 85-1, 85-18.

Dear Sirs:

On behalf of the United Mine Workers of American, I am enclosing for filing with the Industrial Council the enclosed comments regarded proposed rules under consideration by the Council, specifically Rule 01 (85 CSR 1) Rule 18 (85 CSR 18).

Very truly yours,

Bradley J. Pyles
Attorney at Law

BJP: bd

cc: Grant Crandall, General Counsel

UMWA

COMMENTS OF THE UNITED MINE WORKERS OF AMERICA ON THE PROPOSED AMENDMENTS TO RULES 85 CSR 1 AND 85 CSR 18

May 27, 2008

Grant Crandall, General Counsel
Judith Rivlin, Associate General Counsel
United Mine Workers of America
8315 Lee Highway
Fairfax VA 22031-2215

The United Mine Workers of America represents thousands of coal miners in the United States and Canada. Coal mining is a dangerous occupation, and the UMWA has a special interest in protecting the rights of injured employees to a fair, prompt, and financially secure workers' compensation system. In that light, the UMWA offers the following comments and suggestions regarding the proposed amendments to Rules 1 and 18 (85 CSR 1 and 85 CSR 18), pending before the Industrial Council for approval.

85 CSR Rule 01

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

3.1. General.

Immediately after ~~a work place~~ sustaining an occupational injury or becoming aware of an occupational disease, 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 W. Va. Code §23-4-1g and will dilute the credibility and reliability of the injured workers' claim.

Comments: The addition of the phrase "or becoming aware of an occupational disease" is problematic and should be deleted. While it may be reasonable to require prompt notice of an *injury* in order to permit a prompt investigation of compensability and secure immediate medical treatment, those considerations usually do not apply to occupational diseases, most of which do not require immediate treatment.

Imposing a requirement that an employee who becomes aware of an occupational disease to immediately give notice to the employer and file a claim on penalty of "diluting the credibility and reliability" of the claim clearly conflicts with the statutory limitation period for occupational diseases

of three years from last exposure or three years from the time a claimant knew or should have known of the disease. Employees with occupational pneumoconiosis, hearing loss, or carpal tunnel syndrome may often know that they have the disease, but elect to continue to work and not to file claims immediately. An employee who receives notice of a diagnosis of occupational pneumoconiosis from a NIOSH screening x-ray, or gets the results of a periodic audiogram arranged by the employer, or has a discussion with their family physician regarding pain and numbness in their wrists may all be "aware" that they have an occupational disease, but don't choose to pursue treatment immediately. In the unusual situation where an occupational disease requires immediate medical treatment, the treating physician will identify it as an occupational disease and assist the claimant in filing a claim, simply in order to be paid for his or her services. A requirement of prompt notice and filing for occupational diseases makes no sense and is clearly contrary to the statute.

§85-1-~~9~~ 10. Time Standards

~~9~~ 10.2. Occupational Pneumoconiosis claims. -- Non-medical rulings shall be entered in occupational pneumoconiosis claims within ~~fifteen (15)~~ ninety (90) ~~working~~ days from the date of receipt by the ~~Insurance Commissioner or private carrier~~ responsible party of properly executed, prescribed forms ~~from all parties involved~~. The ~~Insurance Commissioner or private carrier~~ responsible party shall consider all information and proof properly submitted in connection with each claim. Whenever the ~~Insurance Commissioner or private carrier~~ responsible party is of the opinion that a claim has not been adequately or properly developed for consideration, it may require the ~~parties to produce~~ production of additional evidence. The ~~fifteen (15)~~ ninety (90) ~~working~~ days shall be tolled for no more than thirty (30) additional days during this evidence gathering process.

Comments: There is no justification for extending the time standard for processing a non-medical order in an occupational pneumoconiosis claim from 15 days to 90 days, with an extra 30 days available for "evidence gathering." When the additional time for referral to the Occupational Pneumoconiosis Board, scheduling of an examination, the findings of the Board and the processing of an award, if made, a claim may take six months or more from filing to decision.

The non-medical order in an occupational pneumoconiosis claim is one of the simplest decisions in the workers' compensation system. It requires three findings: (1) was the claimant exposed within the state for 2 of the last 10 years or 5 of the last 15; (2) the allocation of liability among employers who employed the claimant for at least 60 days within the last three years; and (3) is the claimant entitled to the presumption of pneumoconiosis (10 of last 15 years). W.Va. Code 23-4-15b. All the necessary information is on the claim form. In many cases, the employer has all the information required in their own employment files. The allocation seldom involves more than two or three employers, one of which is the employer with which the claim was filed. At most it may require a couple of phone calls to verify the information on the application. There is no reason why it should require a three or four month investigation to perform what is virtually a clerical function.

85 CSR Rule 18

§85-18-~~11~~10. Voluntary Termination of Self-Insured Status.

~~11~~10.1. ~~If a self-insured employer decides to continue doing business in the state of West Virginia, but~~ A self-insured employer may terminate its self-insured status with the following conditions:

a. ~~the~~ The employer remains forever liable for all accrued and contingent liabilities ~~transferred to the self-insured account on the effective date of self-insurance, and remains liable for all accrued and contingent liabilities resulting from injuries or diseases incurred by its employees during the period of self-insurance and prior to termination of the self-insured status, unless the employer pays into the compensation fund an amount sufficient to cover the estimated cost of all such liability, including the costs of the administration of that liability, in which case the future costs of the liability shall be paid from the compensation fund.~~ which the employer has incurred as a result of being self-insured; ~~The employer must pay a fee of $2,500.00 for the liability calculation.~~

10.2. A self-insured employer may enter into a contract of sale of its business or which transfers some or all of its assets to another entity, and such contract may include, either expressly or impliedly, an agreement as to the assumption by the purchasing entity or transferee of the self-insured employer's accrued and contingent liabilities resulting from the employer's self-insured status: *Provided*, That in the event that such a contract is entered into, the provisions of this rule be adhered to, both with regard to section 9 ("Self-insured employer's modification of business") and this section. Any such contract as described in this subsection and any resulting sales, transfers and consequential effect on the employer's self-insured liabilities are subject to approval of the commissioner prior to taking effect.

Comments: Section 10.1 of the rule makes it clear that an employer seeking to terminate its self-insured status "remains forever liable for all accrued and contingent liabilities" incurred while self-insured. Section 10.2, however, addressing situations where a self-insured employer sells or transfers its business or assets to a purchaser, does not contain language similar to the language in §10.1 that the seller remains liable for the accrued and contingent liabilities in the event of a default by the purchaser. Section 10.2 seems to suggest that the Commissioner may approve such a sale and that such approval may sanction the transfer of existing obligations from the seller to the purchaser, exonerating the purchaser from further liability.

There is no reason to treat a sale of a self-insured employer's business or assets differently from a voluntary termination of self-insured status. It is appropriate to require approval for the sale by Commissioner in order to assure that the existing workers' compensation obligations are provided for. However, such approval should not exonerate the selling employer of those obligations. The seller should remain liable as a surety in the event of a default by the purchaser.

Under ordinary contract law, a purchaser of a business or assets may agree to assume obligations of the seller, including pre-existing obligations to other parties, including injured employees. In such agreements, the purchaser becomes the principal obligor but the seller remains a surety, responsible for the obligation in the event the purchaser defaults. Injured employees for whom the self-insured seller was responsible are creditor beneficiaries of the seller's promise to assume the obligation.

Restatement of Contracts, 2d, comment (b); Petty v. Warren, 90 W.Va. 397, 110 S.E.2d 826 (1922), ["... as between the parties to the agreement the first is the principal and the second becomes the surety, the creditor is entitled in equity to be substituted in his place for the purpose of compelling the party who thus becomes principal to pay the debt"].

The recent experience of the Horizon Natural Resources bankruptcy illustrates the potential problem. Horizon purchased a number of mining operations in the years leading up to the bankruptcy, accruing in the process more debt than it could handle. In many of those purchases, Horizon assumed existing obligations for employee benefits, workers' compensation and environmental liabilities, and other obligations. When the spectacular implosion occurred, the assets were sold free and clear of those obligations and many governmental and private parties to whom those obligations were owed were left holding the bag.

If another such situation arises and the seller has been exonerated by the Commissioner's approval, the existing liabilities of a large bankrupt purchaser could swamp the guaranty pool and jeopardize the benefits of injured employees.

The proposed rule should be amended to make it clear that the seller in a transfer of workers' compensation obligations remains "forever liable for all accrued and contingent liabilities" as a surety in the event of a default by the purchaser. The Commissioner's approval should also require a showing by the seller that it could meet those obligations.

SPILMAN THOMAS & BATTLE, PLLC
ATTORNEYS AT LAW

(304) 340-3829
tcox@spilmanlaw.com

May 29, 2008

Jane L. Cline, Commissioner
West Virginia Division of Insurance
1124 Smith Street
P. O. Box 50545
Charleston, West Virginia 25305

Re: Comments on Workers Compensation Rules; Title 85, Series 1, 2 and 6

Dear Commissioner Cline:

These comments are submitted on behalf of the American Insurance Association (AIA), a national trade association representing property and casualty insurers. AIA members write a major share of property and casualty insurance, including workers' compensation insurance throughout the United States.

SERIES 1 – CLAIMS MANAGEMENT AND ADMINISTRATION

Special Rules for Non-Awarded Partial Benefits

Our understanding is that the "non-awarded partial benefits" addressed in §85-1-8 would be provided voluntarily by a private carrier when an employee has reached maximum medical improvement (MMI), has not returned to work, and is awaiting an assessment of permanent partial disability (PPD). However, subsection 8.1 of §85-1-8 provides that "Non-awarded partial disability benefits will only be payable if the weight of the evidence indicates that a permanent impairment exists." If these are, in fact, voluntarily paid benefits, who would be responsible for weighing the evidence? We recommend defining the term "non-awarded partial benefits" in order to clarify this area.

SERIES 2 – WORKERS' COMPENSATION CLAIMS INDEX

Access to Claims Index

Subsection 5.1 of §85-2-5 permits private carriers or their designated agents to apply for, and be granted access to, the claims index. We recommend clarifying that granting access to a private carrier or one of its designated agents entitles any employee or designated agent to access the claims index without having to make a separate application.

SERIES 6 – WORKERS' COMPENSATION DEBT REDUCTION FUND ASSESSMENTS AND REGULATORY SURCHARGES

Definition of "Total assessable workers' compensation premium due"

The second sentence of subsection 3.10 of §85-6-3 currently reads:

"Total assessable workers' compensation premium due" shall also include all discounts based on deductible provisions in policies."

We recommend the following, in order to increase clarity:

"Total assessable workers' compensation premium due" shall also be computed prior to all discounts based on deductible provisions in policies."

Federal Black Lung Coverage

Subsection 3.10 of §85-6-3 would require assessable premium for Federal Black Lung coverage. Unlike the other federal coverages (e.g., USL&H, FECA and FELA), black lung coverage is only a portion of the rate for a class code. All of the other federal class codes have their own rate, and so one can easily determine which coverage is federal by the class code. However, a rate for a coal mining class code combines both federal and state coverage, and the portion of the rate that is attributed to federal coverage will change each year. Breaking out the premium attributed to black lung in the assessment would require private carriers to incur substantial programming costs, and the information would have to be updated with each rate filing. Accordingly, we recommend that the relatively minor portion of the rate attributed to black lung be excluded from the surcharge's assessable base.

Notice of Rate Changes

Subsection 4.1 of §85-6-4 would establish that the commissioner shall provide private carriers at least sixty (60) days notice prior to changing the private carrier regulatory surcharge percentage amount. We recommend increasing this notice period to 90 days.

Respectfully submitted
on behalf of American Insurance Association

By: _____
T. Randolph Cox, Retained Counsel

TRC/lb;1038482

West Virginia Self-Insurers Association
Post Office Box 1573
Charleston, West Virginia 25326
Tax ID# 55-0654337

West Virginia Self-Insurers Association
Comments on Proposed Rule 85 C.S.R. §1
Public Hearing May 29, 2008

Below is a summary of the Offices of the Insurance Commissioner's (hereafter "Commissioner's") proposed rule changes to 85 C.S.R. §1, pertaining to workers' compensation claims management and administration in West Virginia and comments and recommendations from the West Virginia Self-Insurers Association, (hereafter "WVSIA"). Only those proposed changes which appear to have an impact on substantive or procedural issues are addressed.

85 C.S.R. §1-2.4.c.

Section 2-4.c pertains to "filing" a document, which if sent by electronic mail would be deemed filed on the date on which e-mail is sent to the e-mail address for the recipient.

Comment:

WVSIA recommends that this section be changed to reflect that "electronic mail filing shall only be completed upon proof of receipt." The Insurance Commissioner has some regulatory standards in Title 114 C.S.R. pertaining to electronic transmissions. Perhaps those may be useful herein. In any event, all "filings" by any appropriate method shall be completed upon proof of receipt.

85 C.S.R. §1-2-14.

Section 2.14 sets forth a definition for retirement. As proposed, "Retire" means an individual has permanently ceased working due to age or years of service and has no intent to return to work.

Comment:

WVSIA recommends that the definition be broader. Chapter 23 of the West Virginia Code contains most of the workers' compensation law. The legislature has not defined retirement and the Commissioner's proposed definition is too restrictive. There may be unrelated disability or medical retirement which should be included. The confusion regarding the proposed definition is evident by the term's use in Section 5 of the rule.

85 C.S.R. §1-5.1.

Section 5.1 refers to "temporary total disability" which is defined in the statute. The proposed section states that to qualify for temporary total benefits, the injured worker must have

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

Comment:

WVSIA recommends that this proposed section be clarified by reflecting the statute's clear intent. W. Va. Code §23-4-5 states that temporary total disability benefits are not paid unless the employee misses more than three (3) consecutive work days as a result of a compensable injury. In order for an employee to be eligible for benefits for the first three (3) consecutive work days missed, the injured employee must miss seven (7) consecutive scheduled work days. As proposed, the Commissioner's version does not require three (3) days of consecutive disability from scheduled work before temporary total disability benefits are payable.

85 C.S.R. §1-5.3.

Section 5.3 (p. 5) also pertains to the temporary total disability benefit eligibility. As proposed, if a period of disability includes a reasonably ascertainable period of time during which the injured worker would not have been performing work for any 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.

Comment:

WVSIA recommends that the current version of Section 5.3 be retained. However, an additional sentence should be added to make clear that the section applies specifically to seasonal reductions in work force and seasonal layoffs.

85 C.S.R. §1-6.2.

Section 6.2 (p. 5) pertains to computation of permanent partial disability awards. The proposed rule deletes this section.

Comment:

WVSIA recommends that the current section 6.2 be retained in the rule without amendment.

85 C.S.R. §1-7.2.

Section 7.2 (pp. 5-6) is new and pertains to notice and litigation. The proposal provides that whenever a decision is issued, it must include language stating that the claimant has a right to protest within sixty (60) days from receipt of the decision.

Comment:

WVSIA recommends that this provision be amended further by reflecting the statutory requirement of a 30-day protest period for decisions from the Occupational Pneumoconiosis Board.

The occupational pneumoconiosis statutes provides for a 30 day protest to decisions (issued by responsible parties which incorporate the Findings of the Occupational Pneumoconiosis Board). That statutory provision was not amended and conflicts with the language of W. Va. Code §23-5-1.

85 C.S.R. §1-8.0.

Section 8 pertains to "Rules for Permanent Total Disability" claims. This section is reserved for future rule.

Comment:

WVSIA recommends that this section be deleted. Permanent Total Disability claims are the sole subject of §85 C.S.R. 5, commonly referred to as Rule 5. All claims management and administration of Permanent Total Disability claims should be incorporated only in Rule 5.

85 C.S.R. §1-10.1.

Section 10-1 (p. 7) pertains to time standards. The current rule permits 15 working days for a responsible party to rule on a claim. The proposal shortens the time frame to "15 days".

Comment:

WVSIA recommends that the current section requiring 15 working days be retained. The current rule was passed by the former Workers Compensation Board of Managers after public hearing. The Commissioner's proposed change shortens this time, without any public issue being identified as problematic with the current rule. At the Commissioner's recommendation, the legislature enlarged the timeframe in which any claimant may protest to 60 days, with an additional 60 days provided in which good cause for missing the protest deadline may be shown. There is no identified compelling reason to require responsible parties to make determinations in 15 calendar days instead of the current 15 days. WVSIA urges that the timeframe for ruling not be shortened.

85 C.S.R. §1-10.4.a.

Section 10.4.a (p. 8) pertains to a statutory section which compelled the former Workers' Compensation Commission to refer injured workers for independent medical evaluations at the end of the 120 day period of temporary total disability. Even though the monopoly agency is terminated, the section is applied to responsible parties.

Comment:

WVSIA recommends that this section be deleted, as it is unnecessary. Arguably this statute and proposed rule is an unnecessary claims management tool. The statute directed the former state agency to refer injured workers on temporary total disability benefits for 120 days evaluations, for determination of whether the injured workers were still temporarily totally disabled; and, therefore, eligible for continued receipt of temporary total disability benefits. The law provides that an injured worker is not eligible for continued temporary total disability benefits when that injured worker is found at maximum medical improvement. Historically, the former agency was required to do this so it would not pay improper or unwarranted temporary total disability benefits after the claimant was at maximum medical improvement. In the new private workers compensation competitive market, self-insured employers and insurance carriers will utilize best claims practices and determine more quickly when it is appropriate to refer a claimant for evaluation or will not refer where medical evidence shows that the injured employee remains temporarily totally disabled. The 120 day referred provision is antiquated and should not be a factor in compliance or market conduct.

85 C.S.R. §1-10.5.b.

Section 10.5.b (p. 8) pertains to permanent disability rulings. Section 10.5.b requires referrals for examination and evaluations to take place at the request of claimants within 30 working days from the date of receipt of the request. The Commissioner's proposal deletes the word "working" and requires "30 days."

Comment:

WVSIA recommends that the current Section 10.5.b. be retained with 30 "working" days. This rule was passed by the former Workers Compensation Commission Board of Managers after public hearing. At that time no objections to 30 working days were offered and that body was not persuaded to delete "working" days from the section. WVSIA believes the current rule should remain unchanged.

85 C.S.R. §1-10.5.c.

Section 10.5.c pertains to payment of permanent partial awards. The Commissioner's proposal is new and provides such awards may be paid by lump sum or in installments. Payment of permanent partial disability awards are to commence within 30 days of the decision granting the award.

Comment:

WVSIA recommends that Section 10.5.c. be rewritten to provide that the payment of permanent partial disability awards may be made in either monthly installments or in lump sum at the discretion of the responsible party.

85 C.S.R. §1-10.5.d.

Section 10.5.d pertains to findings of the Occupational Pneumoconiosis Board.

Comments:

This section should not change 30 "working days" to "30 days".

85 C.S.R. §1-10.6.

Section 10.6 pertains to reopening of claims. The Commissioner's proposal states that "applications for reopening for temporary or permanent total disability benefits . . . .

Comments:

WVSIA suggests that the sentence be rewritten by striking the word "total" from line 2, so it is clear that reopening of claims herein are for temporary total disability or permanent partial disability. Permanent total disability claims are the subject of 85 C.S.R. 5, commonly referred to as Rule 5, which proscribe the requirements for filing a permanent total disability claim.

85 C.S.R. §1-12.2.

Section 12. refers to overpayment of benefits. Section 12.2, as proposed, limits the collection of overpayments.

Comment:

WVSIA recommends that this section be rewritten. As proposed, it is contrary to the authority permitting a responsible party to offset overpayments from future benefits. See W. Va. Code §§23-4-1c(h) and 23-4-1d(d).

85 C.S.R. §1-13.1.

Section 13.1 (p. 10) pertains to the processing of occupational lung disease claims as occupational pneumoconiosis claims. The Commissioner's proposal would limit the Occupational Pneumoconiosis Board to evaluation of impairment.

Comment:

WVSIA recommends the current rule be retained but clarified that the occupational lung disease be "processed" as occupational pneumoconiosis claims, not filed as occupational pneumoconiosis claims. The former Workers' Compensation Commission Board of Managers accepted recommendation that claims for occupational lung diseases be "filed as and processed as "occupational pneumoconiosis claims". The purpose of this rule was to insure that lung cancer cases, alleged to have been directly related to or caused by respirable dust or other workplace exposures were referred to the occupational pneumoconiosis medical specialists. Representatives of labor and employers supported the current rule. WVSIA is aware that the rule

has been applied improperly to deny alleged cancer claims on the basis that an individual claimant had no additional dust exposure after the initial occupational pneumoconiosis claim was filed and the time for reopening the claim as provided in W. Va. Code §23-4-16 had passed, or the requirement for an ILO x-ray report was not provided.

The intent of the current rule is to process the claim as an occupational pneumoconiosis claim. The proposed amended rule limits jurisdiction contrary to W.Va. Code §23-4-8(c)(b) regarding the question of causation . . . specifically whether the alleged exposure caused or perceptively aggravated a claimant's occupational pneumoconiosis and caused a resulting disease related to the exposure. There is a medically recognized dose-response relationship between occupational dust and environmental exposures and manifestation of cancers which may be caused by that exposure. Regretfully, there are many other causes for lung diseases and lung cancers that are contracted in men and women having no workplace exposures to occupational dust and environmental hazards. One obvious example is that the United States Surgeon General since 1964 has identified tobacco use as the most significant risk factor for development of lung and heart disease, and identified it as a cause for cancer. It is improper for the Commissioner to limit the jurisdiction of the Occupational Pneumoconiosis Board by not allowing it to consider the cause of any lung disease alleged to be related to work place exposure.

85 C.S.R. §1-16.

Section 16 (p. 13) is new and pertains to complaints which may be by claimants against either private carrier or self-insured employer.

Comment:

WVSIA recommends that this section be changed to require the Commissioner provide a copy of its response to the responsible party (carrier or self-insurer).

85 C.S.R. §1-19.

Section 19 (p. 15) pertains to miscellaneous administrative matters and in the current rule is numbered as Section 18. The Commissioner's proposal deletes the current Section 18.1.

Comment:

WVSIA recommends that the current Section 18.1 providing that "incidents that do not result in material medical treatment, or are not reasonably expected to result in medical treatment need not be reported to the Insurance Commissioner or private carrier by the worker or employer."

INSURANCE COMMISSIONER RESPONSES TO STAKEHOLDER AND PUBLIC COMMENTS RECEIVED ON W. VA. CODE ST. R. § 85-1-1 ET SEQ.

Introduction

Below is the written response of the Insurance Commissioner to the stakeholder and public comments received in regard to the proposed amendment of Title 85 Rule, W. Va. Code St. R. § 85-1-1 et seq. ("Claims Management and Administration"), which was filed with the West Virginia Secretary of State for public comment on 04/29/08. This response is itemized by topic, and addresses all of the substantive comments received at the 5/29/08 Industrial Council meeting as well as written comments received from stakeholders.

Definitions of "Filed" and "Paid"

Comments were made that the definitions of "filed" in subsection 2.4. of the rule should not have been amended in its current definition, but rather should have remained to be defined as "actual receipt by the recipient". The Commissioner disagrees with this comment.

In the workers' compensation context, filing an application, report or other document places a duty upon a person or entity to take an affirmative action to see that the item to be filed is sent to the recipient. It is patently unfair to expect the person required to timely file something to be responsible for the actual receipt by the recipient as long as the action to begin the sending process has occurred. For example, one may place an item in the mail, but for various reasons the item could take more than the usual 1-3 days to be received by the recipient. It would not be fair to blame the sender and deem the item untimely filed for reasons beyond the sender's control. Therefore, the Commissioner believes the amendments to "filed" are appropriate.

For the same reasons, the Commissioner disagrees with similar comments that the definition of "paid" in subsection 2.10. should be amended to require actual receipt by the claimant of the money. It would be unreasonable to expect the carrier to be responsible for the check once it is placed in the mail.

Definition of "Retire"

Several stakeholders suggested that the definition of "retire" in subsection 2.14. of the Rule is problematic because it is too narrow or otherwise could lead to abusive practices. The Commissioner agrees with this comment, and believes that attempting to define this term in rule could lead to unintended consequences. Therefore, this definition has been removed.

Provisions Regarding Timely Reporting of Claims to Employer

It was suggested that the language in subsection 3.1. of the Rule discussing appropriate actions for timely reporting of claims not include occupational diseases but only occupational injuries. This comment is well taken. Occupational diseases are much different in nature than occupational injuries, and have a three year statute of limitations rather than a six month statute. Therefore, the language including occupational diseases within the scope of this subsection was removed.

It was also suggested that the last several sentences of 3.1. regarding the presumption that a claim is timely noticed to an employer if done so within two working days of the injury occurring be stricken. The Commissioner disagrees. There is a valid policy concern in workers' compensation that claimants be encouraged to timely report occurrences at work causing injury to employers. Therefore, this presumption is a reasonable provision. However, it should be noted that language was placed in this subsection clarifying that a carrier or self-insured employer cannot cite failure to timely report to the employer as the sole reason for denial of a claim. This should address concerns of this presumption being used inappropriately to deny claims by adjusters.

Retroactive Adjustments to Underpayments

It was suggested that the provision in 3.2. which limits reimbursement for underpayments made to a claimant to a maximum of two (2) years be removed. The Commissioner agrees with this comment. West Virginia Code Section 23-4-16 contemplates a period of 5 years for reimbursements to claimants for underpayments, and the Commissioner believes that the two year limitation in subsection 3.2 was inconsistent with that Code section.

Reporting of Injury by Employer to Carrier

It was suggested that the requirement in subsection 4.1. that injuries be reported by an employer to their carrier within five days was problematic because it could lead to a report of the injury by the employer to the carrier being deemed the filing of a claim by a claimant without the claimant having actually filed an "application for benefits", which in turn could be deemed to have tolled the statute of limitations. Also, there was concern stated that the carrier will not be able to obtain the necessary information without a properly filled out application.

The Commissioner disagrees with this comment and does not believe these concerns are well founded. Specifically, the expectation is that when a claimant is injured, he or she notify his employer as soon as possible. Then, the employer generally will see that the claimant makes proper application for benefits or is placed in contact with a claims adjuster for the employer's carrier. Alternatively, it is also common that the claimant's application will be filed by the first attending medical provider to see the claimant.

In any event, the Commissioner does not believe that an employer or carrier could reasonably assert that a claim was untimely filed if the claimant provides appropriate notice to the employer and/or carrier simply because the claimant does not fill out a particular form in hard copy format. In the privatized market setting, the primary concern for meeting the statute of limitations is that the claimant provides prompt notice of the injury. From that point, it is the job of the claims adjuster to make sure all proper information is gathered, including an application for benefits if it is the carrier's practice to require a hard copy of the form to be filled out. (Carriers may instead choose to interview the claimant telephonically to obtain information instead). Therefore, the Commissioner is not inclined to strike this provision.

Comment was also made that the second sentence of 4.1. which provided a fine against the employer of $250 per occurrence of not timely reporting was improperly stricken. The Commissioner disagrees. This provision was stricken because in the privatized market, timely reporting of claims to the carrier is best handled in the business relationship between the carrier and insured employer. For example, if an employer continuously does not report injuries timely, the carrier may choose to not renew the policy when it expires, deeming the employer to be a bad risk. It should also be noted that employers are required to post at their workplace the name and contact information of their carrier, so in the event that an employee believes the employer is not timely reporting the claim, they can contact the carrier on their own. Therefore, the Commissioner believes this fine provision was properly stricken as not belonging in this Rule.

Temporary Total Disability Provisions

Several comments were made regarding the provisions in section 5. of the Rule pertaining to temporary total disability benefits ("TTD"). First, several stakeholders said that the language in 5.1. did not adequately reflect the statute or otherwise was worded in a manner which could lead to confusion. After reviewing the relevant statutory language, the Commissioner believes that it is appropriate to add the word "consecutive" prior to "days of work", so that this language is not inconsistent with the statute. Other than this change, the Commissioner believes this language is clear and consistent with the statute.

Second, several stakeholders suggested that the language in 5.2. which bars a claimant from receiving TTD benefits when the claimant retires is problematic as it currently reads, primarily because of the definition of "retired". As noted above, the definition of "retired" was stricken; therefore, this should alleviate the most concerns with the language in this section. To the extent that stakeholders are suggesting that the provision added to clarify that TTD benefits are only barred while the claimant remains retired (i.e., is not working) is inappropriate, the Commissioner disagrees. Specifically, there is no Code language or policy reasons supporting the premise that an injured worker could not resume work then aggravate an injury and be entitled to further TTD benefits upon an appropriate re-opening of the claim.

Finally, several stakeholders suggested that the language in 5.3. which clarifies that workers who regularly have an ascertainable period of time while they do not work during the year (such as teachers and school bus drivers) cannot receive TTD benefits during such off time (unless they can show they would have been working at another job) should be broadened to include "seasonal" workers. The Commissioner disagrees with these comments. Specifically, this terminology goes beyond the scope of what this provision was intended to do, and could potentially lead to certain claimants entitled to TTD benefits to not receive them. Therefore, the Commissioner believes the language in 5.3. in the Rule should not be amended.

Permanent Partial Awards

Several comments were made regarding the provisions in the Rule pertaining to permanent partial disability awards ("PPD"). First, it was suggested that the provision of 6.2. which stated that PPD awards should be based upon the law in effect on the date of award should not have been stricken. The Commissioner disagrees. This provision may have had some use over the years when the law was changed several times regarding the calculation of PPD awards. However, the current calculations in the law for PPD awards have been the same since 2003, and it is not anticipated that any changes will occur in the foreseeable future. Moreover, the provision in this subsection simply states a holding by the West Virginia Supreme Court in response to various approaches which were being taken on this issue. The Commissioner does not believe that it is necessary to re-state law from Supreme Court opinions in rules. Therefore, 6.2. of the Rule will remain stricken.

Second, several comments were made regarding subdivision 10.5.c. of the Rule pertaining to how PPD awards can be made. It was suggested that this provision, which states PPD awards can be paid in a lump sum or in installments be further clarified to indicate that the carrier or self-insured employer has the discretion to determine which method to us in paying the award. It was also suggested that the provision include more details as to how installment payments can be made. The Commissioner agrees and has added language to the 10.5.c. to address both of these concerns.

Notice to Claimant and Parties in Litigation

There were multiple comments regarding the new section 7. in the Rule entitled "Notice and Litigation." First, it was commented that 7.2. should be amended to reflect that a claimant only has thirty (30) days to protest the recommended decision of the OP board. This Commissioner disagrees. The language contained in W. Va. Code §23-5-1(b)(1), as amended by H.B. 4636 (effective March 8, 2008) clarifies that the time frame to protest a decision of a private carrier or self-insured employer is sixty (60) days in the case of any decision made. This language is more recent than statutory language in the Code regarding protesting recommended decisions of the OP board, and therefore, based on general rules of statutory construction, would supersede any previous existing language with which it conflicts.

Second, there was a comment submitted regarding section 7. and asserting that the language in this section is contrary to W. Va. Code §23-5-1 (as amended) and other provisions of the workers' compensation Code. Specifically, the concern was that this section abolishes an employer's right to protest decisions of the employer's carrier. The Commissioner disagrees with these comments.

Section 7. of the Rule was carefully tailored to reflect changes the Legislature made to 23-5-1 regarding workers' compensation litigations. While the Legislature did not abolish an employer's right to protest in these amendments, it did greatly limit this right to several specific instances. Further, this amended code section clarifies that, generally, the carrier has sole authority to act on the employer's behalf in all aspects related to litigation of the claim. Under basic rules of statutory construction, the new language in 23-5-1, which directly and irreconcilably conflicts with other sections of the workers' compensation Code indicating a broader right on behalf of the employer to protest carrier decisions, supersedes the former conflicting language. Therefore, the Commissioner believes that the language in section 7 which reflects 23-5-1 is appropriate and should not be stricken.

Non-Awarded Partial Benefits

Several comments were made on section 8. of the Rule addressing non-awarded partial ("NAP") benefits. First, it was commented that subsection 9.2., which states that NAP benefits are not awarded when a claim has been reopened for TTD benefits and a PPD award has already been made, should be stricken. While the Commissioner does not believe this provision should be stricken, the concern of a claimant not being able to receive NAP benefits if they have re-opened for TTD and then subsequently re-open for PPD benefits is well taken. Therefore, this section was amended to state that NAP benefits are only barred if the claim is *only* re-opened for TTD benefits, which in turn would permit them if it was also re-opened for additional PPD award.

Another comment was made that NAP benefits should be defined more clearly in the Rule. Subsection 7.1. references the Code provision which discusses NAP benefits, and they are clearly defined in this Code provision. As the description in the Code is clear, the Commissioner does not see the need for a definition in the Rule beyond what is provided for in the Code.

Time Standards

Multiple comments were received on section 10. of the Rule pertaining to various time standards. First, it was commented that when a standard involves a certain amount of days, it should always reference "working days" and not "days" or "calendar days".

The Commissioner disagrees that day time standards should uniformly be stated as "working days". Specifically, in various sections establishing day time standards in the workers' compensation Code, the Legislature has, in some instances, referenced "working days", while in other instances just referenced "days". Therefore, it is the

Commissioner's conclusion that the Legislature anticipated some day time standards to involve working days if so designated, while others to involve calendar days. As such, the Commissioner has carefully reviewed the Code, and in instances where the Legislature has specifically designated "working days" in the Code, the section in the Rule which parallels such Code section, if applicable, reflects "working days". Otherwise, the time standards simply reference "days".

Second, it was suggested that sections 10.2. and 10.6., which proscribe time standards for ruling upon OP claims and petitions for re-opening, respectively, should not have been amended to ninety (90) and thirty (30) days, respectively. The Commissioner disagrees. The workers' compensation Code specifically proscribes these time frames for the instances addressed in these subsections. Specifically, W. Va. Code §23-4-15b(a) establishes a time frame of ninety (90) days for ruling on OP claims and W. Va. Code §23-4-16(b) establishes a time frame of thirty (30) days for ruling on a re-opening petition. Therefore, the Commissioner believes amendments to subsections 10.2. and 10.6. are appropriate.

Third, several stakeholders expressed concern with the provisions of subsection 10.4. regarding regularly scheduled medical examinations of claimants while receiving TTD benefits. The concerns were that the provision is outdated and inapplicable to a privatized market. Specifically, it is believed that requiring claimants to have an exam at least every one hundred and twenty (120) days is an unnecessary burden to private carriers and self-insured employers and that these entities should instead be given discretion based on their own claims handling practices as to how often the claimant should be sent out for examination.

While the Commissioner does not disagree with the policy argument espoused by these stakeholders, the requirement of regular examinations to be scheduled by private carriers and self-insured employers is set forth in the Code. Therefore, the Commissioner does not have discretion to strike this provision in its entirety. However, as the relevant Code section provides some discretion to carriers and self-insured employers in scheduling examinations if it is clear that no examination is required, subsection 10.4. was amended to clarify that the carrier or self-insured employer is permitted to not schedule an examination at the end of a one hundred and twenty (120) day period, but rather can wait until the end of the expected period of temporary disability to schedule the examination.

Overpayments

Several stakeholders commented that section 12. of the Rule should be amended to create a system whereby overpayments to claimants can be collected between different carriers and self-insured employers. The Commissioner disagrees with this comment.

While the Commissioner understands that overpayments to claimants can be difficult for the carrier or self-insured employer to recover, the Code provides no statutory authority for the Commissioner to create by rule a system for inter-carrier/self-

insured employer reimbursement of overpayments. Specifically, W. Va. Code §23-4-1c(h) only permits carriers or self-insured employers to recover payments from the same or other claims of the overpaid claimant that the carrier or self-insured employer is also handling.

The Commissioner also notes that the OIC received feedback from the insurance industry on this issue, and the response was that there is no precedent in other jurisdictions for inter-carrier reimbursement of overpayments. (A few states, such as Pennsylvania, do have a "supersedeas fund" to which all carriers contribute for the purpose of reimbursing certain overpayments; however, again, absent a change in law by the Legislature, the OIC has no authority to create this by rule). Therefore, the Commissioner is not inclined to create an inter-carrier/self-insured employer system of overpayment reimbursement in this Rule.

It was also commented that in subsection 12.1. of the Rule, which defines the various types of benefits in which overpayments can be made, should be amended to strike "dependents and 104 week benefits". The Commissioner disagrees. The relevant Code provision on overpayments does not limit the types of benefits in which overpayments by a private carrier of self-insured employer *can occur*; rather, it only limits the types of benefits from which overpayments *can be recovered.* Therefore, it is not inappropriate to include dependent benefits in the list of benefit types in which overpayments can occur. However, it should be pointed out that in 12.2., dependents benefits were stricken as the Code does not appear to permit overpayments to be recovered from such benefits.

Occupational Disease and Pneumoconiosis Claims and the OP Board

Multiple comments were received regarding amendments made to subsection 13.1. of the Rule pertaining to Occupational Pneumoconiosis and Occupation Disease claims and the role of the OP board with regard to the same. The Comments received to the proposed amendment suggest that the purpose of the current language in the Rule is to ensure that lung cancer cases, alleged to have been directly related to or caused by respirable dust or other workplace exposures, are referred to the appropriate occupational pneumoconiosis specialists and processed as occupational pneumoconiosis claims. Concern was also expressed that the amendment takes the issue of compensability and causation in occupational disease cases away from the Occupational Pneumoconiosis Board.

West Virginia statutory authority specifically permits the filing of workers' compensation benefits for occupationally acquired diseases, as well as claims for diseases acquired as a result of hazardous dust exposure in the workplace. The statutory requirements for the filing of each type of claim differ. Additionally, depending upon the type of application filed, a claimant could be entitled to different types of workers' compensation benefits.

An occupational disease claim is defined by statute as "having been incurred in the course of or to have resulted from the employment only if it is apparent to the rational mind, upon consideration of all the circumstances: (1) That there is a direct causal connection between the conditions under which work is performed and the occupational disease; (2) that it can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment; (3) that it can be fairly traced to the employment as the proximate cause; (4) that it does not come from a hazard to which workmen would have been equally exposed outside of the employment; (5) that it is incidental to the character of the business and not independent of the relation of employer and employee; and (6) that it appears to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction." (See W.Va. Code 23-4-1(f)). Temporary total disability benefits, as well as medical benefits are payable in occupational disease claims.

An occupational pneumoconiosis claim is defined by statute as "a disease of the lungs caused by the inhalation of minute particles of dust over a period of time due to causes and conditions arising out of and in the course of the employment. The term "occupational pneumoconiosis" includes, but is not limited to, such diseases as silicosis, anthracosilicosis, coal worker's pneumoconiosis, commonly known as black lung or miner's asthma, silico-tuberculosis (silicosis accompanied by active tuberculosis of the lungs), coal worker's pneumoconiosis accompanied by active tuberculosis of the lungs, asbestosis, siderosis, anthrax and any and all other dust diseases of the lungs and conditions and diseases caused by occupational pneumoconiosis which are not specifically designated. (See W.Va. Code 23-4-1(d)). Occupational Pneumoconiosis claims are considered "no lost time claims." Temporary total benefits are not payable and medical benefits are limited to those permitted under 85 CSR §20(52).

In *Powell v. State Workmen's Compensation Commission*, 166 W.Va. 327, 273 S.E.2d 832 (1980), the West Virginia Supreme Court held that lung cancer can be an occupational disease within the meaning of WV Code §23-4-1, even though it is an ordinary disease of life which occurs in the general public. The West Virginia Code provides coverage for new occupational diseases as medical science verifies it and establish it as such. If studies and research clearly link a disease to a particular hazard of a workplace, a prima face case of causation arises upon showing that the claimant was exposed to the hazard and is suffering from the disease in which it is connected.

The Supreme Court expanded upon the *Powell* decision in *Newman v. Richardson*, 186 W.Va. 66, 410 S.E.2d 705 (1991). The Court held that when a claim for an occupational disease is filed, the Commissioner is to follow the usual processing procedure for personal injury claims and apply the six criteria outlined in §23-4-1 to determine if the alleged disease was "incurred in the course of and resulting from employment." The Court further held that when a claim for occupational pneumoconiosis alleging asbestosis or any other disease defined by WV Code §23-4-1, as occupational pneumoconiosis is filed, the Commissioner must follow the processing system for occupational pneumoconiosis claims and limit the initial determination to

exposure and other non-medical facts as required by W.V. Cade §23-4-15b. The Court clarified that its holding did not change the statutory definition of occupational pneumoconiosis, nor did it affect the processing system for an occupational pneumoconiosis claim.

Thus, based upon the holdings in *Powell* and *Newman*, even though the claimant alleges that he has acquired a disease caused by the inhalation of minute particles of dust, such as cancer caused by exposure to asbestos, the claimant has the *option* to file his request for benefits as either a claim for occupational disease or a claim for occupational pneumoconiosis. The Claims Administrator must process the application as it is filed.

There has been concern expressed that the amendment takes the issue of causation in occupational disease cases away from the Occupational Pneumoconiosis Board. However, with the limited exception discussed below, in occupational pneumoconiosis claims, the issue of compensability and causation are not within the jurisdiction of the Occupational Pneumoconiosis Board. The claims administrator exclusively retains jurisdiction to consider the issue of compensability/causation in both occupational pneumoconiosis and occupational disease cases. The Comissioner does not believe that there should not be an exception made to this rule regarding to occupational disease claims as a result of cancer caused by the inhalation of minute particles of dust.

It should also be noted that the proposed amendment retains the expertise of the Occupational Pneumoconiosis Board for a determination of whole person impairment in both occupational pneumoconiosis and occupational disease claims. Should the claims administrator choose to take the issue of causation to the Occupational Pneumoconiosis Board in either an occupational disease claim or a occupational pneumoconiosis claim, a referral can be made to the Board. This is known as a *Fraga* referral, named after the West Virginia Supreme Court's holding in *Fraga v. State Workers' Compensation Commission*, 125 W.Va. 107, 23 S.E.2d 641 (1942). In that case, the Supreme Court held that the claims administrator has the authority to refer issues related to exposure to the Occupational Pneumoconiosis Board prior to the entry of an initial decision. The Board will review the evidence relating to exposure and advise the whether the exposure is satisfactory. Regarding the processing of occupational disease claims, the OIC believes that the Claims Administrator retains the right to determine the issue of compensability and causation, just as they do when making a non-medical ruling upon receipt of an application for occupational pneumoconiosis benefits.

Further, the amendments in the Rule seek to clarify an industry wide misuse and misinterpretation of the current rule. There have been numerous complaints received regarding problems in filing claims where the claimant alleges he has been diagnosed with mesothelioma or lung cancer caused by a workplace dust exposure. The OIC is aware of instances where the claims administrator requires the claimant to file the application for benefits when alleging an occupationally acquired lung cancer as an occupational pneumoconiosis claim pursuant to the claims administrators' interpretation of Rule 1. The claims administrator then requires the claimant to provide a properly completed application for occupational pneumoconiosis benefits as required under Rule

20. Under 85 CSR §20(52.1), a properly completed application must include 1) a completed WC-105 form; 2) a completed WC-205 form; 3) an ILO form properly completed by a certified "B" reader; and 4) a listing of all alleged exposures to harmful dust, including type of dust, and extent and duration of exposure with each named employer.

Mesothelioma is not a disease which is diagnosed by x-ray. Rather, it is diagnosed by pathology. The OIC is aware of instances where the claims administrator has rejected the application for benefits related to mesothelioma, because the application did not include an x-ray interpretation by a B reader, despite the fact the claimant's disease has been definitely diagnosed by a pathologist. In these instances, the claimant must seek recourse in a protest of the claims administrator's ruling before the Office of Judges. The OIC considers this practice a misuse of the Rule 1 provision, and offers the proposed amendments as clarification.

Finally, the OIC is aware of instances where temporary total disability benefits, as well as medical benefits, are denied in compensable cancer claims, under the purported authority of Rule 1, as "cancer claims must be processed as occupational pneumoconiosis claims." As noted above, temporary total benefits are not payable in occupational pneumoconiosis claims, and benefits are limited to those outlined in Rule 20. The OIC considers this practice another misuse of the current Rule 1 provision, and offers the proposed amendments as clarification.

Travel Reimbursements

Several comments were made on the current mileage reimbursement provisions in section 15. of the Rule. Specifically, one stakeholder suggested that the current language requiring 15 cents per mile reimbursement for medical related travel of a claimant for treatment purposes should be increased to the normal rate for reimbursement for reimbursing State employees. Another stakeholder commented that the provision is appropriate as it currently reads.

This issue has been fully debated before the Industrial Council. The OIC has proposed no substantive amendments to this subsection and continues to recommend that it remain as currently written.

Response to Complaints

Several stakeholders commented on the provisions of section 16 of the Rule which addresses the response time for private carriers and self-insured employers to a consumer complaint filed against them with the Insurance Commissioner. First, it was commented that the time frame for providing a response to a complaint should be made to read consistent with the corresponding provision addressing this topic in the Insurance Code and Rules. The Commissioner agrees, and this section was amended to parallel the Insurance Code and Rules in this regard. Specifically, the language was changed from "days" to "working days".

Second, it was commented that this section be amended to not require a response to a complaint when the matter involved is in litigation. The Commissioner disagrees. While the fact that the matter is currently being litigated might be an appropriate response to the Complaint, the Commissioner does not believe the simple fact that the issue is being litigated should abrogate the entity from being required to file any type of response to the consumer complaint.

Finally, it was commented that this section should include a provision which requires the OIC to copy the carrier or self-insured employer on all written correspondence with the claimant regarding the complaint. The Commissioner does not believe this Rule is the appropriate place to include such a provision. The purpose of this section was only to address the time frame for responding to the complaint.

Expert Witness Fees

Several comments were made regarding the provisions of 17.1. and 17.2. in the Rule pertaining to the payment of expert deposition appearance fees. In response to these Comments, the Commissioner states that these provisions reflect a compromise agreed to between labor and the employer community regarding the payment of these fees in depositions, and that these provisions are reflected also in the Office of Judges Procedural Rule. Further, the issues surrounding this compromise and the language in these provisions were fully debated and commented upon during the 2007 version of this Rule. Therefore, the Commissioner does not believe that re-opening this topic for debate at this time is appropriate. If the fee paying arrangement reflected in these provisions appears to be causing unintended consequences or other problems in the future, this topic can be appropriately revisited at that time.

Carrier or Self-Insured Employer Compliance

A comment was made that several provisions should be added to the Rule providing for fines against carriers and self-insured employers for various non-compliance issues. The Commissioner does not believe this Rule is the appropriate place for such provisions. Further, the Commissioner notes that carriers and self-insured employers are subject to fines and sanctions in the Code and other rules for non-compliance with the law. For example, carriers and self-insured employers can be made to pay attorney fees for unreasonable denials under Chapter 23 of the Code, and carriers are subject to fines under Chapter 33 of the Code and to most provisions of the Unfair Trade Practices Act. Additionally, self-insured employers are subject to fines under W. Va. Code St. R. §85-18-1 et seq. for non-compliance.

Reporting of Incidents

Several comments were made that the language in subsection 19.1. of the Rule which permits employers not to report incidents should not have be stricken. The Commissioner responds that this provision was stricken primarily because it was in

conflict with section 4. of the Rule which requires and employer to report "every injury sustained by any person in its employ" to its private carrier.

Additionally, while the Commissioner can understand an employer's desire not to report every "incident" to a carrier, there is no apparent reconciliation between this and section 4., as an "injury" could be any mild bruise, cut, etc. Further, the policy concerns behind requiring all injuries, no matter how mild they may initially appear, being reported for workers' compensation purposes outweigh any burden placed on an employer to report such injuries to their carrier. Specifically, what initially may appear to be a mild injury could end up being more severe and require extensive treatment and lost time.

Ultimately, it is within the discretion of the employer to determine whether an incident constitutes and "injury" that should initially be reported to its carrier. (As mentioned earlier in this document, this can potentially affect the relationship between the carrier and insured employer). However, having language in rule which states that no incidents which are not reasonably expected to result in medical treatment need be reported could cause unintended consequences of discouraging an employer from reporting injuries they should be reporting. Therefore, the Commissioner believes this subsection should remain stricken from the Rule.