WEST VIRGINIA
SECRETARY OF STATE
BETTY IRELAND
ADMINISTRATIVE LAW DIVISION

Form #5

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OFFICE OF 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 WV Code §§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

WV Code §§23-2C-5(c)(2) and 33-2-10(b)

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 October 15, 2007

James Robert Alsop
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

Title

Title (Cont'd)

85-1-19. Preferred Drug List.

85-1-20. Severability.

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 West Virginia Insurance Commissioner, private carriers, third-party administrators, claimants, health care providers, vocational professionals, and others involved in the administration of claims. This rule also applies to self-insured employers to the extent that provisions of this rule expressly reference self-insured employers or to the extent that this rule addresses subject matter applicable to private carriers and not addressed by W. Va. Code St. R. §85-18-1 et seq.

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. -- September 11, 2007

1.4. Effective Date. -- October 15, 2007

§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 shall not be limited to, any one of the following: 1) received and processed; 2) contacted an injured worker, 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" is the workers' compensation board of review pursuant to W. Va. Code §23-5-1 et seq.

2.3. "Filing" means actual receipt by the recipient.

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

2.5. "Injured worker's employer" or "employer" means an employer within the meaning of 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. "Insurance Commissioner" means the insurance commissioner of West Virginia as provided in W. Va. Code §33-2-1, 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 the check is deposited in the mail or presented in person to the claimant, claimant's attorney or anyone acting in his behalf.

2.10. "Private carrier" means an insurer authorized by the insurance commissioner to provide workers' compensation insurance pursuant to chapter twenty-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 the day the document is scanned or otherwise entered into the Insurance Commission's or private carrier's computer system.

2.12. "Self-insured employer" means an employer who has applied for permission to elect and thereafter has elected to maintain its own benefit fund or system of compensation to ensure the payment of benefits to its injured employees and their dependents in amounts at least equal in value to the workers' compensation benefits provided by law and ordered to be paid under the provisions of chapter twenty-three of the West Virginia Code, and any third-party administrator designated by the self-insured employer to adjust West Virginia workers' compensation claims.

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

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

3.1. General.

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

3.2. Benefit rate calculation; wage information.

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

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

4.1. General.

The injured worker's employer shall report to the Insurance Commissioner or 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. Failure to comply with this reporting requirement may result in the employer being fined by the Insurance Commissioner up to $250 per occurrence. Any employer that has five (5) or more occurrences within any three hundred sixty-five (365) day period shall be fined up to $500 per occurrence as determined in the sole discretion of the Insurance Commissioner.

4.2. Benefit rate calculation; wage information.

It is the joint responsibility of the injured worker and the employer to ensure that the correct wage information is provided to the Insurance Commissioner or private carrier so that the correct benefit rate can be paid the injured worker. If inaccurate wage information is received by

the Insurance Commissioner or private carrier, the Insurance Commissioner or private carrier will, upon receipt of accurate wage information, adjust prospectively the benefit rate. There shall be no retroactive adjustments to previous underpayments beyond two (2) years. The submission of inaccurate wage information submitted by the employer or the receipt of benefits based on inaccurate wage information by the injured worker may serve as evidence of abuse or fraud under the applicable provisions of the West Virginia Code.

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

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

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

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 employer, then temporary total disability indemnity benefits shall not be paid during that period. This Section shall not apply to periods of time caused by a reduction in force, lay-off, or time-off provided in connection with an employee benefit.

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

6.1. Notice.

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

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.

6.3. Payment of permanent partial disability award.

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

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

[RESERVED]

§85-1-8. Special Rules for Non-Awarded Partial Benefits.

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

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

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

8.4. The Insurance Commissioner or private carrier may cease paying non-awarded partial disability benefits if the Insurance Commissioner or private carrier concludes that the amount of non-awarded partial disability benefits already paid will likely exceed the expected partial disability award and may, as soon as practicable thereafter, enter a permanent partial disability award based on the most current information available and the guidelines set forth in W. Va. Code St. R. §85-20-1 et seq., if applicable.

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

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

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

partial disability rate.

§85-1-9. Time Standards.

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

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

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

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

9.5. 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.

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

9.6. Permanent disability rulings.

a. Permanent disability evaluation reports received from physicians to whom

claimants have been referred by the Insurance Commissioner or private carrier in claims based upon injuries and occupational diseases other than occupational pneumoconiosis shall be acted upon within thirty (30) days.

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

9.7. Petitions for reopening.

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

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

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

§85-1-10. Child Support and Spousal Support Orders.

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

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

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

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

85-1-11. Overpayments.

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

11.2. Overpayments to injured workers may be collected by the Insurance Commissioner or private carrier by withholding future disability benefits payable to the injured worker or the worker's dependents in the same or other claims. The overpayment specifically can be withheld from temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, dependents benefits, fatal (104 week) benefits, travel reimbursement, and any other monies awarded or paid by the Insurance Commissioner or private carrier.

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

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

§85-1-12. Occupational Pneumoconiosis and Occupational Disease Claims.

12.1. 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.

12.2. 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.

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

§85-1-13. Special Rules on Closure of Claims.

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

§85-1-14. Procedures for Suspension for Claimant Abuse.

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

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

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

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

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

15.1. General.

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

15.2. Physical limitations.

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

15.3. Claimant's residence.

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

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

1. Where the distance between the residence and the situs of the examination is less than four hundred (400) miles, meal and lodging expenses shall be payable as provided in subsections 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, to a maximum amount of the round trip air fare, economy class, between the closest

airports offering scheduled commercial passenger service, as of the date said examination was scheduled;

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

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

§85-1-16. Expert Witness Appearances.

16.1. 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 an injured worker will be paid a fee by the Insurance Commissioner, private carrier or self-insured employer commensurate with the service rendered for such appearance and testimony, not to exceed $100 per quarter hour.

16.2. All other expert witness appearance fees, including, but not limited to, any physician other than those physicians mentioned in subsection 16.1. 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, then it will be 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.

§85-1-17. Implementation and Stay of Orders from the Office of Judges.

17.1. Subject to the provisions of subsections 17.2. through 17.6. of this section, the Insurance Commissioner, private carriers, and self-insured employers shall comply with any Order entered by the Office of Judges within thirty (30) calendar days of the entry of the Order. This provision is intended to apply to self-insured employers in lieu of W. Va. Code St. R. § 85-18-15.5.j., thereby repealing that subdivision in favor of this subsection regarding self-insured employers.

17.2. The Insurance Commissioner, private carrier or self-insured employer 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.

17.3. A motion as described in subsection 17.2. of this section filed with the Office of Judges must be filed within ten (10) calendar days of the date of entry of such order. A motion as described in subsection 17.2. of this section filed with the Board of Review must be filed contemporaneously with the petition for appeal. Any such 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) calendar 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) calendar days from receipt of the motion.

17.4. Any motion as described in subsection 17.2. of this section must include the following minimum content: (1) A statement of the reasons why the stay is being sought; and (2) a statement of the grounds for the underlying appeal. Failure to include the minimum content as described in this section shall be grounds for the motion to be summarily denied.

17.5. Any order granting a motion as described in subsection 17.2. of this section shall expressly limit the stay to temporary total or permanent partial indemnity benefits paid in the claim as a result of the underlying Office of Judges order. No order granting a motion as described in subsection 17.2. of this section may stay any medical, rehabilitation or permanent total disability benefits.

17.6. Any order granting a motion as described in subsection 17.2. of this section by the Office of Judges shall expressly limit the time 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 of the underlying appeal if an appeal is filed. Any order granting a motion as described in subsection 17.2. of this section by the Board of Review shall expressly limit the time 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.

§85-1-18. Miscellaneous Administrative Matters.

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

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

§85-1-19. 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 Insurance Commissioner and any private carrier 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.

§85-1-20. Severability.

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

TABLE 1a

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

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 regarding the proposed limited amendment of W. Va. Code St. R. § 85-1-1 et seq. ("Rule 1," or "the Rule" - "Claims Management and Administration"), which was filed with the West Virginia Secretary of State for public comment on June 5, 2007. This response is itemized by topic and order of sequence in the Rule, and addresses all of the comments received at the July 5, 2007 Industrial Council meeting as well as other selected substantive written comments received from stakeholders.

It should be noted that, as was made clear at the outset of this proposed amendment process, this proposed amendment to Rule 1 is only to address three substantive issues: (1) Mileage reimbursement in subsection 15.1. of the Rule; (2) expert witness fees in section 16 of the Rule; and (3) the stay process in section 17 of the Rule. Therefore, the Insurance Commissioner is limiting this response to substantive comments pertaining to these three areas.

In the near future, the Insurance Commissioner plans to do a comprehensive amendment to Rule 1 addressing any additional necessary changes in the Rule. As such, all public and stakeholder comments received for this Rule which pertain to other topics within the Rule other than the three (3) areas noted above will not be responded to in this documents, but will be taken under advisement for the future comprehensive amendment of Rule 1.

Mileage Reimbursement

Several entities representing employer interests commented on the changes being made to section 15.1., regarding travel reimbursement to claimants for medical related travel. Specifically, the language in the current effective version of Rule 1 provides that claimants are to be reimbursed for travel associated with undergoing medical examinations at the request of an insurer or self-insured employer. Under the current Rule, this reimbursement, which includes reimbursement for mileage, meals and lodging, is to be paid at the same rate as is paid to State employees. The current Rule additionally provides that employees are entitled to a mileage reimbursement rate of fifteen (15) cents per mile for all other medical travel related to a claim (i.e., travel to visit treating providers).

An inconsistency within section 15.1. regarding the mileage reimbursement rate for travel related to undergoing a requested examination (to be reimbursed at the State employee rate – currently forty-four and one-half (44.5) cents per mile) versus travel related to undergo medical treatment (to be reimbursed at fifteen (15) cents per mile) was brought to the attention of the Commissioner several months ago. In the original draft of

the Rule, subsection 15.1. was amended to provide a single mileage reimbursement rate – the rate consistent with the rate paid to State employees. This change sparked comment from several stakeholders that the current inconsistency in subsection 15.1. was a "compromise" of sorts negotiated between labor interests, employer interests and the WCC, and that the increase of the "treatment related" medical travel from fifteen (15) cents per mile to the higher rate equal to the rate paid to State employees would cause undue economic burden to private carriers, self-insured employers and the West Virginia Old Fund.

The receipt of these comments in turn caused the Commissioner to take a closer look at the statutory provisions which specifically address travel reimbursement to claimants. Specifically, W. Va. Code § 23-4-8 provides that claimants are entitled to reimbursement for reasonable travel expenses related to medical travel, but only medical travel related to undergoing an examination as ordered by a private carrier or self-insured employer. As a result of the clear intent of the legislature as stated in the West Virginia Code to provide travel reimbursement to claimants for travel related to undergoing a requested medical examination, but no statement in the law entitling a claimant to reimbursement for travel related to medical treatment associated with an occupational injury, subsection 15.1. of the Rule was amended to be consistent with the law.

Expert Witness Fees

The Commissioner received comment from an attorney representing workers' compensation claimants that subsection 16.1. of the Rule, which requires that the private carrier or self-insured employer pay for expert witness fees for the deposition of treating physicians, should be amended to also include other providers, such as vocational rehabilitation specialists and physical therapists.

The Insurance Commissioner disagrees with this comment. The purpose of amending section 16 of the Rule was to make the Rule consistent with the provisions found in the procedural rule of the Office of Judges pertaining to expert witnesses. Specifically, W. Va. Code St. R § 93-1-8.4.F.2., which actually references this Rule, provides that the insurer or self-insured employer pay for the deposition of a treating physician or a consulting physician referred by the treating physician. In order to make these two regulatory provisions consistent, this change is necessary.

The Commissioner received additional comment from another workers' compensation attorney addressing several other concerns with section 16. First, it is argued that subsection 16.2. should not place the burden of paying for expert witness fees on the party requesting the deposition, because traditionally, the party retaining the expert evidence was responsible for paying for the deposition.

While the Commissioner understands that in previous years, the retaining party may have been responsible for paying deposition appearance fees, as noted above, the Commissioner made changes to section 16 with a goal of making these provisions consistent with the provisions of the procedural rule of the Office of Judges regarding

expert witnesses. This change is consistent with W. Va. Code St. R § 93-1-8.4.F.1. and 2, and as such, makes the two rule provisions consistent. Moreover, in other areas of litigation, the party requesting a deposition is generally responsible for paying the appearance fee for the expert. For these reasons, the Commissioner is not inclined to make the requested change to this section.

Second, comment was made that the last sentence of subsection 16.2. of the Rule, which provides that in the event that an expert demands in excess of $100 per quarter hour to appear, the retaining party is required to pay the difference, should be stricken. Alternatively, it was suggested that a provision be placed in the Rule requiring experts to apply to the Insurance Commissioner before being permitted to charge in excess of $100 per hour for testimony.

While the Commissioner understands that excessive expert witness fees can be an issue, the Commissioner is hesitant to place any firm restrictions upon an expert witness in regard to the fee charged for appearing and providing testimony in workers' compensation cases. Rather, the Commissioner believes that this provision provides general guidelines for fees to be charged by expert witnesses, and provisions which essentially punish the retaining party in the event that an expert wishes to charge an excessive fee. Additionally, the Office of Judges can further address the issue of excessive expert testimony fees by taking measures such as refusing to accept evidence of an expert that is charging exorbitant fees, thereby preventing the opposing side from deposing that expert. For these reasons, the Commissioner is in disagreement with this comment.

Time Period to Respond to Stay Motions

Several attorneys representing workers' compensation claimants commented that only permitting a claimant five (5) days to respond to a stay motion in subsection 17.3. of the Rule did not provide the claimant sufficient time to respond to a stay motion. The Insurance Commissioner agrees with this comment. Consequently, subsection 17.3. of the Rule was amendment to provide the claimant ten (10) days to rule on a stay motion.

Lack of Substantive Criteria or Standards for Granting Stays

Several attorneys representing workers' compensation claimants commented that section 17 of the Rule should be amended to add substantive criteria or standards to guide the Office of Judges or the Board of Review in ruling on motions to stay. Currently, subsection 17.4. of the Rule provides that the "minimum content" of a stay motion include: (1) A statement of the reasons why the stay is being sought; and (2) a statement of the grounds for the underlying appeal. It further provides that failure to provide this minimum content is grounds for the motion to be summarily denied.

It is argued that this subsection implies that as long as these minimum contents are present, the motion to stay should be granted. The Commissioner disagrees with this argument. To the contrary, this section merely sets forth the minimum contents required

for the motion to *even be considered* by the reviewing ALJ or Board of Review. The subsection actually implies the opposite – that something more is needed to actually have the stay motion granted.

Moreover, it is argued that without some specific standards to guide the reviewing ALJ or Board of Review in regard to stay motions, the stay motions will most often be granted. Again, the Insurance Commissioner disagrees with this argument. The intent of subsection1 17.4. is to provide the *minimum*, not the *sufficient*, contents for a stay motion. The Commissioner believes that the discretion whether a stay should be granted or not should lie solely with the reviewing ALJ or Board of Review, because they will be the ones most familiar with the particular facts, record and applicable law of the underlying case. For this reason, the Commissioner is hesitant to create any specific criterion or standards to guide the reviewing ALJ or Board of Review in ruling on a stay motion.

It should be pointed out, however, that based on the legislative changes made in S.B. 595, the legislature has clearly that stays are only to be granted on a case by case basis, and that stays should be the exception, and not the rule. This being the case, the Commissioner will continue to closely monitor statistics regarding how stay motions are being handled, and if it appears that the Office of Judges and/or Board of Review is not appropriately addressing stay motions, Rule 1 can be amended to provide additional guidance on this topic.

Joy Zirkle

From: ED WATSON [watsonrehabwv@comcast.net]
Sent: Friday, May 25, 2007 5:28 PM
To: Joy Zirkle
Subject: 5-31-07 INDC Meeting
Attachments: Series 1 Draft - 5-25-07.doc; CV.doc

I would like to propose an amendment to Series 1 -see highlighted section. How might I make this suggestion formally? Thank you.

When I first read this rule provision I simply thought it confirmed the injured worker could not draw Rehab TTD and NAP at the same time and, therefore, thought little about it. However, the first time I saw it applied, a man with a very bad post-op back who had been certified as at MMI by his treating physician (and placed on NAP) was then referred to me for participation in a physical rehab program - I wrote a Rehab Plan but he lasted just one day. The claims adjuster paid the day of Rehab TTD but would not place the injured back on NAP citing this Rule. I suggested this was a misapplication of the Rule and was then advised by the claims adjuster's supervisor this was appropriate and it would not take long for the injured worker, a single parent, to be seen for an IME and a PPD rating.

In fact, by the time he had any income again (a PPD award), 4 months had passed.

The sole purpose of inclusion of NAP in Statute by the Legislature was to bridge the gap between suspension of TTD at MMI and the PPD award for those who cannot return to work at MMI. An injured worker ought not be penalized for attempting rehabilitation.

I would like to propose:

~~9.5~~ 8.5. If the injured worker begins to receive rehabilitation temporary total benefits, non-awarded partial disability benefits shall not be paid until ~~the~~ rehabilitation ~~process is completed.~~ temporary total benefits are suspended.

Edwin S. Watson, CRC, LPC, CDMS, CCM
Watson Rehabilitation Services
PO Box 798
Winfield, WV 25213
(304 755-0599

Edwin S. Watson
PO Box 798
Winfield, WV 25213
Phone/Fax: (304) 755-0599
watsonrehabwv@adelphia.net

PROFESSIONAL EXPERIENCE

October, 1996 to Present	Watson Rehabilitation Services Rehabilitation Counselor/Consultant
March, 1988 to September, 1996	Comprehensive Rehabilitation Associates Supervisor/Rehabilitation Consultant
February, 1986 to February, 1988	Vocational & Injury Consultants Supervisor/Rehabilitation Consultant
January, 1978 to January, 1986	WV Workers Compensation Assistant Division Director; Rehabilitation Counselor I and II

CREDENTIALS

Certified Rehabilitation Counselor (CRC 24897)

Certified Disability Management Specialist (CDMS 00004932)

Certified Case Manager (CCM 10488)

Licensed Professional Counselor (WV LPC 00895)

Qualified Rehabilitation Professional (QRP00000130)

EDUCATION

West Virginia University
Bachelor of Arts (1976)
Political Science/Sociology

ADDITIONAL INFORMATION

Past Chair of the Rehabilitation Committee of the
American Association of State Compensation Insurance Funds

Past member of the WV Workers Compensation
Health Care Advisory Panel

Past President of the West Virginia Chapter of the
International Association of Rehabilitation Professionals

~~9.2~~ 8.2. Non-awarded partial disability benefits shall not be payable in a claim that has been re-opened for temporary total disability benefits if a permanent partial disability award was previously made in the claim.

~~9.3~~ 8.3. Non-awarded partial disability benefits paid prior to entry of the permanent disability award are to be deducted from the permanent partial disability award when it is granted. If the non-awarded partial disability benefits exceed the amount of the award, the injured worker will not be entitled to any further benefits from the award. The excess is considered to be an overpayment and shall be collected from any future disability award in the same or any future claim, including, but not limited to, an award for temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits.

~~9.4~~ 8.4. The ~~Commission~~ Insurance Commissioner or private carrier may cease paying non-awarded partial disability benefits if the ~~Commission~~ Insurance Commissioner or private carrier concludes that the amount of non-awarded partial disability benefits already paid will likely exceed the expected partial disability award and may, as soon as practicable thereafter, enter a permanent partial disability award based on the most current information available and the guidelines set forth in ~~85 CSR 20~~ W. Va. Code St. R. §85-20-1 et seq., if applicable.

~~9.5~~ 8.5. If the injured worker begins to receive rehabilitation benefits, non-awarded partial disability benefits shall not be paid until the rehabilitation process is completed.

~~9.6~~ 8.6. Non-awarded partial disability benefits shall be immediately suspended if the injured worker fails, without good cause, to present for an examination or rating. If suspended with good cause, benefits can be reinstated, without back pay, once the injured worker presents for the examination or rating.

~~9.7~~ 8.7. Non-awarded partial disability benefits are paid at the same rate as the permanent partial disability rate.

~~§85-1-10~~ 85-1-9. Time Standards.

~~10.1~~ 9.1. Injury and occupational disease claims. -- Those claims based upon injuries and occupational diseases other than occupational pneumoconiosis that are filed with the ~~Commission~~ Insurance Commissioner or private carrier upon properly executed, prescribed forms shall be ruled on within fifteen (15) working days from the date of receipt of all required information by the ~~Commission~~ Insurance Commissioner or private carrier. The ~~Commission~~ Insurance Commissioner or private carrier shall consider all information and proof properly submitted in connection with each claim. Whenever it is of the opinion that a claim has not been

Joy Zirkle

From: Suter Randy [Randy.Suter@brickstreet.com]
Sent: Thursday, July 05, 2007 11:27 AM
To: charles.bayless@mail.wvu.edu; iron549@stratuswave.net; dmarshall@verizon.net; walterpellish@mac.com
Cc: Jane Cline; Mary Jane Pickens; Ryan Sims
Subject: Comments on Proposed 85 CSR 1, ""Claims Management and Administration"
Attachments: Comments BrickStreet 7-5-07.pdf

Members of the Industrial Council:

Attached please find BrickStreet Insurance's comments on the rule 1 proposal.

Thank you for considering our comments. I will bring hard copies to the Council's meeting.

Randall B. Suter, Attorney
BrickStreet Insurance
4700 MacCorkle Avenue, S.E.
Charleston, WV 25304
(304) 926-3423 Phone
(304) 926-5372 Fax
Randy.Suter@brickstreet.com

Office of General Counsel

July 5, 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.

Comment §2.1. While this provision states that any one of the 6 listed items constitutes a claim being "acted upon," the last of the serial is preceded by an "and." To clarify the provision, we request this be changed to "or."

Comment §3.2. This provision is repeated in its entirety at §4.2. Suggestion: delete 3.2.

Comment §9.7.b. This provision references the "Fund". This reference should be deleted.

Comment §11.2. This section might be utilized to design a system so that one carrier can collect claimant overpayments from another carrier's payouts.

Comment §15. Travel expenses.

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

4700 MacCorkle Avenue, S.E.
P.O. Box 4907 Charleston, West Virginia 25364
304.926.3470 Ext. 5348-phone ■ 304.926.5372-fax ■ 866.45.BRICK
www.brickstreet.com

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.

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 new proposed rate of 44.5 cents/mile, the cost would have been $3,361,640.19 instead of $1,201,327.62, an increase greater than **$2.15 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 .445 cents/mile = $8,528,153.90

The **increased cost to the system would be $7.3 million per year** to be absorbed by both BrickStreet and the Old Fund.

NCCI loss costs filings for July 1, 2007, 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 the carrier alone.

The 15 cent/mile reimbursement rate for general medical travel is a reasonable compromise. Higher rates are allowed when the employer or carrier requires the claimant to make medical visits.

Comment §17.1. There appears to be an incorrect citation of provisions of §18.

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

Joy Zirkle

From: Jennifer Meeks [jennifermeeks@wvdhhr.org]
Sent: Monday, July 02, 2007 2:11 PM
To: Ryan Sims
Subject: Rule 1 Comments

Attachments: WordPerfect 6.1

Comments to
)osed Rule 1.2

Attached are my personal comments, as a practitioner in the field, to proposed Rule 1. Thank you for your consideration, and please call if you wish to discuss these or any other workers' compensation matter.

Jennifer J. Meeks
State Capitol Complex
Building 3, Room 201
Charleston, WV 25305
(304)558-6989

COMMENTS TO PROPOSED
SERIES 1
"CLAIMS MANAGEMENT AND ADMINISTRATION"

As a general matter, in many places in this proposed rule, reference is made only to the Insurance Commissioner and the private carrier, omitting reference to self-insured employers. (See, e.g., section 8.4, and all of sections 9, 11, 14, 15, 16, 18, and 19.) This oversight should be corrected, unless the Insurance Commissioner intends self-insured employers not to be addressed in this Rule. If self-insured employers are not intended to be addressed here, the definitions of self-insured employer, and other references to self-insured employers, should be deleted.

Section 2.10 and 2.12: Definitions of "Private carrier" and "Self-insured employer." These definitions include not only the main entity, but also "any third-party administrator." The definitions' inclusiveness should be carefully reviewed, considering how the inclusion of the third-party administrator might encourage disputes as to which entity is responsible for payments owed to claimants or to the Insurance Commissioner.

Section 2.12 should be revised to delete the reference to "and ordered to be paid under the provisions of chapter twenty-three of the West Virginia Code" to avoid adding an unnecessary requirement.

Section 2.13 should be revised consistent with the language in section 2.12: delete "consistent with . . ." and substitute "in amounts at least equal in value to the workers' compensation benefits provided by law."

Former section 5, Special rules for Owner and Officer Claims, has been deleted. However, some provision probably should be made in this Rule for administering claims by owners and officers of default employers, consistent with other rules' requirements.

Proposed section 5.2: this is a good and reasonable provision, prohibiting those who have retired from "double-dipping" by getting TTD benefits again after retirement, since TTD benefits are wage replacement benefits. It is valuable to have this common sense rule published.

Section 6.1: Providing notice, in writing, to the parties of a PPD award or refusal to make an award, and advising the parties of the protest procedures. This provision is fine, but there is no similar provision under section 5 (regarding TTD benefits).

Section 6.3: Revision is suggested so the provision reads "shall be paid in <u>equal</u> monthly installments <u>over a period of months equal to the percentage of</u> impairment awarded."

Section 7: Rules for PTD claims. This section should be included before the revisions become effective. It is far too important a class of benefits to be left unaddressed here.

Section 8.3: NAP benefits creating an overpayment collectible from future awards. This begs the question of what happens when a carrier is owed an overpayment, but the claimant's employer thereafter changes carriers. How would an overpayment be "advertised" among carriers, and how

would the monies be recouped between different carriers?

Section 8.6: Suspension of NAP benefits where the claimant fails to attend an evaluation. Because "good cause" cannot be determined absent interactive communication with the claimant, I suggest you revise this provision to state: ". . . shall be immediately suspended if the injured worker fails to present for an examination or rating, without contacting the Insurance Commissioner or the carrier in advance to demonstrate good cause for the failure to appear. After suspension of [NAP] benefits, benefits can be reinstated once the claimant demonstrates good cause for his or her failure to present for the examination or rating, and/or once the claimant presents for a rescheduled examination or rating." The provision should be accompanied by some explanation of how "good cause" will be evaluated, who has discretion in making that determination, and whether that determination is subject to protest and litigation. (I will be happy to discuss the various explanations I have heard in the course of my practice, if that would be helpful.)

Sections 9.3 and 9.4: Time standards for making decisions on requests for medical treatment or appliances, devices and supplies. These provisions should include language similar to that found in the two preceding sections, regarding tolling of the time standard where additional evidence is needed.

Section 9.6.a: Permanent evaluation reports should also "be transmitted to the parties within thirty (30) working days from the date of receipt by the Insurance Commissioner or private carrier [or self-insured employer]."

Section 9.8: You may receive comments critiquing the fact that this section references only applications for modification of awards "filed by employers," and not addressing applications from claimants. The statutory language references applications filed by both parties (unless recently amended). However, claimants really should be requesting "modifications" through the reopening process, rather than through this process. Since employers do not have the reopening process available to them, it is appropriate to restrict this process to use by employers.

Section 10.1: Allowing for compensation benefits to be sent for child and/or spousal support. You should clarify whether temporary total disability benefits paid while a claimant is engaged in a vocational rehabilitation program are or are not subject to this provision. (Those benefits are sometimes termed "temporary total rehabilitation benefits," which is similar, but not identical to, "temporary partial rehabilitation benefits" included in this provision.) "Rehabilitation temporary total" is included in section 10.4, I note.

Table 1a: specifying percentages of awards to be withheld. I suggest you clarify that the "another family" referenced is any family that is not also the family owed child and/or spousal support, to avoid unnecessary confusion and argument.

Section 11.2: This section includes "travel reimbursement, and any other monies awarded or paid. . ." in those benefits that can be withheld due to overpayments. I assume the "other monies awarded or paid" would include medical treatment payments. If travel reimbursement and "any other monies awarded or paid" are not specifically exempt by statute from withholding, it is at least poor public

policy to make it more difficult for an injured claimant to comply with the evaluation process, or to recover from the injury. I suggest you remove these words.

Section 11.3: collection of overpayments. To avoid disputes over vague language, I suggest you revise the proviso to this section to allow 100% withholding only where "the overpayment was based upon fraud or abuse, committed or caused by the injured worker or his or her agent. . ."

Section 11.4: the reference to "travel reimbursement" should be deleted, for reasons outlined above.

Section 12.1: The specific reference to dust-induced cancers being handled as OP claims is very good, and clear, and should avoid some problems previously experienced in claims administration. You may get comments critical of the fact that this provision does not toll the statute of limitations until a claimant "should reasonably have known" that his or her cancer or other disease occurred "in the course of and resulting from" employment.

Section 12.2: Because carpal tunnel syndrome is such a problematic diagnosis, particularly from a causation standpoint, I suggest that you add to the end of this provision: ". . ., as shown by conclusive evidence of causation by the primary diagnosis/diagnoses."

Section 12.3: This is an excellent observation to embody in the Rule. (See W. Va. Code § 23-4-1f.)

Section 13.1: The language in the first two lines is confusing, to the extent it includes "and claims for temporary total disability benefits." I suggest you rewrite this. I presume the section is intended to stop medical benefits and administratively close the claim where no medical service has been provided for six months. If so, the term "medical" should be added, so the phrase ending the first sentence reads "after the last date of medical service." Also, language from an existing rule should be added, to clarify that a visit to the doctor, without provision of some substantial treatment, does not qualify as "medical service" sufficient to avoid administrative closure. Also, you probably should address whether prescription medication refills do or do not qualify as medical service sufficient to avoid administrative closure.

Section 14.4: I suggest that the introductory phrase, "In claims pending prior to approval of a managed health care plan," be deleted. The language appears to be unnecessary, and may lead to confusion. Any time a claimant is instructed to select a treating physician from an approved managed health care plan, he or she should do so or face suspension.

Section 15.1: a reference should be provided here, for interested readers to be able to locate the travel regulations applicable to West Virginia State employees.

Section 15.2: Based upon long experience, I think you need to require advance notification of health conditions requiring special travel arrangements, and that payment for such special arrangements be authorized prior to being incurred.

Section 15.3: Arranging examinations "as near as practicable to the claimant's residence." This provision will spawn litigation regarding how "practicable" is defined. Claimant's will argue that

the claimant-oriented IME physicians in his or her town (or otherwise close by) must be used by employers and by the Insurance Commissioner and private carriers. Opposing parties must retain discretion to send the claimant to whatever expert they deem reasonably necessary to obtain a fair and unbiased evaluation. I suggest you delete this first sentence. An alternative is to allow employers and the Commissioner to pick their own evaluators, but require payment for "reasonable accommodations (such as overnight stays)" that are made necessary due to distance from the claimant's home or work to the evaluator.

Section 16.2: This section will generate many comments, as it shifts payment responsibility to the party requesting cross-examination of an expert. Traditionally, in workers' compensation litigation in this State, under prior rules, the party offering the expert's opinion in support of his or her case is the party who bears the expense of the expert's appearance. There is no good reason, of which I am aware, to alter that payment structure now. I suggest the paragraph be revised to state that appearance fees "will be the responsibility of the party who has retained the services of the expert, or who has submitted a report or records of the expert as evidence in the case, to pay the appearance fee." The last sentence of the provision should be deleted, and all experts should be required by this rule to limit their appearance fees to $100 for each 15 minutes of appearance, without exception. Alternatively, you could add a provision permitting the expert to apply to the Insurance Commissioner, the private carrier and/or the self-insured employer for permission to charge a fee in excess of the limitation. The same sort of "exception" procedure could be given to the parties, to shift the responsibility for payment of the appearance fee where some unusual circumstance might justify the shift.

A new section 16.3 should be added, to address payment of court reporter fees. It is my understanding that the Insurance Commissioner will pay reasonable court reporter fees where a deposition transcript has been introduced as evidence in a protest before the Office of Judges, and that the Insurance Commissioner will pay a reasonable appearance fee where a deposition does not take place but the court reporter's services were not cancelled prior to his or her appearance. This continues prior practice, and should be embodied in the rule.

Section 17.1: To the extent this seeks to repeal 85 C.S.R. 18, §15.5.j, I question the effectiveness of the revocation. The Insurance Commissioner should also revise that series in accord with the requirement sought to be substituted here. The provisions of section 17 do not expressly indicate stays are not to be routinely granted, but I do not recommend changing the language. This is a reasonable explanation of the process, as I understand it to exist today.

Section 18: These are good provisions to include. Please retain them. I would suggest that in line two of section 18.1, the language be revised for consistency to include incidents that are not expected "to result in material medical treatment." This revision will avoid potential disagreement about the difference between "material medical treatment" and "medical treatment." Alternatively, you could delete the term "reasonably" (so that the phrase reads "or that are not expected to result in medical treatment"). Some thought could be given to defining "material medical treatment." If that term is defined, it could also be used to clarify the type of medical treatment that will avoid suspension of benefits under section 13.

Section 19: this section deletes prior references to making exceptions to the requirement that generic medications be used. I assume this is because that procedure is outlined elsewhere (for example, in Rule 20).

From: ED WATSON [mailto:watsonrehabwv@comcast.net]
Sent: Thursday, May 31, 2007 6:37 PM
To: Ryan Sims
Subject: RE: Title 85, Series 1 rule

OK, suggestions related to the travel rate section (highlighted). I question there will not be a major objection to a "normal" mileage rate - as I said, the 15 cents per mile was a compromise over ZERO. The argument is the injured worked had to driver 5 days a week to work and he/she is getting a wage replacement while traveling to the doctor, therapy, etc less often than that. As I recall, it was suggested taking it to zero would save $5 or 6 million per year.

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

Joy Zirkle

From: wvcomplaw@aol.com
Sent: Wednesday, May 30, 2007 7:45 PM
To: Ryan Sims
Subject: Written comments to proposed Rule 1 changes
Attachments: Public comment RE Rule 1.wpd

Ryan:

Hope all is well. I received the agenda for tomorrow's IC meeting on Friday afternoon, and that was the first time I was aware of the Rule 1 changes. I did receive the proposed Rules 8 and 11, but for some reason, as I indicated in the attached letter, I must have fallen off the list for Rule 1. When you have time (I know) could you check on that?

I will not be able to attend the meeting and prepared written comments. I now understand, however, that the changes were to address the "stay" procedures, and that there is a 30 day window to provide comment (I was not sure of that, hence the attached.) If it would be helpful, I would be happy to amend the attached comments to include concerns about the stay provisions, or delete the initial paragraph concerning notice. The comment is not signed, and is not on letterhead, but all things being equal I have time to send it more formally.

Hope to see you soon. Much news in the comp arena.

Sue Howard

May 30, 2007

Ryan Sims, Esq.
Associate Counsel, Legal Division
West Virginia Office of the Insurance Commissioner
1124 Smith Street
P.O. Box 50540
Charleston, WV 25305

RE: Written comment to proposed amendments -
85 CSR 1

Dear Mr. Sims:

Thank you for forwarding a notice of the Industrial Council meeting of May 31, 2007, indicating that permission is being sought for initial filing of Amendments on Title 85, Series 1, (Claims Management and Administration) with the Secretary of State's Office. I received notice of the agenda by email forwarded late Friday afternoon. Prior to that time, I did not receive a draft of the proposed Rule 1 amendments as I have received regarding amendments to other rules. I would request that the mailing list be reviewed to determine if my name was inadvertently dropped.

In light of the above, please consider this my written comment to the proposed changes in Rule 1.

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

COMMENT: Paragraph 3.1 should be deleted. The provision that an injured worker be required to give written notice to an employer within 2 working days of a date of injury is contrary to the statutory 6 month statute of limitations. The West Virginia Workers' Compensation Act does not provide two classes of injured workers (those who provide written notice of an injury with two days and those who provide written notice of injury in the time period between three days and six months) who would qualify for benefits under the disparate standards.

In addition, a regulatory mandate that failure to provide written notice of an injury to an employer within two working days lacks a rational basis because there is no relationship between such reporting of an injury and the occurrence of a legitimate occupational injury. There are many reasons that an injured worker might provide written notice: examples are instances where it is not readily apparent that a significant injury has occurred; the injured worker may not be aware of the regulation; the injured worker may be illiterate and unable to file a written report; or the injured worker may be reluctant to file a claim from fear of discrimination, etc.

Such a regulatory mandate is contrary to public policy. Despite the fact that an injured worker may suffer a legitimate injury in the course of and resulting from their employment, but fail to provide written notice to employers within a two day period, claims administrators would have a tremendous incentive to deny compensability of claims and bar access to medical treatment for injured workers. An unintended consequence of the proposed regulation is that it would likely provide a "legal basis" for claims administrators to rely upon in asserting that the denial was not "unreasonable" pursuant to *West Virginia Code* §23-2C-21(c), which sets forth the following standard:

> "A denial is unreasonable if, after submission by or on behalf of the claimant, of evidence of the compensability of the claim. . . .the company, private carrier or self-insured employer is unable to demonstrate that it had evidence or a **legal basis supported by legal authority at the time of the denial** which is relevant and probative and supports the denial of the award." (Emphasis added).

Such a result is strongly contrary to public policy which should disfavor rejection of compensable injuries for legitimate occupational injuries. Disabled workers should not bear the burden of physical suffering and financial destitution occasioned by an inability to work as a result of an occupational injury simply because they may not have been aware of the regulation and did not report an injury until three days later. *See also*:

> "It is the policy of this chapter that the rights of claimants for workers' compensation be determined as speedily and expeditiously as possible to the end that those incapacitated by injuries and the dependents of deceased workers may receive benefits as quickly as possible in view of the severe economic hardships which immediately befall the families of injured or deceased workers." *West Virginia Code* §23-5-13.

In addition to the reporting provisions, paragraph 3.1 of the rule continues with an even more draconian section, and states, "Enforcement of an employer's personnel policy requiring that an injured worker report an injury immediately shall not be deemed a discriminatory practice under chapter twenty three of the West Virginia Code." To be clear about the application of this provision, a legitimately injured worker who reports his/her injury on the third day following that injury can not only have his/her claim "reasonably" rejected, but be terminated from employment. Such a result shocks the conscience. I believe the regulation is clearly contrary to the anti-discriminatory provisions of *West Virginia Code* §23-5A-1, *et seq.* Nonetheless, such a provision may induce employers to discriminate against injured workers by including a two day written notice requirement in their personnel policy. Furthermore, the legislature has spoken clearly and unambiguously regarding such a regulation:

> "No employer or employee shall exempt himself from the burden or waive the benefits of this chapter by any contract, agreement, rule or regulation, and any such contract, agreement, rule or regulation shall be pro tanto void." *West Virginia Code* §23-2-7.

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

COMMENT: Paragraph 6.3 should be changed to conform with *West Virginia Code* §23-4-18, which mandates that, "In all cases where compensation is **awarded or increased**, the amount of compensation **shall** be **calculated and paid from the date of disability**." Clearly, the legislature directed that benefits, including permanent partial disability benefits, be paid from the "date of disability" and not from the date that a claim administrator enters an "award" as provided by this regulation. To illustrate the difference between the date of "disability" and the arbitrary date of an award, it is useful to discuss the history of workers' compensation and statutory scheme which recognizes that an essential element of the workers' compensation bargain is that statutorily defined benefits are reduced from earlier tort liability damages but must be promptly provided.

As the industrial revolution grew in the United States at the turn of the 20th century, increasing numbers of workers injured in the workplace were creating a public burden in large part due to the inherent delays associated with the traditional tort liability system. In addition, common law defenses of the fellow servant rule, contributory negligence and assumption of risk resulted in relatively few workers obtaining any relief for workplace injuries, and those few who prevailed were often left destitute while their cases progressed through the tort system. Results were also problematic for employers who were liable for unpredictable damages.[1] State legislatures began to enact laws which eroded the common law defenses of employers and liability insurance was increasing despite a tort system that provided an inadequate delivery system to injured workers. To alleviate the social costs due to the financial consequences of workplace injuries, state legislatures eventually undertook the task of providing an alternate form of relief for industrial accidents. Between 1911 and 1921, forty-three states adopted workers' compensation laws, including West Virginia.

Universally, workers' compensation legislation mandated some form of industrial insurance which provided prompt but limited structured benefits to disabled victims of industrial accidents who were injured in the course of and as a result of employment. In exchange, employers providing such coverage to employees were provided immunity from civil liability for their negligence.

To this day, the West Virginia Legislature continues to recognize the essential element of prompt benefit payment to disabled workers:

> "It is the further intent of the Legislature that this chapter be interpreted so as to assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter." *West Virginia Code* §23-1-1(b) [2005, as amended]: and

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[1]See *Adequacy of Earnings Replacement in Workers' Compensation Programs*, National Academy of Social Insurance, H. Allan Hunt, ed., W.E. Upjohn Institute for Employment Research, pub., (2004), at 4-6.

"The Legislature hereby finds and declares that two of the primary objectives of the workers' compensation system established by this chapter are to provide benefits to an injured claimant promptly and to effectuate his or her return to work at the earliest possible time." *West Virginia Code* §23-4-7(a) [2005, as amended].

In crafting a benefit structure, the Legislature established certain specified classifications of and criteria for disability benefits when a compensable injury occurs. With respect to medical benefits, the Legislature declared that "injured claimants should receive the type of treatment needed as promptly as possible." *West Virginia Code* §23-4-7a(a) [2005, as amended].

With respect to indemnity benefits,[2] when an injured worker is disabled from employment, the Commission is required to pay temporary total disability benefits until a claimant reaches his/her maximum medical improvement, is released to return to work or actually returns to work, or engages in activities which are inconsistent with an injury.[3] *West Virginia Code* §23-4-7a(e) [2005, as amended].

Upon closing of a claim for temporary total disability benefits, the Commission must compensate injured workers for any permanent partial disability which has resulted from the compensable injury. Unless temporary total disability benefits close due to a return to work, the Commission is required to pay "non-award partial" [hereinafter "NAP"] benefits to the claimant at the permanent partial disability rate until the entry of a permanent disability award or return to work (*West Virginia Code* §23-4-7a(c)(2) [2005, as amended]) so that disabled claimants are provided some level of financial support. The NAP benefits are deducted from the permanent partial disability award in the claim, and any excess in NAP benefits is declared an overpayment which may be recovered from future benefits under any claim. *Id.* Where the authorized treating physician recommends a permanent partial disability award of fifteen percent or less, the Commission is required to enter a protestable award based upon that recommendation and other available information. *West Virginia Code* §23-4-7a(2) [2005, as amended], governs claims where the amount of permanent disability is either not recommended by the treating physician or exceeds fifteen percent,[4] and mandates that a claimant be referred to a physician of the Commission's selection for

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[2]This category of benefits is commonly referred to as "indemnity" benefits as they are monetary benefits paid directly to the injured worker to indemnify him/her against earnings loss (temporary or permanent total disability); loss of physical functioning resulting from an occupational injury (permanent partial disability); or both (permanent total disability).

[3]Disabled workers are limited to an aggregate 104 weeks of temporary total disability benefits in a claim regardless of their medical status by virtue of *West Virginia Code* §23-4-6(c) [2005, as amended].

[4]*West Virginia Code* §23-4-7a(f) [2005, as amended] does provide an exception that "the requirement of mandatory examinations and evaluations pursuant to the provisions of this subsection shall not apply to any claimant who sustained a brain stem or spinal cord injury with resultant paralysis or an injury which resulted in a amputation necessitating a prosthetic appliance."

an evaluation prior to entry of an award. Although time standards for referrals to medical examiners are governed by the agency's regulations, the Legislature provided that the time of payments for permanent partial and permanent total disability benefits shall begin within fifteen working days from the date of the award. *West Virginia Code* §23-4-1d(a) [2005, as amended]. The mode of payment for awards must be as follows:

> "Payments for permanent disability shall be paid on or before the third day of the month in which they are due. In all cases where compensation is awarded or increased, the amount thereof shall be calculated and paid from the date of disability. *West Virginia Code* §23-4-18 [1995, as amended].

Given this statutory scheme, it is abundantly clear that the regulation attempts to shift the time requirement for payments of permanent disability, whether due to an award or an increase in an award due to a protest or modification, from the "date of disability" to the "month following the award." For the following reasons, the relationship between a "date of disability" and the "month following the award" is tenuous at best.

In the case of Wampler Foods, Inc., v. Workers' Compensation Division, 216 W. Va. 129, 602 S.E.2d 805 (2004), the West Virginia Supreme Court of Appeals adopted the definition of "award" which was proposed by the agency. An award was found to be any decision upon an issue submitted for resolution by the claim administrator, whether favorable to the claimant or not. Thus, subsequent orders of the Office of Judges, Board of Review and Supreme Court of Appeals were governed by standards that related back to the date of that award.

In contrast, "disability" is frequently referenced in the statute and relates to the claimant's physical condition. Temporary total disability has been defined as an "inability to return to substantial gainful employment requiring skills or activities comparable to those of ones previous gainful employment during the healing or recovery period after injury." Allen v. Workers' Compensation Commissioner, 314 S.E.2d 401 (W.Va. 1984). Because injured workers must demonstrate specific periods of temporary total disability to obtain benefits under *West Virginia Code* §23-4-7a, such disability is present for a fixed period of time. As the healing process continues, a claimant whose disability does not fully resolve is found to have a different type of disability which is deemed "permanent" in nature. In other words, if a claimant who sustains a compensable occupational injury does not fully recover and has a permanent partial "disability," such disability must have flowed from that injury which occurred in the course of and as a result of employment.

Although case law has established that the legislative intent of *West Virginia Code* §23-4-7a was "to reduce to the greatest extent possible the hiatus between the cessation of temporary total disability benefits and the award of permanent partial disability" UMWA v. Lewis, 172 W. Va. 560, 309 S.E.2d 58 (1983), numerous claims exist wherein the Commission has never evaluated claimants for permanent disability. *See also*, State ex rel. Conley v. Pennybacker, 131 W.Va. 442, 48 S.E.2d 9 (1948), holding: "The commissioner is not required to fix the permanent compensation immediately after the end of the period for which the claimant has been paid on a temporary basis, but may delay the determination of a permanent award until the result of the injury has reached the

stage where a fair and proper award can be made, at which time permanent compensation payments may be made to begin when payments of a temporary basis ended;" *and* Baker v. State Workmen's Compensation Commissioner, 164 W.Va. 389, 263 S.E.2d 388 (1970).

In recognition of the number of claimants whose permanent disability evaluations have been delayed, the Legislature has created a statute of limitations which bars claimants from requesting evaluation of their permanent disability.[5] For those who remain eligible for an evaluation, up to five years may have passed between the disability and the award of benefits. For many decades, the Commission properly applied the statute, and calculated and paid permanent partial disability benefits from the date of closure of temporary total disability or the last payment of permanent partial disability.

In shifting the date that permanent partial disability benefits are paid, the regulation effectively creates an interest-free loan to the employer or claims administrator from the meager resources of disabled workers. In addition, a side-effect of this regulation offends the clear intent of the statute because it rewards the delay of evaluations and entry of awards.

The following illustration demonstrates what has occurred under this regulation:

The claimant sustained a compensable injury to his neck and low back in May of 2003. He continued to work while undergoing treatment for his injury. He was not referred for a permanent partial disability evaluation until March of 2005. Based on that evaluation, he was granted a 5% permanent partial disability award the following month, which he protested. An administrative law judge increased the permanent partial disability award to 15% in the fall of 2006. The claim administrator "stayed" that decision from the Office of Judges and paid nothing on the increase. In the spring of 2007, the Board of Review affirmed the decision which increased the 2005 award. The claim administrator considers the Board of Review order to be an award and rather than pay benefits to the date of disability, it initiated payment of monthly benefits following the Board of Review order.

This fact pattern is occurring in numerous claims.

I hope that these comments are helpful in assisting the Insurance Commission and Industrial Council in their review of the proposed changes to Rule 1 in order to promulgate regulations which are reasonably consistent with the various statutory provisions. If I can provide any further information, please do not hesitate to contact me.

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[5]"Except as provided in section twenty-two [§23-4-22] of this article, in any claim which was closed without the entry of an order regarding the degree, if any, of permanent disability that a claimant has suffered, or in any case in which no award has been made, any request must be made within five years of the closure." *West Virginia Code* §23-4-16(a)(1) [2005, as amended].

Very truly yours,

Sue Anne Howard

SAH/dm

PUBLIC HEARING

JULY 5, 2007

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, July 5, 2007, at 3:00 p.m., Offices of the West Virginia Insurance Commissioner, 1124 Smith Street, Room 400, Charleston, West Virginia.

Industrial Council Members Present:
Bill Dean, Chairman
Dan Marshall
Walter Pellish (via telephone)
Charles Bayless (via telephone)
Delegate Nancy Guthrie
Jane L. Cline, Commissioner

Ryan Sims (Associate Counsel, Offices of the WV Insurance Commissioner): Chairman Bayless and members of the Industrial Council, good afternoon. As Chairman Dean noted we are bring before you today Title 85, Series 1 rule, which addresses Claims Management and Administration provisions. We presented it to you during the May 31, 2007, Industrial Council meeting. We did not have a meeting in June, but we presented this in May for permission to initially file with the Secretary of State. It was filed with the Secretary of State and there has been the thirty days for public comment. The public comment period on this rule concludes today with the Public Hearing before you.

One thing I would like to stress is we are attempting just to address a few substantive issues in this rule – limited to just those issues. We plan in the future to do a more comprehensive amendment to this rule, but at this time we are just intending to address the three issues substantively that we addressed in the initial draft. And that would be expert fees in Section 16; the stay pending appeal process mandated by the Legislature in Senate Bill 595 which is in Section 17 of the rule; and the mileage reimbursement issue which is in Section 15 of the rule. Again, it is our intent to just address these three issues from a substantive perspective. There is some technical

cleanup as well in the rule, as with all the rules. Also note that we have received a handful of comments on this rule, but the majority of the comments received actually address other issues than these three issues. So we will, of course, take those under consideration when we do a more comprehensive amendment to this rule in the future. But for purposes of public comment we are hoping that anyone that wishes to comment before you verbally keeps it just to these three issues that we want to address in this version of the rule. With that I'll open the floor.

Chairman Dean: Mr. Marshall, do you have any questions?

Dan Marshall: No, not at this time.

Chairman Dean: We do have a couple of people who would like to speak. Mr. Atkins. . .

Edward G. Atkins (Atkins & Atkins PLLC): Thank you very much. My name is Edward Atkins. I am basically a claimant's representative in workers' compensation claims. I used to be on the stakeholder list, but I didn't know that this particular revision of Title 1 was going to be on the agenda this afternoon. But I have reviewed it and I wish to make some comments.

My understanding was that stays were only to be granted in instances where it was pretty clear that the decision of the administrative law judge was wrong and if there was a clear likelihood that on appeal that the decision of the ALJ, if it was favorable to the claimant, would be reversed. If you take a look at 17.4, it says, ". . .this section must include the following minimum content: (1) A statement of the reasons why the stay is being sought; and (2) a statement of the grounds for the underlying appeal." That's all it says. It doesn't say anything about any further requirement that a stay would only be granted under extraordinary circumstances. Only that this is what it has to contain. Now in many instances – we on the claimant side – oftentimes look at this stay situation as kind of a punishment for winning the case. I've had some compensability decisions that I thought were clearly right that there was an appeal by BrickStreet or whomever and not a stay entered, and nothing has happened until you get to the Board of Review.

So, in my particular case I think that this rule is deficient in the sense that it should make clear that stays only ought to be granted under certain special circumstances that there is a clear likelihood or that the. . .clearly likely that the decision of the administrative law judge be reversed. Now that decision would have to be made by

who is reviewing it – either by the administrative law judge who entered the opinion or by the Board of Review should they decide to hear this stay.

The whole "stay issue" originated in original Rule 1 which created the stay to begin with. There was no statutory basis for it as far as the claimants' attorneys and the claimants' representatives were concerned. It was basically invented by a rule. And despite the fact we have objections to it, the stays were granted whenever BrickStreet or whoever the self-insured wanted to issue the stay. So in the last Legislative Session I like to think that I had a personal influence on this. I asked somebody to introduce legislation that would clearly say that there weren't any stays. Well it turned out differently than what I asked them to do. The legislation I introduced, or requested to be introduced, didn't turn out to be what came out. But in any event if you're going to have "stays," then there ought to be an expression as to the grounds for the stay. And it's got to be some clear reason why the decision is clearly wrong, and there is no such statement anywhere in any of the rules. And I suggest that it be amended to that effect. So, that's my comment on Rule 1.

The time period that the claimants have to respond is very short too – only five days. That's a bit short. I think should be at least another two days. Thank you.

Chairman Dean: Mr. Marshall, do you have any comments?

Mr. Marshall: Well I think Mr. Atkins' points are, at least initially, well taken and I'd like to hear perhaps from Ryan as to. . .perhaps a little bit about the intent in drafting as you did and whether or not it would be possible to come up with something that might address what are to me some legitimate concerns.

Mr. Sims: Sure. I'd be glad to. When we drafted this our intent was really just to draft the procedural aspects for the state as far as how many days there was to file, etcetera. As far as the minimal contents, we essentially made this so that no frivolous motions for stays would be filed. In other words, those are the minimum contents that you have to state the reason you're asking for it and that you have to state the grounds for the underlying appeal, both which would be germane to any motion for a stay. We felt it was implicit in those minimum requirements that a judge would look at the reasons the stay is being requested and would take a look at those reasons and only grant one in extraordinary circumstances. Generally in common law when Circuit Judges have the ability to grant stays they only grant them in extraordinary circumstances. We certainly didn't mean to put anything in here. . .I don't believe this section says that

there is any sort of automatic stay or that a stay should be liberally granted. We were just trying to set forth the minimum contents, and we think it is at least implied in here that judges will use a great amount of discretion in granting a stay and they're not to grant them by any means liberally. I guess that's all it said at this point. We certainly will take the comment in mind and into consideration.

Mr. Marshall: And it may be that if the Order is implemented as written, what would be appropriate is that attorneys in Mr. Atkins' position and other claimant practitioners. . .let's follow this thing and see if it is working as anticipated and if not then we could address what changes might be appropriate.

Mr. Sims: Correct. Obviously down the road it would be good to get some data and percentages of stays that are being granted and that type of thing. I think Judge Leach already has some data in that regard. But that's true. I guess our feeling was that, again, when you look at other civil litigation, stays are usually brought before a judge. The judge is intimately familiar with the case and the circumstance of that case and stays are generally only granted in extraordinary circumstances or when there is good cause shown for the stay. So, we didn't necessarily want to put a list of criteria in here which said you could only grant it in this situation but we didn't necessarily want to take the discretion away from the judge. In other words, we think it is implicit with those minimum contents. You have to state why you want it, and then it's within the discretion of the judge. Of course, you're right, Mr. Marshall. If there was a trend where too many stays were being granted or a trend where more often than not a stay was granted, that might be an issue. We don't believe that will be the case.

Mr. Marshall: Thank you.

Chairman Dean: Mr. Pellish, do you have any comments?

Mr. Pellish: I have no comments.

Chairman Dean: Chairman Bayless. . .

Charles Bayless: The issue that was just raised. . .in mathematical terms. . .if we're going to do this rule completely later, somebody could likely draw an inference in court, that because we left out something we meant to leave it out. This is what just came up. . .the fact that they did not do it – in this case the Workers' Comp Commission – the fact that they did not do it they were entitled to an inference that they knew about it and

didn't want to do it. I mean by passing an incomplete rule, just by leaving the stay language out, the court may be entitled to say, "Well, they obviously meant to. . ." Just say that anybody that asks for a stay gets it. The question is by not passing the whole rule and leaving things out, are we setting ourselves up for that kind of interpretation?

Chairman Dean: Ryan will answer that or try to.

Mr. Sims: Are you, Chairman Bayless, speaking in particular to the stay provision or the general intent of. . .?

Mr. Bayless: The stay was just an example.

Mr. Sims: Because our attempt was just to address three narrow issues in this rule and then do a more comprehensive amendment to the rule in the future. I'm not so sure that the fact that we're not including the more comprehensive amendments right now could, in my mind at least, lead courts to any conclusion that we didn't intend to address them. I mean I don't think we've even announced the other areas that we're going to address in Rule 1 yet. We are meeting with stakeholders right now to talk about other changes. It doesn't seem to be a concern in my mind.

Commissioner Jane L. Cline: This is Jane Cline. I think just for further clarification because this was a result of legislation that just passed and we needed to address it immediately, that's why he went ahead and moved forward on this provision, knowing that we still need to address the other provisions. But from a timing standpoint, didn't have the opportunity to do the complete research that needs to be done and the complete outreach with the other stakeholders.

Chairman Dean: Delegate Guthrie, do you have any questions or comments?

Delegate Nancy Guthrie: No. The only comment that I would make is that sometimes silence is deafening and better to be. . .if you're looking to do a trend line, then you might want to put some language in there that addresses the trend or collecting any information.

Mr. Marshall: My sense would be that that would be something perhaps Judge Leach could address in his reports, which are very informative and comprehensive and the trend would reveal itself pretty quickly I believe.

Judge Timothy G. Leach (Chief Administrative Law Judge): We're required by statute to report on any topics selected by the Industrial Council. . .the Board of Review, they're not doing these yet. But I think they are reporting to you maybe quarterly or something of that nature. I won't have any statistics on their trends, just on the ones decided by the Office of Judges.

Mary Jane Pickens (General Counsel OIC): I believe, at least at the last meeting that I attended which might have been the meeting before that, I think Judge Leach did report to the Industrial Council on some preliminary stay data.

Commissioner Cline: There is stay information in his current report on page five.

Ms. Pickens: Okay.

Chairman Dean: Mr. Monfradi, you have some comments?

Charles Monfradi: Mr. Chairman, Commissioner Cline, your Honor, I would like to address an issue that is not particularly one that you discussed Mr. Sims, but it is on page three, item 3.1, regarding the requirement to report an accident within two working days. As an employer, I was a general contractor for 25 years and I had a few workmen's comp and it was all handled professionally. And I'm looking at this from one of the 7,325 instances that Mr. Sims' discussed earlier.

My sister was hurt in the operating room. She tripped over a cord, broke her thumb. . . implant of some sort and rammed her shoulder. And this occurred on the 18th of November. She went on vacation two days later; a couple weeks later it was bothering her. I don't know whether I should report it or not. The hospital is laying off an awful lot of people – cost curtailment; cutback program. There's an awful of people laid off. So she was actually concerned for her job. Anyhow, she filed for workmen's comp on the. . .I believe it was the 3rd of January, after Christmas, after another vacation; and the form was filled out by the hospital by the 17th, and actually she received it on the 22nd. So basically they violated the five day rule. But the main thing that they contested was that she didn't report it within two days. Now if you would take 100,000 workers in West Virginia, I bet you can't find 500 that would know they have to report it within two days. I think it is discriminatory, even though in this paragraph it says it is not discriminatory. Perhaps you have to realize that my sister was able to draft this one page letter. It's reasonably concise. She sent it out. The claim was denied. Now in rebuttal, Herndon, Morton, Herndon & Yeager sent 35 pages as rebuttal

to my sister's one page letter. That's almost like killing a gnat with a sledgehammer. Now get a grip. The woman has worked for the hospital for 19 or 20 years; missed minimal work; she had one other accident; she fell on a wet floor in the operating room; broke the same thumb. That was in 2005. She reported it a month or two later. She was covered by workmen's comp. Everything was fine. She was paid for the four weeks. They had to redo it. Now she can't get anything. But as a coincidence, she had to have all the timeframe in to the Office of the Judges, your Honor, by the 30th of May. On June 1, she was laid off. She was put on medical leave. Now I don't know whether the hospital is using it as a strategy to assist them in their cost containment. But perhaps someone in your office might want to take a look at that. I feel that she has been done a grave injustice and she was hurt very seriously. She can't lift her arm like this. She has a complete shoulder replacement on the 23rd of this month. I just think. . .I'd like you to reflect on that. Thank you very much for your time. I appreciate the opportunity to speak to such an august body.

Chairman Dean: Mr. Marshall, do you have any questions?

Mr. Marshall: No. On observation, this is not one of the sections that we're adopting anything. . .

Mr. Monfradi: I understand.

Mr. Marshall: . . .other than a few technical corrections.

Mr. Monfradi: Perhaps you ought to reconsider the two days and make it two months. West Virginia State law requires six months for you to file. We're saying two days. Perhaps there is somewhere in between. I think that should be reviewed. Thank you.

Mr. Bayless: This is Charles Bayless. I think there are a lot of injuries. My wife had one. She didn't know she was injured for probably a week. She broke her ribs and she knew her side hurt, but she didn't fully discover what had happened.

Chairman Dean: Mr. Pellish, do you have any comments.

Mr. Pellish: No comments at the moment.

Mr. Marshall: Just one more thing. We will be revisiting this particular section at sometime in the not too distant future, would you say Ryan?

Mr. Sims: Correct.

Mr. Marshall : Okay. Good.

Mr. Sims: I think a couple of things should be pointed out about this. First of all, this section Mr. Monfradi was referring to, what it does is enables an insurer to. . .in inappropriate situations. . .use the fact that it was filed beyond two days is an inference that it perhaps it's not a compensable injury. Under no circumstances should a carrier simply deny the claim because it was filed beyond two days. That is absolutely incorrect. If any carrier or self-insured employer uses only that reason to deny a claim, anyone that is aware of that should report that to our Consumer Services Division. And basically what this provision is meant to address is what employers have referred to as "Monday morning claims." Often somebody will get injured on a Saturday and then they will come in a Monday and say that they incurred the injury at work the previous week. Again what this provision does is saying you can use that as one criterion to weigh against compensability. It does not. . .sir. . .

Mr. Monfradi: Does that not in that terminology say that it weighs in favor of the employer rather than the employee?

Mr. Sims: The fact that it wasn't reported to the employer in two days, weigh is one factor that can weigh against compensability.

Mr. Monfradi: That's the prime criteria they used in the rejection. And I think it's not well thought out.

Mr. Sims: Again, I'm just trying to make the point. If there are insurers out there, private carriers or self-insureds that are using that sole reason to deny the claim, that is inappropriate and it can be litigated. It should be protested and litigated because that is inappropriate and should also be filed with us as a consumer complaint. That's the first point I want to make. In other words, this "two day" item can be cited by a carrier in addition to a number of other things as a reason to deny compensability. But under no circumstances should a carrier or self-insured just cite the failure to report in two days. That's the point I'll make in addition to the fact that it's there to address what they call these "Monday morning claims." And as far as the six months, claimants do have six

months to file a workers' compensation claim. That's very clear. And again that's why it would inappropriate for a carrier to deny it because they just didn't report in two days. That's just one piece of evidence that a carrier can consider among many others. If it's obviously the type of injury that maybe could not manifest itself to the claimant for several days, then obviously it would be inappropriate for a carrier to deny it just based on the fact that they didn't report it in two days. That would be my only comment.

Commissioner Cline: Ryan, I think that one other comment would be the fact that the sooner the insurer knows about the injury the better the opportunity to get them the quickest care and the most appropriate care, thereby improving their opportunity for a full recovery or at least the best opportunity to be able to rehabilitate them and get them back to work. I think that is another key point. And no employer should be taking action against an employee that is hurt on the job either. We do have the employer compliance piece here as well.

Mr. Sims: That's actually criminal to do that.

Commissioner Cline: Right. But another aspect of that is really to get to the claimant the quickest treatment and the best treatment available.

Chairman Dean: Very good. Any other comments on Title 85, Series 1?

Mr. Pellish: I would just echo Commissioner Cline's comments that no employer should use that type of thing as a penalty. I mean it just shouldn't happen.

Commissioner Cline: Right. And if that's going on, then that complaint should be filed here so that we can have the appropriate review and respond appropriately for the claimant.

Mr. Pellish: Absolutely.

Chairman Dean: Very good. Mr. Weaver, do you have a comment?

Bob Weaver: Commissioner Cline, members of the Industrial Council, my name is Bob Weaver. I'm a partner in the law firm of Maroney Williams Weaver & Pancake. We represent probably as many if not more claimants than anyone in the state.

One comment on Section 3.1. I understand we're not here on that today. But just to echo the concerns, I can document for you claims that have been rejected because they were reported six days after the injury and not within two days. We have more than one occasion of that going on, and we have that going up on appeal through the Office of Judges and even on with the Benefits Review Board. I don't know if it's a question of someone not being a practitioner and not understanding how certain people are interpreting this, but despite the explanation of what the intent of something is, it's being not abused but it's being exploited at times. And that's being used as the sole grounds for rejecting a claim. Now I don't disagree that when someone gets hurts they ought to report it, but as you've heard from other people, we do a lot of folks that get a lot of bumps and bruises and strains and everything else that don't run to report them every time that they have a twinge because they are hoping it's going to work itself out. These are the kind of people that we are having the problem with. Obviously if someone has a severe injury, it's going to get reported. That's not the kind of case that this be affected by that.

I also agree that the longer we wait to address it more people are being affected by it. And if there is any way that the Commissioner will consider it sooner, it would be appreciated. I've already filed written comments with Ryan. I faxed them to him earlier today.

Regarding what Garth talked about [Mr. Atkins] on these stays. These stays should only be for the most extreme circumstances. With the way they have changed the burden of proof, the preponderance of the evidence, weighing of the evidence, for someone to actually win a claim anymore is a real accomplishment. Then to win the claim and have someone apply and get a stay. . .for another four to six months. These are people that can't file through insurance because they say its workers' comp; they can't get medical benefits because it is rejected; they can't get monetary benefits; and can't feed their family. It is just wrong to grant any sort of a stay unless it is just the most egregious or extreme circumstances where someone has clearly made a mistake in issuing the ruling. I'm not really sure how it is going to work with the Board of Review. How the Board is going to be able to issue a stay when they haven't even heard anything. But as I understand under this proposed rule, either the administrative law judge who issued the ruling or the Board of Review will have the ability to review the petition for a stay.

I would also like to add that I concur that this five days is. . .our five days to respond doesn't. . .it starts when the Petition is filed. Someone files a petition on Thursday and

by the time I get it on Monday I'm on my fourth day. It doesn't say from receipt. And while it may not take a week to respond, we need more time than that. In talking to Ryan today I understand that the Board of Review felt five days wasn't sufficient for them and they wanted more time. I can understand that. But if we could give ten days for them to file the Petition, ten days to respond and ten days to rule on, maybe that would be a little more equitable way to divide up the 30 day time period on it. I understand we're trying to keep it on a 30 day time period.

Lastly, something no one else has talked about, I'm not sure if this one of the three issues – the expert witness appearance fee. We would ask that as long as the physician has been authorized or the consulting physician has been authorized or even if it is a rehab specialist or physical therapist – that they have been authorized – their testimony ought to be paid for by the carrier or by the private employer. I'll give Ryan an example. If I have a client who can't get back to work and someone approves 20 hours of rehab and they formulate a plan and it gets submitted and the carrier denies the plan and I need to take testimony from that expert, we are having to pay for that when that carrier has already authorized the rehab person. It would be a logical flow of this rule if you are going to do it for the authorized treater to also do it for a rehab person or somebody else. Now it will be once in a blue moon that would ever come up. But if they're going to be authorized treaters they ought to be paid for. Now if it's someone that I'm asking to cross-examine, then that's different. But if it's somebody who's already been authorized as the treater or authorized by the carrier, then we would ask that their test may also be paid for as a part of that authorization. Thank you.

Chairman Dean: Any comments Mr. Marshall? Mr. Pellish, do you have any comments?

Mr. Pellish: No comment.

Chairman Dean: Chairman Bayless. . .?

Mr. Bayless: None.

Chairman Dean: Delegate Guthrie, do you have any comments?

Delegate Guthrie: No.

Industrial Council Meeting
PUBLIC HEARING
Title 85, Series 1
Claims Management and Administration
Offices of the West Virginia Insurance Commissioner
July 5, 2007

Name	Address	Telephone Number	Group Affiliation	Do you desire to address the Council?	Agenda item to which you desire to speak
~~Atkins~~ Ed RG Atkins	1335 Va St E	346-0516		Yes	Rule 5 Withdrawal
CHARLES MONFRADI	262 Brown's Run	242-4422		YES	TITLE 85 3.1
RANDY SUTER	4700 MACCORKLE		BRICKSTREET	NO	
Steve White	600 Leon Sullivan		ACT	No	
Bob Weaver	608 Va. St. E	346-9629	MWP, PLLC	Yes	
Mark Grigoraci	400 5th 3rd Center		Robinson + McElwee	NO	
Zach Klein	WFPM		~~Hoge~~ Weis Farge	NO	
Barbara Sandlin	OIC		OIC	No	
Harold Clifton	WVDHHR		WVDHHR	NO	