Wisconsin Worker's Compensation Claims

The Latest Amendments to the Wisconsin Worker's Compensation Act and Pending Amendments to Wis. Admin. Code DWD 80

by Attorney Philip Lehner
E-mail: wclawyer@tds.net

GRAHOVAC & KALLENBACH, S.C.
Racine, Wisconsin

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GRAHOVAC & KALLENBACH S.C.
ATTORNEYS

GRAHOVAC & KALLENBACH, S.C., 6233 Bankers Road, Suite 11, Racine, WI 53403 Phone: (262) 551-2050

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1.0 The Latest Amendments to the Worker's Compensation Act

The Wisconsin Worker's Compensation Act is amended every two years on the basis of recommendations by the Worker's Compensation Advisory Council. In October of last the Worker's Compensation Advisory Council did finally conclude negotiations on the agreed bill for the amendments to the Wisconsin Worker's Compensation Act. Unfortunately, they were so far behind schedule that their proposed amendments were not passed by the legislature before the end of last year, so that the amendments could take effect on January 1.

There were then some further delays and the amendments were not passed until March 2004. The latest amendments, in the form of 2003 Wisconsin Act 144, then became effective on March 30, 2004. 2003 Wisconsin Act 144 is attached as Exhibit A. A Plain Language Summary by James T. O'Malley, Director, Legal Services Bureau, Worker's Compensation Division, DWD, is attached as Exhibit B.

The rates for TTD and PPD in 2004 were already part of the last agreed bill that was passed in 2001 as 2001 Wisconsin Act 37. Those 2001 amendments included an agreement on rates for 2002-2005. The maximum PPD rate for 2004 is $232, based upon a gross average weekly wage of $348. (Wis. Stat. § 102.11(1), as amended by 2001 Wisconsin Act 37, section 7.)

The TTD rate is based upon a formula that uses that state's average wage for 2003, as computed by the Unemployment Insurance Division, DWD. (Wis. Stat. § 102.11(1), as amended by 2001 Wisconsin Act 37, section 7.) The 2004 maximum TTD rate is $687.00, based upon a gross average weekly wage of $1,030.50.

Some of the most significant amendments to the WCA are discussed below.

1.1 Physician Assistants and Advanced Practice Nurse Prescribers as Practitioners Under the WCA

There has already been some confusion about one part of the new amendments. Physician assistants and advanced practice nurse prescribers were added as practitioners under the WCA, so various different statutes were amended to make that change. An injured employee will now have the option of selecting a physician assistant or advanced practice nurse prescriber as a treating practitioner under § 102.42(2)(a) of the WCA.

However, physician assistants and advanced practice nurse prescribers are only given limited authority to render expert opinions. That is, they are being given the same authority that dentists already have. Wis. Stat. § 102.17(1)(d)1, as amended by 2003 Wis. Act 144, section 17, provides, in part:

> Certified reports by doctors of dentistry, physician assistants, and advanced practice nurse prescribers are admissible as evidence of the diagnosis and necessity for of treatment but not of the cause and extent of disability.

Therefore, a physician assistant or an advanced practice nurse prescriber may diagnose a condition and recommend a course of treatment. However, they may *not* render opinions on causation or disability. Thus, if there is a dispute about whether the condition arose out of the employment, they may *not* render an opinion on that causation issue. They also may *not* impose work limitations or take an employee off from work. They may *not* render opinions on resulting permanent disability. That is, the limitations are the same as the existing limitations for dentists.

1.2 Reasonableness of Fee and Necessity of Treatment Disputes

An amendment to Wis. Stat. § 102.16(2)(d) changes the standard for determining whether a fee charged by a health service provider is reasonable.[1] Challenges to reasonableness of fees are made on the basis of databases that have been certified by the Department of Workforce Development under Wis. Stat. § 102.16.[2] Under the existing statute, fees are not reasonable if they are more than 1.5 standard deviations from the mean fee for the particular health service procedure that was billed. The amended statute now sets that standard at 1.4 standard deviations from the mean. There is a lot of controversy as to the overall impact of the change, but it appears that insurers/employers in Wisconsin may save millions of dollars each year because of the change.

Other amendments set minimum limits of $25 for the amount of disputes that may be submitted to the Department as to the reasonableness of fees or the necessity of treatment.[3] The minimum limit of $25 applies until the health service provider has concluded all treatment for the injury.[4]

There has been one other change in the Department's administrative dispute resolution process for disputes as to the reasonableness of fees or the necessity of treatment. Once the Department makes a determination on such a dispute, the Department may set aside the determination within 30 days, "for any reason that the department considers sufficient."[5]

1.3 Payment of Minimum PPD Ratings Under § DWD 80.32

If a worker's compensation claim is for a conceded injury and there is a mandatory minimum PPD rating that applies under Wis. Admin. Code § DWD 80.32, then the insurer is supposed to automatically begin payment on conceded PPD benefits upon the end of healing, whenever the insurer has enough information to apply the rule. An amendment to Wis. Stat. § 102.32(6) now clarifies this requirement. The statute, as amended, now provides:

> 102.32 (6) (a) If compensation is due for permanent disability following an injury or if death benefits are payable, payments shall

[1] 2003 Wisconsin Act 144, § 13.
[2] A list of certified databases is available from the Department's Web site at: http://www.dwd.state.wi.us/wc/insurance/radiology/databaselist.pdf.
[3] Disputes as to the reasonableness of fees are subject to Wis. Stat. § 102.16(2) and Wis. Admin. Code § DWD 80.72. Disputes as to the necessity of treatment are subject to Wis. Stat. § 102.16(2m) and Wis. Admin. Code § DWD 80.73.
[4] 2003 Wisconsin Act 144, §§ 12, 15.
[5] 2003 Wisconsin Act 144, §§ 14, 16.

be made to the employee or dependent on a monthly basis as provided in pars. (b) to (e).

(b) Subject to par. (d), if the employer or the employer's insurer concedes liability for an injury that results in permanent disability and if the extent of the permanent disability can be determined based on a minimum permanent disability rating promulgated by the department by rule, compensation for permanent disability shall begin within 30 days after the end of the employee's healing period.

(c) Subject to par. (d), if the employer or the employer's insurer concedes liability for an injury that results in permanent disability, but the extent of the permanent disability cannot be determined without a medical report that provides the basis for a minimum permanent disability rating, compensation for permanent disability shall begin within 30 days after the employer or the employer's insurer receives a medical report that provides a basis for a permanent disability rating.

(d) The department shall promulgate rules for determining when compensation for permanent disability shall begin in cases in which the employer or the employer's insurer concedes liability, but disputes the extent of permanent disability.[6]

(e) Payments for permanent disability, including payments based on minimum permanent disability ratings promulgated by the department by rule, shall continue on a monthly basis and shall accrue and be payable between intermittent periods of temporary disability so long as the employer or insurer knows the nature of the permanent disability.[7]

2.0 Pending Amendments to Wis. Admin. Code DWD 80

Administrative rules are passed by state agencies rather than by the legislature. For the Worker's Compensation Act, the corresponding administrative rules are Wis. Admin. Code Chapter DWD 80, by the Wisconsin Department of Workforce Development. There is now a pending set of amendments to DWD 80. The amendments were expected to be effective May 1, 2004, but the tentative effective date has been moved back to July 1, 2004.

The pending amendments to Wis. Admin. Code Chapter DWD 80 are attached as Exhibit C.[8] A Plain Language Summary by James T. O'Malley, Director, Legal Services Bureau, Worker's Compensation Division, DWD, is attached as Exhibit D.

[6] The proposed Department rule under this subsection is discussed below in section 2.2 of this paper.
[7] Wis. Stat. § 102.32(6), as amended by 2003 Wisconsin Act 144, §§ 22, 23.
[8] Wisconsin State Legislature, Revisor of Statutes Bureau, Clearinghouse Rule 03-125.

Some of the most significant proposed amendments are discussed below.

2.1 Notice to the Department and the Employee of Denial or Investigation of Claims

2.11 Notice to the Department

Wis. Admin. Code § DWD 80.02(1) was amended, effective January 1, 1998, to expressly provide that only *compensable* injuries have to be reported to the Department on a WKC-12 Employer's First Report. A number of the new proposed amendments are intended to make the other rules more consistent with the rule that only compensable injuries must be reported.

The current version of Wis. Admin. Code § DWD 80.02(2)(g) provides:

> **(2)** SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES. Except as provided in sub. (3m), for injuries under sub. (1) (a) self-insured employers and insurance companies shall submit all of the following reports to the department:
>
> . . .
>
> (g) Written notice within 7 days, with a copy to the employee, after each of the following:
>
> 1. Payments are stopped for any reason. If any payments are stopped for a reason other than the employee's return to work, the self-insured employer or insurance carrier shall explain why it stopped payments and shall advise the employee what to do to reinstate payments.
>
> 2. A decision to deny liability for payment of compensation is made, giving the reason for the denial and advising the employee of the right to a hearing before the department.
>
> 3. Amputation will require an artificial member or appliance.

The proposed amendment to subsection 80.02(2)(g)2 of the rule provides:

> 2. A decision to deny liability for payment of compensation <u>for reported claims after a concession of liability</u> is made, giving the reason for the denial and advising the employee of the right to a hearing before the department.

The amendment is intended to clarify the rule, to make it clear that it only applies to *reported* claims after *liability is conceded*, but a decision is then made to deny liability. The current rule is inconsistent with the requirement of § DWD 80.02(1) that only *compensable* injuries need to be reported to the Department. Under the amended rule, if you send a denial letter to the

employee, you only have to send a copy to the Department if the claim was already reported to the Department on a WKC-12 and you initially conceded liability.

2.12 Notice to the Employee

The current version of Wis. Admin. Code § DWD 80.02(2)(h) provides that the insurer must submit a report to the Department:

> (h) Within 14 days of the date of an alleged injury under sub. (1) (a), if the claim is not paid or denied because the insurance carrier or self-insured employer is still investigating the claim, a written explanation giving the reason for further investigation, with a copy to the employee. If notice from an insured employer to its insurance carrier under sub. (1) is not timely, the insurance carrier shall comply within 14 days of receiving notice of the alleged injury from any source.

The proposed amendments would repeal the above rule of subsection (h). Subsection (h) would be replaced with a new § DWD 80.02(2)(m):

> **(2m)** SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES; NOTICE TO EMPLOYEE.
>
> (a) For all injuries under sub. (1) (a), self-insured employers and insurance companies shall provide written notice to the employee within 14 days of the date of an alleged injury indicating one of the following:
>
> 1. A decision to deny liability for payment of compensation giving the specific reason for the denial and advising the employee of the right to a hearing before the department.
>
> 2. An explanation that the claim is not paid because the insurance company or self-insured employer is still investigating the claim. The notice shall specify if additional medical or other information is needed to complete the investigation. The notice shall advise the employee of the right to a hearing before the department if the claim is subsequently denied.
>
> (b) If the notice of injury from the employee to the insured employer or from the insured employer to its insurance company was not made within 7 days of the date of the alleged injury, the insurance company shall provide notice under subd. (a)1. or (a)2. within 14 days of receiving notice of the alleged injury from any source.

Under the amended rule, if the injury is not compensable and you have not reported it to the Department on a WKC-12, then if you send a denial letter to the employee you do *not* have to send a copy of the denial letter to the Department.

2.13 Suggested Language for Denial Letters

When you are sending a denial letter to the employee, you are required to include notice of the employee's right to a hearing. I would suggest include the following two paragraphs at the end of your denial letter, after you explain the basis for the denial:

> If you disagree with this determination, you have the right to start a worker's compensation proceeding and to have a hearing on your claim. You may start such a proceeding by filing a Hearing Application with the Wisconsin Worker's Compensation Division, DWD, P.O. Box 7901, Madison, WI 53707-7901.
>
> You may obtain the form for a Hearing Application by writing to the Wisconsin Worker's Compensation Division at the above address, or by calling them at the main office in Madison: (608) 266-1340. If you complete and file the Hearing Application form you will be starting a worker's compensation proceeding. Your claim will be scheduled for a hearing before an administrative law judge of the Wisconsin Worker's Compensation Division. At the hearing you will have an opportunity to present evidence and litigate your claim.

Finally, there is another proposed change to § DWD 80.02(2)(b), to clarify the requirement that once you do report an injury to the Department, you are then required to submit a WKC-13 Supplementary Report on Accidents and Industrial Diseases. This does not change the rule that you are *not* required to report no-lost-time or denied claims, but once you do report a claim you will then have to file a WKC-13. The proposed amendment to § DWD 80.02(2)(b) reads as follows:

> **DWD 80.02 (2)(b)** A supplementary report with the information required by form WKC-13 on or before the 30th day following the day on which the injury in par. (a) occurred or on or before the 30th day following the day the injury was reported to the department, if the injury was not required to be reported under par. (a).

2.2 Payment of Permanent Disability

An amendment to Wis. Stat. § 102.32(6), as to payment of permanent disability benefits, also provides that the Department is supposed to promulgate an administrative rule for conceded injuries when an insurer wishes to dispute the permanent disability rating by a treating practitioner.[9] Therefore, proposed § DWD 80.52 provides as follows for the payment of permanent disability benefits:

> **DWD 80.52 Payment of permanent disability where the degree of permanency is disputed.** Where injury is conceded, but the employer or the employer's insurer disputes the extent of permanent disability, payment of permanent disability shall begin:

[9] Wis. Stat. § 102.32(6), as amended by 2003 Wisconsin Act 144, § 23.

> **(1)** Within 30 days of a report that provides the permanent disability rating, in the amount of the permanency set forth in the report; or
>
> **(2)** Within 30 days after the employer or insurer receives a report from an examination performed under s. 102.13(1)(a), Stats., in the amount of the permanent disability found as a result of that medical examination, if any. If such an examination had not previously been performed, the employer or employer's insurer must give notice of a request for such an examination within 30 days of a receiving a report that establishes the permanent disability under sub. (1), and in the event that a report from the examination is not available within 90 days of the request for the examination, the employer and insurer shall begin payment of the permanent disability set forth in the report under sub. (1).

2.3 Reasonableness of Fee and Necessity of Treatment Disputes When Liability or Extent of Disability is Disputed

If you are disputing the reasonableness of a fee for a health service procedure under Wis. Stat. § 102.16(2) and Wis. Admin. Code § DWD 80.72, you have 30 days from the date you receive the bill in which to give the health service provider written notice that you are disputing the fee. The proposed amendment to § DWD 80.72(3)(a) requires that if you are disputing liability or the extent of disability, you must give written notice to the health service provider within the same 30-day period.

When you are disputing the necessity of treatment on a bill from a health service provider under Wis. Stat. § 102.16(2m) and Wis. Admin. Code § DWD 80.73, you have 60 days from the date you receive the bill in which to give the health service provider written notice that you are disputing the fee. The proposed amendment to § DWD 80.73(3)(a) requires that if you are disputing liability or the extent of disability, you must give written notice to the health service provider within the same 60-day period.

Attached Exhibit E is my own suggested form letter for giving notice of such disputes. Note that this form is *not* intended for giving notice of a dispute as to the *necessity of treatment*.

If you are intending to dispute the *necessity of treatment*, then you need to use a different form that includes all of the elements required by Wis. Stat. § 102.16(2m) and Wis. Admin. Code § 80.73. Attached Exhibit F is my own suggested form letter for giving notice to the health service provider when you are disputing the necessity of treatment.

Attorney Philip Lehner
E-mail: wclawyer@tds.net

GRAHOVAC & KALLENBACH, S.C.
6233 Bankers Road, Suite 11
Racine, Wisconsin 53403
(262) 551-2050

About the author . . .

Philip Lehner received his undergraduate degree from Northwestern University in 1970 and his J.D. from the University of Wisconsin Law School in 1973. He practices with the Racine firm of GRAHOVAC & KALLENBACH, S.C. His practice is limited exclusively to the defense of worker's compensation claims for employers and insurance carriers throughout the state. He is a frequent lecturer and author on Wisconsin worker's compensation law and claims management. He served as the chairperson of the Wisconsin Manufacturers & Commerce (WMC) Worker's Compensation Council for 1994–1999. He served as the president of the Wisconsin Association of Worker's Compensation Attorneys (WAWCA) for 2003.

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Date of enactment: **March 15, 2004**

2003 Assembly Bill 669 Date of publication*: **March 29, 2004**

2003 WISCONSIN ACT 144

AN ACT ***to renumber and amend*** 102.17 (1) (d) and 102.32 (6); ***to amend*** 102.13 (1) (a), 102.13 (1) (b) (intro.), 102.13 (1) (b) 1., 102.13 (1) (b) 3., 102.13 (1) (b) 4., 102.13 (1) (d) 1., 102.13 (1) (d) 2., 102.13 (1) (d) 3., 102.13 (1) (d) 4., 102.13 (2) (a), 102.13 (2) (b), 102.16 (2) (a), 102.16 (2) (d), 102.16 (2) (f), 102.16 (2m) (a), 102.16 (2m) (e), 102.17 (1) (g), 102.18 (1) (e), 102.29 (3), 102.31 (2) (a), 102.32 (6m), 102.35 (1), 102.42 (2) (a), 102.44 (1) (intro.), 102.44 (1) (a), 102.44 (1) (b), 102.49 (5) (a), 102.59 (2), 102.81 (1) (a) and 102.82 (1); and ***to create*** 102.32 (6) (d) of the statutes; **relating to:** making various changes in the worker's compensation law and granting rule−making authority.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 102.13 (1) (a) of the statutes is amended to read:

102.13 **(1)** (a) Except as provided in sub. (4), whenever compensation is claimed by an employee, the employee shall, upon the written request of the employee's employer or worker's compensation insurer, submit to reasonable examinations by physicians, chiropractors, psychologists, dentists, physician assistants, advanced practice nurse prescribers, or podiatrists provided and paid for by the employer or insurer. No employee who submits to an examination under this paragraph is a patient of the examining physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist for any purpose other than for the purpose of bringing an action under ch. 655, unless the employee specifically requests treatment from that physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist.

SECTION 2. 102.13 (1) (b) (intro.) of the statutes is amended to read:

102.13 **(1)** (b) (intro.) An employer or insurer who requests that an employee submit to reasonable examination under par. (a) or (am) shall tender to the employee, before the examination, all necessary expenses including transportation expenses. The employee is entitled to have a physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist provided by himself or herself present at the examination and to receive a copy of all reports of the examination that are prepared by the examining physician, chiropractor, psychologist, podiatrist, dentist, physician assistant, advanced practice nurse prescriber, or vocational expert immediately upon receipt of those reports by the employer or worker's compensation insurer. The employee is also entitled to have a translator provided by himself or herself present at the examination if the employee has difficulty speaking or understanding the English language. The employer's or insurer's written request for examination shall notify the employee of all of the following:

* Section 991.11, WISCONSIN STATUTES 2001−02 : Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

SECTION 3. 102.13 (1) (b) 1. of the statutes is amended to read:

102.13 **(1)** (b) 1. The proposed date, time, and place of the examination and the identity and area of specialization of the examining physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, or vocational expert.

SECTION 4. 102.13 (1) (b) 3. of the statutes is amended to read:

102.13 **(1)** (b) 3. The employee's right to have his or her physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist present at the examination.

SECTION 5. 102.13 (1) (b) 4. of the statutes is amended to read:

102.13 **(1)** (b) 4. The employee's right to receive a copy of all reports of the examination that are prepared by the examining physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, or vocational expert immediately upon receipt of these reports by the employer or worker's compensation insurer.

SECTION 6. 102.13 (1) (d) 1. of the statutes is amended to read:

102.13 **(1)** (d) 1. Any physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, or vocational expert who is present at any examination under par. (a) or (am) may be required to testify as to the results ~~thereof~~ of the examination.

SECTION 7. 102.13 (1) (d) 2. of the statutes is amended to read:

102.13 **(1)** (d) 2. Any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist who attended a worker's compensation claimant for any condition or complaint reasonably related to the condition for which the claimant claims compensation may be required to testify before the department when ~~it~~ the department so directs.

SECTION 8. 102.13 (1) (d) 3. of the statutes is amended to read:

102.13 **(1)** (d) 3. Notwithstanding any statutory provisions except par. (e), any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist attending a worker's compensation claimant for any condition or complaint reasonably related to the condition for which the claimant claims compensation may furnish to the employee, employer, worker's compensation insurer, or the department information and reports relative to a compensation claim.

SECTION 9. 102.13 (1) (d) 4. of the statutes is amended to read:

102.13 **(1)** (d) 4. The testimony of any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist who is licensed to practice where he or she resides or practices in any state and the testimony of any vocational expert may be received in evidence in compensation proceedings.

SECTION 10. 102.13 (2) (a) of the statutes is amended to read:

102.13 **(2)** (a) An employee who reports an injury alleged to be work−related or files an application for hearing waives any physician−patient, psychologist−patient or chiropractor−patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding ss. 51.30 and 146.82 and any other law, any physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, worker's compensation insurer, or department or its representative, provide that person with any information or written material reasonably related to any injury for which the employee claims compensation.

SECTION 11. 102.13 (2) (b) of the statutes is amended to read:

102.13 **(2)** (b) A physician, chiropractor, podiatrist, psychologist, dentist, physician assistant, advanced practice nurse prescriber, hospital, or health service provider shall furnish a legible, certified duplicate of the written material requested under par. (a) upon payment of the actual costs of preparing the certified duplicate, not to exceed the greater of 45 cents per page or $7.50 per request, plus the actual costs of postage. Any person who refuses to provide certified duplicates of written material in the person's custody that is requested under par. (a) shall be liable for reasonable and necessary costs and, notwithstanding s. 814.04 (1), reasonable attorney fees incurred in enforcing the requester's right to the duplicates under par. (a).

SECTION 12. 102.16 (2) (a) of the statutes is amended to read:

102.16 **(2)** (a) ~~The~~ Except as provided in this paragraph, the department has jurisdiction under this subsection, sub. (1m) (a), and s. 102.17 to resolve a dispute between a health service provider and an insurer or self−insured employer over the reasonableness of a fee charged by the health service provider for health services provided to an injured employee who claims benefits under this chapter. A health service provider may not submit a fee dispute to the department under this subsection before all treatment by the health service provider of the employee's injury has ended if the amount in controversy, whether based on a single charge or a combination of charges for one or more days of service, is less than $25. After all treatment by a health service provider of an employee's injury has ended, the health service provider may submit any fee dispute to the department, regardless of the amount in controversy. The department

shall deny payment of a health service fee that the department determines under this subsection, sub. (1m) (a), or s. 102.18 (1) (b) to be unreasonable.

(am) A health service provider and an insurer or self−insured employer that are parties to a fee dispute under this subsection are bound by the department's determination under this subsection on the reasonableness of the disputed fee, unless that determination is set aside on judicial review as provided in par. (f). A health service provider and an insurer or self−insured employer that are parties to a fee dispute under sub. (1m) (a) are bound by the department's determination under sub. (1m) (a) on the reasonableness of the disputed fee, unless that determination is set aside or modified by the department under sub. (1). An insurer or self−insured employer that is a party to a fee dispute under s. 102.17 and a health service provider are bound by the department's determination under s. 102.18 (1) (b) on the reasonableness of the disputed fee, unless that determination is set aside, reversed, or modified by the department under s. 102.18 (3) or by the commission under s. 102.18 (3) or (4) or is set aside on judicial review under s. 102.23.

SECTION 13. 102.16 (2) (d) of the statutes is amended to read:

102.16 **(2)** (d) The department shall analyze the information provided to the department under par. (c) according to the criteria provided in this paragraph to determine the reasonableness of the disputed fee. The department shall determine that a disputed fee is reasonable and order that the disputed fee be paid if that fee is at or below the mean fee for the health service procedure for which the disputed fee was charged, plus ~~1.5~~ 1.4 standard deviations from that mean, as shown by data from a database that is certified by the department under par. (h). The department shall determine that a disputed fee is unreasonable and order that a reasonable fee be paid if the disputed fee is above the mean fee for the health service procedure for which the disputed fee was charged, plus ~~1.5~~ 1.4 standard deviations from that mean, as shown by data from a database that is certified by the department under par. (h), unless the health service provider proves to the satisfaction of the department that a higher fee is justified because the service provided in the disputed case was more difficult or more complicated to provide than in the usual case.

SECTION 14. 102.16 (2) (f) of the statutes is amended to read:

102.16 **(2)** (f) ~~The~~ Within 30 days after a determination under this subsection, the department may set aside, reverse, or modify ~~a determination under this subsection within 30 days after the date of~~ the determination for any reason that the department considers sufficient. Within 60 days after a determination under this subsection, the department may set aside, reverse, or modify the determination on grounds of mistake. A health service provider, insurer, or self−insured employer that is aggrieved by a determination of the department under this subsection may seek judicial review of that determination in the same manner that compensation claims are reviewed under s. 102.23.

SECTION 15. 102.16 (2m) (a) of the statutes is amended to read:

102.16 **(2m)** (a) ~~The~~ Except as provided in this paragraph, the department has jurisdiction under this subsection, sub. (1m) (b), and s. 102.17 to resolve a dispute between a health service provider and an insurer or self−insured employer over the necessity of treatment provided for an injured employee who claims benefits under this chapter. A health service provider may not submit a dispute over necessity of treatment to the department under this subsection before all treatment by the health service provider of the employee's injury has ended if the amount in controversy, whether based on a single charge or a combination of charges for one or more days of service, is less than $25. After all treatment by a health service provider of an employee's injury has ended, the health service provider may submit any dispute over necessity of treatment to the department, regardless of the amount in controversy. The department shall deny payment for any treatment that the department determines under this subsection, sub. (1m) (b), or s. 102.18 (1) (b) to be unnecessary.

(am) A health service provider and an insurer or self−insured employer that are parties to a dispute under this subsection over the necessity of treatment are bound by the department's determination under this subsection on the necessity of that treatment, unless that determination is set aside on judicial review as provided in par. (e). A health service provider and an insurer or self−insured employer that are parties to a dispute under sub. (1m) (b) over the necessity of treatment are bound by the department's determination under sub. (1m) (b) on the necessity of that treatment, unless that determination is set aside or modified by the department under sub. (1). An insurer or self−insured employer that is a party to a dispute under s. 102.17 over the necessity of treatment and a health service provider are bound by the department's determination under s. 102.18 (1) (b) on the necessity of that treatment, unless that determination is set aside, reversed or modified by the department under s. 102.18 (3) or by the commission under s. 102.18 (3) or (4) or is set aside on judicial review under s. 102.23.

SECTION 16. 102.16 (2m) (e) of the statutes is amended to read:

102.16 **(2m)** (e) ~~The~~ Within 30 days after a determination under this subsection, the department may set aside, reverse, or modify ~~a determination under this subsection within 30 days after the date of~~ the determination for any reason that the department considers sufficient. Within 60 days after a determination under this subsection, the department may set aside, reverse, or modify the determination on grounds of mistake. A health service

provider, insurer, or self−insured employer that is aggrieved by a determination of the department under this subsection may seek judicial review of that determination in the same manner that compensation claims are reviewed under s. 102.23.

SECTION 17. 102.17 (1) (d) of the statutes is renumbered 102.17 (1) (d) 1. and amended to read:

102.17 **(1)** (d) 1. The contents of certified medical and surgical reports by physicians, podiatrists, surgeons, dentists, psychologists, physician assistants, advanced practice nurse prescribers, and chiropractors licensed in and practicing in this state, and of certified reports by experts concerning loss of earning capacity under s. 102.44 (2) and (3), presented by a party for compensation constitute prima facie evidence as to the matter contained in ~~them~~ those reports, subject to any rules and limitations the department prescribes. Certified reports of physicians, podiatrists, surgeons, dentists, psychologists, physician assistants, advanced practice nurse prescribers, and chiropractors, wherever licensed and practicing, who have examined or treated the claimant, and of experts, if the practitioner or expert consents to ~~subject himself or herself~~ being subjected to cross−examination also constitute prima facie evidence as to the matter contained in ~~them~~ those reports. Certified reports of physicians, podiatrists, surgeons, psychologists, and chiropractors are admissible as evidence of the diagnosis, necessity of the treatment, and cause and extent of the disability. Certified reports by doctors of dentistry, physician assistants, and advanced practice nurse prescribers are admissible as evidence of the diagnosis and necessity ~~for~~ of treatment but not of the cause and extent of disability. Any physician, podiatrist, surgeon, dentist, psychologist, chiropractor, physician assistant, advanced practice nurse prescriber, or expert who knowingly makes a false statement of fact or opinion in such a certified report may be fined or imprisoned, or both, under s. 943.395.

2. The record of a hospital or sanatorium in this state ~~operated by any department or agency of the federal or state government or by any municipality, or of any other hospital or sanatorium in this state which~~ that is satisfactory to the department, established by certificate, affidavit, or testimony of the supervising officer ~~or~~ of the hospital or sanitorium, any other person having charge of ~~such records~~ the record, or ~~of~~ a physician, podiatrist, surgeon, dentist, psychologist, physician assistant, advanced practice nurse prescriber, or chiropractor to be the record of the patient in question, and made in the regular course of examination or treatment of ~~such~~ the patient, constitutes prima facie evidence ~~in any worker's compensation proceeding~~ as to the matter contained in ~~it~~ the record, to the extent that ~~it~~ the record is otherwise competent and relevant.

3. The department may, by rule, establish the qualifications of and the form used for certified reports submitted by experts who provide information concerning loss of earning capacity under s. 102.44 (2) and (3). The department may not admit into evidence a certified report of a practitioner or other expert or a record of a hospital or sanatorium that was not filed with the department and all parties in interest at least 15 days before the date of the hearing, unless the department is satisfied that there is good cause for the failure to file the report.

SECTION 18. 102.17 (1) (g) of the statutes is amended to read:

102.17 **(1)** (g) Whenever the testimony presented at any hearing indicates a dispute~~, or is such as to create~~ or creates a doubt as to the extent or cause of disability or death, the department may direct that the injured employee be examined ~~or~~, that an autopsy be performed, or that an opinion ~~of a physician, chiropractor, dentist, psychologist or podiatrist~~ be obtained without examination or autopsy, by or from an impartial, competent physician, chiropractor, dentist, psychologist or podiatrist designated by the department who is not under contract with or regularly employed by a compensation insurance carrier or self−insured employer. The expense of ~~such~~ the examination, autopsy, or opinion shall be paid by the employer or, if the employee claims compensation under s. 102.81, from the uninsured employers fund. The report of ~~such~~ the examination, autopsy, or opinion shall be transmitted in writing to the department and a copy ~~thereof~~ of the report shall be furnished by the department to each party, who shall have an opportunity to rebut such report on further hearing.

SECTION 19. 102.18 (1) (e) of the statutes is amended to read:

102.18 **(1)** (e) Except as provided in s. 102.21, if the department orders a party to pay an award of compensation, the party shall pay the award no later than 21 days after the date on which the order is mailed to the last−known address of the party, unless ~~a~~ the party files a petition for review under sub. (3). This paragraph applies to all awards of compensation ordered by the department, whether the award results from a hearing, the default of a party, or a compromise or stipulation confirmed by the department.

SECTION 20. 102.29 (3) of the statutes is amended to read:

102.29 **(3)** Nothing in this chapter shall prevent an employee from taking the compensation ~~he or she~~ that the employee may be entitled to under ~~it~~ this chapter and also maintaining a civil action against any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist for malpractice.

SECTION 21. 102.31 (2) (a) of the statutes is amended to read:

102.31 **(2)** (a) No party to a contract of insurance may cancel ~~it~~ the contract within the contract period or terminate or not renew ~~it~~ the contract upon the expiration date until a notice in writing is given to the other party fixing

the proposed date of cancellation or declaring that the party intends to terminate or does not intend to renew the policy upon expiration. Except as provided in par. (b), when an insurance company does not renew a policy upon expiration, the nonrenewal is not effective until 60 days after the insurance company has given written notice of the nonrenewal to the insured employer and the department. Cancellation or termination of a policy by an insurance company for any reason other than nonrenewal is not effective until 30 days after the insurance company has given written notice of the cancellation or termination to the insured employer and the department. Notice to the department may be given ~~either~~ by personal service of the notice upon the department at its office in Madison ~~or~~, by sending the notice by ~~facsimile machine transmission or~~ certified mail addressed to the department at its office in Madison, or by transmitting the notice to the department at its office in Madison by facsimile machine transmission, electronic mail, or any electronic, magnetic, or other medium approved by the department. The department may provide by rule that the notice of cancellation or termination be given ~~by certified mail or facsimile machine transmission~~ to the Wisconsin compensation rating bureau rather than to the department and that the notice of cancellation or termination be given to the Wisconsin compensation rating bureau by certified mail, facsimile machine transmission, electronic mail, or other medium approved by the department after consultation with the Wisconsin compensation rating bureau. Whenever the Wisconsin compensation rating bureau receives such a notice of cancellation or termination it shall immediately notify the department of the notice of cancellation or termination.

SECTION 22. 102.32 (6) of the statutes is renumbered 102.32 (6) (a) and amended to read:

102.32 **(6)** (a) If compensation is due for permanent disability following an injury or if death benefits are payable, payments shall be made to the employee or dependent on a monthly basis~~. Compensation for permanent disability that results from an injury for which~~ as provided in pars. (b) to (e).

(b) Subject to par. (d), if the employer or the employer's insurer concedes liability ~~and that is~~ for an injury that results in permanent disability and if the extent of the permanent disability can be determined based on a minimum permanent disability rating promulgated by the department by rule, compensation for permanent disability shall begin within 30 days after the end of the employee's healing period ~~or~~.

(c) Subject to par. (d), if the employer or the employer's insurer concedes liability for an injury that results in permanent disability, but the extent of the permanent disability cannot be determined without a medical report that provides the basis for a minimum permanent disability rating, compensation for permanent disability shall begin within 30 days after the employer or the employer's insurer receives a medical report that provides a basis for a permanent disability rating~~, whichever is later. Compensation for permanent disability that results from an injury for which the employer or the employer's insurer does not concede liability or that is based on a permanent disability rating that is above a minimum permanent disability rating promulgated by the department by rule shall begin within the later of those 30−day periods unless within the later of those 30−day periods the employer or insurer notifies the employee that the employer or insurer is requesting an examination under s. 102.13 (1) (a), in which case compensation for permanent disability shall begin within 30 days after the employer or insurer receives the report of the examination or within 90 days after the date of the request for the examination, whichever is earlier~~.

(e) Payments for permanent disability, including payments based on minimum permanent disability ratings promulgated by the department by rule, shall continue on a monthly basis and shall accrue and be payable between intermittent periods of temporary disability so long as the employer or insurer knows the nature of the permanent disability.

SECTION 23. 102.32 (6) (d) of the statutes is created to read:

102.32 **(6)** (d) The department shall promulgate rules for determining when compensation for permanent disability shall begin in cases in which the employer or the employer's insurer concedes liability, but disputes the extent of permanent disability.

SECTION 24. 102.32 (6m) of the statutes is amended to read:

102.32 **(6m)** The department may direct an advance on a payment of unaccrued compensation for permanent disability or death benefits if the department determines that the advance payment is in the best interest of the injured employee or the employee's dependents. In directing the advance, the department shall give the employer or the employer's insurer an interest credit against its liability. The credit shall be computed at 7%.

SECTION 25. 102.35 (1) of the statutes is amended to read:

102.35 **(1)** Every employer and every insurance company that fails to keep the records or to make the reports required by this chapter or that knowingly falsifies such records or makes false reports shall forfeit to the state not less than $10 nor more than $100 for each offense. The department may waive or reduce a forfeiture imposed under this subsection if the employer or insurance company that violated this subsection requests a waiver or reduction of the forfeiture within 45 days after notice of the forfeiture is mailed to the employer or insurance company and shows that the violation was due to mistake or an absence of information.

SECTION 26. 102.42 (2) (a) of the statutes is amended to read:

102.42 **(2)** (a) ~~Where~~ When the employer has notice of an injury and its relationship to the employment, the employer shall offer to the injured employee his or her choice of any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist licensed to practice and practicing in this state for treatment of the injury. By mutual agreement, the employee may have the choice of any qualified practitioner not licensed in this state. In case of emergency, the employer may arrange for treatment without tendering a choice. After the emergency has passed the employee shall be given his or her choice of attending practitioner at the earliest opportunity. The employee has the right to a 2nd choice of attending practitioner on notice to the employer or its insurance carrier. Any further choice shall be by mutual agreement. Partners and clinics are ~~deemed~~ considered to be one practitioner. Treatment by a practitioner on referral from another practitioner is ~~deemed~~ considered to be treatment by one practitioner.

SECTION 27. 102.44 (1) (intro.) of the statutes is amended to read:

102.44 **(1)** (intro.) Notwithstanding any other provision of this chapter, every employee who is receiving compensation under this chapter for permanent total disability or continuous temporary total disability more than 24 months after the date of injury resulting from an injury which occurred prior to ~~January 1, 1978,~~ May 13, 1980, shall receive supplemental benefits which shall be payable in the first instance by the employer or the employer's insurance carrier, or in the case of benefits payable to an employee under s. 102.66, shall be paid by the department out of the fund created under s. 102.65. These supplemental benefits shall be paid only for weeks of disability occurring after January 1, ~~1980~~ 1982, and shall continue during the period of such total disability subsequent to that date.

SECTION 28. 102.44 (1) (a) of the statutes is amended to read:

102.44 **(1)** (a) If such employee is receiving the maximum weekly benefits in effect at the time of the injury, the supplemental benefit for a week of disability occurring after ~~January 1, 2002~~ the effective date of this paragraph .... [revisor inserts date], shall be an amount which, when added to the regular benefit established for the case, shall equal ~~$202~~ $233.

SECTION 29. 102.44 (1) (b) of the statutes is amended to read:

102.44 **(1)** (b) If such employee is receiving a weekly benefit which is less than the maximum benefit which was in effect on the date of the injury, the supplemental benefit for a week of disability occurring after ~~January 1, 2002~~ the effective date of this paragraph .... [revisor inserts date], shall be an amount sufficient to bring the total weekly benefits to the same proportion of ~~$202~~ $233 as the employee's weekly benefit bears to the maximum in effect on the date of injury.

SECTION 30. 102.49 (5) (a) of the statutes is amended to read:

102.49 **(5)** (a) In each case of injury resulting in death, the employer or insurer shall pay into the state treasury the sum of ~~$5,000~~ $10,000.

SECTION 31. 102.59 (2) of the statutes is amended to read:

102.59 **(2)** In the case of the loss or of the total impairment of a hand, arm, foot, leg, or eye, the employer shall pay ~~$7,000~~ $10,000 into the state treasury. The payment shall be made in all such cases regardless of whether the employee~~,~~ or the employee's dependent or personal representative commences action against a 3rd party as provided in s. 102.29.

SECTION 32. 102.81 (1) (a) of the statutes is amended to read:

102.81 **(1)** (a) If an employee of an uninsured employer, other than an employee who is eligible to receive alternative benefits under s. 102.28 (3), suffers an injury for which the uninsured employer is liable under s. 102.03, the department or the department's reinsurer shall pay to or on behalf of the injured employee or to the employee's dependents an amount equal to the compensation owed them by the uninsured employer under this chapter except penalties and interest due under ss. 102.16 (3), 102.18 (1) (b) and (bp), 102.22 (1), 102.35 (3), 102.57, and 102.60.

SECTION 33. 102.82 (1) of the statutes is amended to read:

102.82 **(1)** An uninsured employer shall reimburse the department for any payment made under s. 102.81 (1) to or on behalf of an employee of the uninsured employer or to an employee's dependents and for any expenses paid by the department in administering the claim of the employee or dependents, less amounts repaid by the employee or dependents under s. 102.81 (4) (b). The reimbursement owed under this subsection is due within 30 days after the date on which the department notifies the uninsured employer that the reimbursement is owed. Interest shall accrue on amounts not paid when due at the rate of 1% per month.

SECTION 34. Initial applicability.

(1) FEE DISPUTES AND NECESSITY OF TREATMENT DISPUTES.

(a) The treatment of section 102.16 (2) (a) and (d) and (2m) (a) of the statutes first applies to fee disputes and necessity of treatment disputes submitted to the department of workforce development on the effective date of this paragraph.

(b) The treatment of section 102.16 (2) (f) and (2m) (e) of the statutes first applies to fee dispute and necessity of treatment dispute determinations made by the depart-

ment of workforce development 30 days before the effective date of this paragraph.

(2) PAYMENT OF AWARDS. The treatment of section 102.18 (1) (e) of the statutes first applies to orders awarding worker's compensation mailed to a party on the effective date of this subsection.

(3) PERMANENT DISABILITY PAYMENTS. The renumbering and amendment of section 102.32 (6) of the statutes and the treatment of section 102.32 (6m) of the statutes first apply to compensation for permanent disability that becomes due on the effective date of this subsection.

SECTION 35. Effective date.

(1) This act takes effect on January 1, 2004, or on the day after publication, whichever is later.

2003 AMENDMENTS TO THE WISCONSIN WORKER'S COMPENSATION ACT PLAIN LANGUAGE SUMMARY

Benefits/Payment of Benefits

Supplemental Benefits The maximum supplemental benefit rate is increased by this amendment from $202.00 per week to $233.00 per week for injuries occurring before May 13, 1980 and payable for weeks of disability beginning January 1, 2004. s.102.44 (1), Wis. Stats.

Uniform 21-Day Payment Standard This amendment clarifies that in cases where orders award a portion of the benefits claimed, and the order is appealed by the employee, the insurance carrier or self-insured employer is required to pay the undisputed/uncontested amount within 21 days rather than after the appeal is resolved. s.102.18(1)(b), Wis. Stats.

Payment of Permanent Partial Disability This amendment clarifies the requirements for the prompt payment of compensation for permanent partial disability. Where permanent partial disability is based on a minimum rating set by Department rule payment is to begin within 30 days after the end of the employee's healing period. In situations where the extent of permanent partial disability cannot be determined without a medical report that provides the basis for a minimum permanent disability rating, payment shall begin within 30 days after the employer or insurance carrier receives a medical report that provides a basis for a permanent partial disability rating. The Department shall promulgate a rule for determining when compensation for permanent disability shall begin in cases where the employer or insurance carrier concedes liability but disputes the extent of permanent partial disability. s.102.32(6), Wis. Stats.

Advance Payment This amendment clarifies that the Department may direct advance payment of death benefits or of unaccrued compensation for permanent partial disability. s.102.32 (6m), Wis. Stats.

Healthcare Treatment

Standard Deviation for Determining Reasonableness of Fee Disputes This amendment reduces the standard deviation from 1.5 to 1.4 for determining reasonableness of fee disputes over health care fees. s.102.16(2)(d), Wis. Stats.

Employee Choice of Treating Practitioner This amendment permits employees to select physician assistants and advance practice nurse prescribers licensed to practice and practicing in Wisconsin to provide treatment for injuries. s.102.42(2)(a), Wis. Stats.

Access to information or Written Material This amendment includes physician assistants and advanced practice nurse prescribers as practitioners who must provide reports reasonably related to worker's compensation claims upon request. s.102.13(2)(a) and (b), Wis. Stats.

Certified Reports This amendment adds physician assistants and advance practice nurse prescribers as practitioners who can complete certified medical reports. Physician assistants and advanced practice nurse prescribers are given the same status as dentists to prepare certified reports. Certified reports by dentists, physicians assistants and advance practice nurse prescribers are admissible as evidence of the diagnosis and necessity of treatment but not of the cause and extent of disability. s.102.17(1)(d), Wis. Stats.

Physician Assistants and Advance Practice Nurse Prescribers Physician assistants and advance practice nurse prescribers are included as practitioners who employers and insurance carriers can select to conduct examinations of employees. s.102.13(1)(a), (b) and (d), Wis. Stats.

Employer Assessments

Payment to State Fund-Death Claim This amendment increases the payment (assessment) to the Work Injury Supplemental Benefit Fund by employers and worker's compensation insurance carriers for injuries resulting in death from $5,000.00 to $10,000.00. s.102.49(5)(a), Wis. Stats.

Payments to State Fund-Injuries Resulting in Dismemberment This amendment increases the payment (assessment) to the Work Injury Supplemental Benefit Fund by employers and worker's compensation insurance carriers for injuries resulting in dismemberment from $7,000.00 to $10,000.00. s. 102.59(2), Wis. Stats.

Insurance Coverage

Waiver or Reduction of Forfeitures This amendment authorizes the Department to waive or reduce a forfeiture on the grounds that it was imposed due to a mistake or an absence of information if the employer or worker's compensation insurance carrier requests a waiver or reduction within 45 days after notice of the forfeiture is mailed by the Department. s.102.35(1), Wis. Stats.

Notice of Cancellation or Termination This amendment permits insurance carriers to give notice of cancellation or termination of a policy to the Wisconsin Compensation Rating Bureau by certified mail, facsimile machine transmission, electronic mail or any other medium approved by the Department. s.102.31(2)(a), Wis. Stats.

Reasonableness of Fee Disputes/Necessity of Treatment Disputes

Minimum Threshold for Reasonableness of Fee Disputes This amendment creates a minimum $25.00 threshold amount for utilizing the reasonableness of fee dispute resolution process. The minimum $25.00 amount may be based on a single charge or a combination of charges for one or more dates of service. There is no minimum threshold amount after treatment provided to the employee for the injury by the health service provider has ended. s.102.16(2)(a) and (am), Wis. Stats.

Extension of Time for Modifying Reasonableness of Fee Decisions This amendment will give the Department an additional 30 days (60 total days) to set aside, reverse or modify a reasonableness of health service fee determination on the grounds of mistake. s.102.16(2)(f), Wis. Stats.

Minimum Threshold for Necessity of Treatment Disputes This amendment creates a minimum $25.00 threshold amount for utilizing the necessity of treatment dispute resolution process. The minimum $25.00 amount may be based on a single charge or a combination of charges for one or more dates of service. There is no minimum threshold amount after treatment to the employee for the injury by the health service provider has ended. s.102.16 (2m)(a) and (am), Wis. Stats.

Extended Time for Modifying Necessity of Treatment Determination This amendment provides an additional 30 days (60 days total) for the Department to set aside, reverse or modify a necessity of treatment determination on grounds of mistake. s.102.16(2m)(e), Wis. Stats.

Miscellaneous

Malpractice Actions This amendment adds physician assistants and advance practice nurse prescribers as practitioners employees may maintain a civil action against for malpractice. s.102.29(3), Wis. Stats.

Reimbursement by Uninsured Employer This amendment authorizes the Department to claim reimbursement from uninsured employers for claims administration expenses paid by the Department in addition to all payments made to or on behalf of employees or to employees' dependents. s.102.82(1), Wis. Stats.

Uninsured Employers Fund This is a technical amendment by the drafter to include a reference to payments on behalf of the injured employee or to the employees' dependents. s. 102.81(1) (a), Wis. Stats.

Examination Autopsy or Opinion This is a technical amendment by the drafter to modernize the language in this section. s.102.17(1)(g), Wis. Stats.

Clearinghouse Rule 03-125

State of Wisconsin

Department of Workforce Development

Chapter DWD 80

WORKER'S COMPENSATION

The Wisconsin Department of Workforce Development proposes an order to repeal s. DWD 80.02(2)(h); to renumber ss. DWD 80.02(3m)(a) and 80.02(3m)(b); to amend ss. DWD 80.02(2)(title), 80.02(2)(b), 80.02(2)(g)2., 80.62(7)(a)3., 80.65, 80.72(3)(a), and 80.73(3)(a); and to create ss. DWD 80.02(2m), 80.02(3m)(a), 80.02(3m)(b), 80.02(3m)(b)1., 80.02(3m)(b)2., 80.02(3m)(b)3., and 80.52, relating to worker's compensation.

Analysis Prepared by the Department of Workforce Development

Statutory authority: Sections 102.15(1) and 227.11, Stats.
Statutes interpreted: Sections 102.16(2), 102.16(2m), 102.31(2)(a), 102.32(6), 102.35(1), 102.37, 102.38, and 102.82, Stats.

The proposed rules make the following changes, as agreed to by the Worker's Compensation Advisory Council:

Supplementary reports by employers and insurance companies. Under the current rule self-insured employers and insurance companies are required to submit supplemental reports only if the reported injury meets the definition of lost time under DWD 80.02(1)(a). The proposed amendment to s. DWD 80.02(2)(b) will require self-insured employers and insurance companies to submit supplemental reports for all claims reported whether or not they meet the lost-time definition. The amendment will not require the reporting of no lost time or denied claims but will require the filing of supplemental reports for all claims that are reported.

Written notice by employers and insurance companies. The proposed amendment to s. DWD 80.02(2)(g)2 will require self-insured employers and insurance companies to provide notice of denial to the department and employees for claims that are initially reported and paid but later denied. The current rule is inconsistent with the requirement to report only compensable claims.

Written notice by employers and insurance companies. The proposed rules repeal s. DWD 80.02(2)(h). Under the current rule, self-insured employers and insurance companies are required to provide the department with written notice related to denial or

Exhibit C

continued investigation of claims with copies of the report provided to employees. This provision is repealed because the requirement for self-insured employers and insurance companies to submit reports about the denial or investigation of claims to the department is eliminated. The newly-created DWD 80. 02 (2m) replaces this provision and requires self-insured employers and insurance companies to provide notice of denial or investigation of claims to employees only and not to the department.

Notice by employers and insurance companies to employees. The proposed rules amend s. DWD 80.02(2m) to clarify that a notice of denial or investigation of claims is to be sent to the employee along with a statement advising the employee of the right to a hearing before the department. The notice of investigation will specify if additional medical or other information is needed to complete the investigation. This notice must be sent to the employee and is not required to be sent to the department.

Electronic reporting. The proposed amendment to s. DWD 80.02(3m) will permit the department to require self-insured employers and insurance companies to submit all or selected information in reports or amendments to reports to be filed via electronic, magnetic, or other media satisfactory to the department. Under the current rule self-insured employers and insurance companies may request to submit required reports electronically but are not required to do so. This amendment will allow the department discretion to require electronic reporting to help the self-insured employer or insurance company to meet reporting requirements. This amendment also permits the department to grant waivers from the requirement to submit reports by electronic means if the employer, self-insured employer or insurer can establish good cause.

Payment of permanent disability. A new section is created at s. DWD 80.52 to establish when payment for compensation for permanent disability must begin in cases in which the self-insured employer or insurance company concedes liability but disputes the extent of permanent disability. Under this rule payment is to begin (1) within 30 days after the self-insured employer or insurance company receives a report that provides a permanent disability rating or (2) within 30 days after receiving a report from an examination performed under s. 102.13(1)(a), Stats., in the amount of permanent disability found as a result of the examination. If no examination was previously performed, the self-insured employer or insurance company may give notice of a request for an examination within 30 days of receiving a report that establishes permanent disability. If the examining practitioner's report is not available within 90 days of the request for an examination, payment must begin by that date.

Uninsured employers fund. Section DWD 80.62(7)(a)3 is amended to allow the department to seek reimbursement from uninsured employers for payments made by the Uninsured Employers Fund for claims administration expenses.

Notice of cancellation or termination. The proposed rules amend s. DWD 80.65 to permit insurance companies to give notice of cancellation or termination of insurance policies to the Wisconsin Compensation Rating Bureau by facsimile machine transmission, electronic mail, or any electronic, magnetic, or other medium approved by

the department. The current rule permits notice only by certified mail or personal service. The rule is amended to authorize notice by different means to comply with a recent amendment to s. 102.31(2)(a), Stats.

Reasonableness of fee disputes. Section DWD 80.72(3)(a) is amended to require self-insured employers and insurance companies to raise disputes over liability or the extent of disability of the underlying claim and give notice within 30 days after receiving a completed bill from a healthcare provider, unless there is good cause for the delay in providing this notice.

Necessity of treatment. Section DWD 80.73(3)(a) is amended to require self-insured employers and insurance companies to raise disputes over liability or the extent of liability of the underlying claim and give notice within 60 days after receiving a bill from the healthcare provider, unless there is good cause for the delay in providing this notice.

SECTION 1. DWD 80.02 (2)(title), 80.02 (2)(b), and DWD 80.02 (2)(g)2. are amended to read:

DWD 80.02 (2)(title) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES; REPORTS.

DWD 80.02 (2)(b) A supplementary report with the information required by form WKC-13 on or before the 30th day following the day on which the injury in par. (a) occurred or on or before the 30th day following the day the injury was reported to the department, if the injury was not required to be reported under par. (a).

DWD 80.02 (2)(g)2. A decision to deny liability for payment of compensation for reported claims after a concession of liability is made, giving the reason for the denial and advising the employee of the right to a hearing before the department.

SECTION 2. DWD 80.02 (2)(h) is repealed.

SECTION 3. DWD 80.02 (2m) is created to read:

DWD 80.02 (2m) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES; NOTICE TO EMPLOYEE. (a) For all injuries under sub. (1) (a), self-insured employers and insurance companies shall provide written notice to the employee within 14 days of the date of an alleged injury indicating one of the following:

1. A decision to deny liability for payment of compensation giving the specific reason for the denial and advising the employee of the right to a hearing before the department.

2. An explanation that the claim is not paid because the insurance company or self-insured employer is still investigating the claim. The notice shall specify if additional medical or other information is needed to complete the investigation. The notice shall advise the employee of the right to a hearing before the department if the claim is subsequently denied.

(b) If the notice of injury from the employee to the insured employer or from the insured employer to its insurance company was not made within 7 days of the date of the alleged injury, the insurance company shall provide notice under subd. (a)1. or (a)2. within 14 days of receiving notice of the alleged injury from any source.

SECTION 4. DWD 80.02 (3m) (a) and (b) are respectively renumbered DWD 80.02 (3m) (a) 1. and 2.

SECTION 5. DWD 80.02 (3m) (a), (b), and (b) 1., 2., and 3. are created to read:

DWD 80.02 (3m) (a) *Employer or insurer request*.

DWD 80.02 (3m) (b) *Department requirement*. 1. The department may require an employer, self-insured employer, or insurer to submit all or selected information in reports or amendments to reports required to be filed with the department in sub. (1) or (2) via electronic, magnetic, or other media satisfactory to the department. The department may require an employer, self-insured employer, or insurer to use electronic, magnetic, or other reporting media after considering the extent to which it will help the employer, self-insured employer, or insurer meet or exceed the applicable reporting requirements and performance standards in subs. (1) to (3).

2. The directive that requires reporting by electronic, magnetic, or other media shall be in writing and set forth terms and conditions that include a deadline for compliance.

3. An employer, self-insured employer, or insurer may request a waiver within 60 days of the date of the department's directive that requires reporting by electronic, magnetic, or other media. The department shall, within its discretion, grant the waiver if the department is satisfied that the employer, self-insured employer, or insurer has established good cause.

SECTION 6. DWD 80.52 is created to read:

DWD 80.52 Payment of permanent disability where the degree of permanency is disputed. Where injury is conceded, but the employer or the employer's insurer disputes the extent of permanent disability, payment of permanent disability shall begin:

(1) Within 30 days of a report that provides the permanent disability rating, in the amount of the permanency set forth in the report; or

(2) Within 30 days after the employer or insurer receives a report from an examination performed under s. 102.13(1)(a), Stats., in the amount of the permanent disability found as a result of that medical examination, if any. If such an examination had not previously been performed, the employer or employer's insurer

must give notice of a request for such an examination within 30 days of a receiving a report that establishes the permanent disability under sub. (1), and in the event that a report from the examination is not available within 90 days of the request for the examination, the employer and insurer shall begin payment of the permanent disability set forth in the report under sub. (1).

SECTION 7. DWD 80.62 (7)(a)3., 80.65, 80.72 (3)(a), and 80.73 (3)(a) are amended to read:

DWD 80.62 (7)(a)3. To seek reimbursement from employers under s. 102.82(1), Stats., for payments made from the fund to or on behalf of employees or their dependents and for claims administration expenses.

DWD 80.65 Notice of cancellation or termination of a policy under s. 102.31 (1) (a), Stats., shall be given ~~by certified mail, or personal service~~ to the Wisconsin compensation rating bureau, as defined in s. 626.02 (2), Stats., rather than to the department. The notice may be given by certified mail; personal service; facsimile machine transmission; electronic mail; or any electronic, magnetic**,** or other medium approved by the department. Whenever the Wisconsin compensation rating bureau receives notice of cancellation or termination pursuant to this section, it shall immediately notify the department of cancellation or termination.

DWD 80.72 (3)(a) In a case where liability or the extent of disability is in dispute, an insurer or self-insured employer shall provide written notice of the dispute to the health care provider within 30 days after receiving a completed bill that clearly identifies the provider's name, address and phone number; the patient–employee; the date of service; and the health service procedure, unless there is good cause for delay in providing notice. In a case where liability or the extent of disability is not in issue, and a health care provider charges a fee which an insurer or self-insurer refuses to pay because it is more than the formula amount, the insurer or self-insurer shall, except as provided sub. (6) (b), mail or deliver written notice to the provider within 30 days after receiving a completed bill which clearly identifies the provider's name, address and phone number; the patient-employee; the date of service; the health service procedure; and the amount charged for

each procedure. The notice from the insurer or self-insurer to the provider shall specify all of the following:

DWD 80.73 (3) (a) In a case where liability or the extent of liability is in dispute, an insurer or self-insured employer shall provide written notice of the dispute to the health care provider within 60 days after receiving a bill that documents the treatment provided to the worker, unless there is good cause for delay in providing notice. An insurer or self-insurer which refuses to pay for treatment rendered to an injured worker because it disputes that the treatment is necessary shall, in a case where liability or the extent of liability is not an issue, give the provider written notice within 60 days of receiving a bill which documents the treatment provided to the worker. The notice shall specify all of the following:

SECTION 8. EFFECTIVE DATE. This rule shall take effect on the first day of the month following publication in the Wisconsin administrative register as provided in s. 227.22 (2)(intro.), Stats.

AMENDMENTS TO DWD 80 OF THE WISCONSIN ADMINISTRATIVE CODE
PLAIN LANGUAGE SUMMARY
~~EFFECTIVE MAY 1, 2004~~

1. **Supplementary Reports by Employers and Insurance Carriers**. Under the current rule self-insured employers and insurance carriers are required to submit supplemental reports only if the reported injury meets the definition of lost time under DWD 80.02(1)(a). This amendment will require self-insured employers and insurance carriers to submit supplemental reports for all claims reported whether or not they meet the lost-time definition. The amendment will not require the reporting of no lost time or denied claims but will require the filing of supplemental reports for all claims that are reported. DWD 80.02(2)(b) of the Wisconsin Administrative Code.

2. **Written Notice by Employers and Insurance Carriers**. This amendment will require self-insured employers and insurance carriers to provide notice of denial to the Worker's Compensation Division and employees for claims which are initially reported and paid but later denied. The current rule is inconsistent with the requirement to report only compensable claims. DWD 80.02(g)2 of the Wisconsin Administrative Code.

3. **Written Notice by Employers and Insurance Carriers**. DWD 80.02(2)(h) of the Wisconsin Administrative Code is repealed. Under the current rule self-insured employers and insurance carriers are required to provide the Worker's Compensation Division with written notice related to denial or continued investigation of claims with copies of the report provided to employees. A new subsection will be created to cover this situation.

4. **Notice by Employers and Insurance Carriers to Employees**. DWD 80.02(2m) of the Wisconsin Administrative Code is created. This amendment will clarify that notice of denial or investigation of claims is to be sent to the employee along with a statement advising the employee of the right to a hearing before the department. The notice of investigation will specify if additional medical or other information is needed to complete the investigation. This notice must be sent to the employee and is not required to be sent to the Worker's Compensation Division.

5. **Electronic Reporting**. This amendment will permit the Worker's Compensation Division to require self-insured employers and insurance carriers to submit all or selected information in reports or amendments to reports to be filed via electronic, magnetic or other media satisfactory to the Worker's Compensation Division. Under the current rule self-insured employers and insurance carriers may request to submit required reports electronically but are not required to do so. This amendment will allow the Worker's Compensation Division discretion to require electronic reporting to help the self-insured employer or insurance carrier to meet reporting requirements. DWD 80.02(3m) of the Wisconsin Administrative Code.

6. **Payment of Permanent Disability**. DWD 80.52 of the Wisconsin Administrative Code will be created to establish when payment for compensation for permanent disability must begin in cases in which the self-insured employer or insurance carrier concedes liability but

disputes the extent of permanent disability. Under this rule payment is to begin (1) within 30 days after the self-insured employer or insurance carrier receives a report which provides a permanent disability rating or, (2) within 30 days after receiving a report from an examination performed under s. 102.13(1)(a), Wis. Stats., in the amount of permanent disability found as a result of the examination and, (3) if no examination was previously performed the self-insured employer or insurance carrier must give notice of a request for an examination within 30 days of receiving a report which establishes permanent disability and payment must begin within 90 days of the request for the examination in the event the examining practitioner's report is not available by that date.

7. **Uninsured Employers Fund**. This amendment allows the Worker's Compensation Division to seek reimbursement from an uninsured employer for payments made by the Uninsured Employers Fund for claims administration expenses. DWD 80.62(7)(a)3 of the Wisconsin Administrative Code.

8. **Notice of Cancellation or Termination**. This amendment permits insurance carriers to give notice of cancellation or termination of insurance policies to the Wisconsin Compensation Rating Bureau by facsimile machine transmission, electronic mail or any electronic, magnetic or other medium approved by the Worker's Compensation Division. The current rule permits notice only by certified mail or personal service. The rule is amended to authorize notice by different means to comply with the amendment to s. 102.31(2)(a), Wis. Stats. DWD 80.65 of the Wisconsin Administrative Code.

9. **Reasonableness of Fee Disputes**. This amendment requires self-insured employers and insurance carriers to raise disputes over liability or the extent of disability and give notice within 30 days after receiving a completed bill from a healthcare provider unless there is good cause for the delay in providing this notice. DWD 80.72(3)(a) of the Wisconsin Administrative Code.

10. **Necessity of Treatment**. This amendment requires self-insured employers and insurance carriers to raise disputes over liability or the extent of liability and give notice within 60 days after receiving a bill from the healthcare provider unless there is good cause for the delay in providing this notice. DWD 80.73(3)(a) of the Wisconsin Administrative Code.

(Name and address of health care provider)

To:		Date:	

Employee/Patient:	
Social Security No.:	
Employer:	
Insurer:	
Our Claim No.:	
Date of Injury:	

Re: **Notice as to denial of bill for treatment expense on worker's compensation claim**

Dear Health Care Provider:

We are the (insurance carrier)(self-insured employer)(claims adjusting company)(third party administrator) on the worker's compensation claim described above. We have your bill(s) for treatment on this claim, as follows:

Your Account No.:	
Date(s) of Service for Disputed Treatment:	
Amount(s) Charged:	
Amount(s) Disputed:	

We are unable to make payment on the bill(s) for treatment you submitted because:

- ☐ This is a denied claim, on the basis that there was no injury arising out of the employment.
- ☐ It appears that the treatment was not directed to cure or relieve the effects of the conceded employment injury.
- ☐ We need a copy of the record(s) of the treatment to review before we can make payment on the bill. Please resubmit the bill with a copy of the record(s) of the treatment being billed.
- ☐ We are unable to match the bill with any known claim. We have no notice of any injury.
- ☐ We just received notice of this claim and an investigation is now pending. We do not yet have sufficient information about the claim to accept responsibility for the treatment expense. It will be 30 days before we will be able to accept or deny the bill.
- ☐ The bill indicates that it is *not* for treatment of an employment injury.

- ☐ The bill is not complete. It does not include either the CPT codes or other standard procedure codes as required by Wis. Stat. section 102.16(2), Wis. Admin. Code section 80.73, and Wis. Admin. Code section Ins 3.65.
- ☐ The bill represents out-of-state treatment that is not covered by section 102.42(2) of the Wisconsin Worker's Compensation Act, because it was not: (1) upon mutual consent, or (2) on a referral by a Wisconsin practitioner.
- ☐ The employee-patient has exceeded the two choices of treating practitioners allowed by section 102.42(2) of the Wisconsin Worker's Compensation Act.
- ☐ This claim has already been resolved on a compromise settlement that includes treatment expense, so that we have no further liability for any treatment expense.
- ☐ This claim is barred by the statute of limitations under section 102.17(4) of the Wisconsin Worker's Compensation Act, so that we have no further liability for any treatment expense.
- ☐ We believe that the bill represents treatment that is not medically necessary. There is a contested worker's compensation proceeding now pending and we propose to litigate the issue as to necessity of the treatment at a hearing before an administrative law judge, as provided by Wis. Stat. section 102.18(1)(bg)2.
- ☐ We previously gave you notice that the necessity of treatment was being disputed, and more than 9 months have elapsed without you having filed a Necessity of Treatment Dispute Resolution Request form (WKC-9380) with the Wisconsin Worker's Compensation Division, DWD, so that the bill is now barred.
- ☐ The bill represents a charge for preparation of a routine report on a worker's compensation claim. It is the policy of the Worker's Compensation Division, Wisconsin Department of Workforce Development that treating practitioners on worker's compensation claims are expected to provide routine reports to the employer/insurer without any additional charge for doing so.
- ☐ The bill represents a charge for copies of treatment records, and the rate charged exceeds the rate limited by statute. Wis. Stat. section 102.13(2)(b) provides that charges for providing copies of treatment records on worker's compensation claims are limited to a maximum of $.45 per page (but subject to a minimum charge of $7.50), plus *actual* postage and Wisconsin sales tax.
  - ☐ We are forwarding our check in the amount of $_____ for the statutory rate.
- ☐ Other: _____

Very truly yours,

_____
[Name of insurance company/self-insured employer/etc.]

_____
[Name of claims representative]

(Name and address of health care provider)

	Date:	

Employee/Patient:	
Social Security No.:	
Employer:	
Insurer:	
Our Claim No.:	
Date of Injury:	

Re: **Notice as to disputed treatment expense for unnecessary treatment**

Dear Health Care Provider:

We are the (insurance carrier)(self-insured employer)(claims adjusting company)(third party administrator) on the worker's compensation claim described above. We have your bill(s) for treatment of the employee on this claim, as follows:

Your Account No.:	
Date(s) of Service for Disputed Treatment:	
Amount(s) Charged:	
Amount(s) Disputed:	

We are disputing liability for the bill(s) you submitted on the basis that the treatment you provided to this employee-patient was not necessary. We are writing to give notice of the dispute as to the necessity of the treatment, as provided by Wis. Stat. section 102.16(2m) and Wis. Admin. Code section DWD 80.73(3).

Our Basis for Disputing Necessity of Treatment

We believe the treatment was unnecessary for the following reason(s):

(Describe the basis for disputing the necessity of treatment. Describe the organization and the credentials of any person who provides supporting medical documentation.)

Your Right to Submit Dispute to the Worker's Compensation Division

You have the right to submit this dispute to the Wisconsin Worker's Compensation Division, Department of Workforce Development for review and resolution at any time within nine months of this notice. However, at least 30 days before you submit the dispute to the Division, you must first submit a written explanation to us explaining why you believe the treatment was necessary to cure and relieve the effects of the injury. Your explanation must include a diagnosis of the condition for which treatment was provided. You should write to us at the following address:

(Name and address of insurance carrier/self-insured employer/etc., and name of claim representative)

If you submit a written explanation to us, we will notify you within 30 days to advise you whether we accept your explanation.

Prohibition on Attempting Collection from Patient

We are also required to notify you that you are now prohibited by law from collecting a fee for the disputed treatment from, or bringing an action for collection of the fee for that disputed treatment against, the employee-patient who received the treatment, as provided by Wis. Stat. section 102.16(2m)(b).

Dispute Resolution Process and Assessment of Costs

Once the dispute is filed with the Wisconsin Worker's Compensation Division, Department of Workforce Development, the Division will obtain an expert opinion on the treatment in dispute

from an impartial health care services review organization. If chiropractic treatment is involved, the Division will select a chiropractic expert from a panel of experts selected by the Division.

The Division will charge one of the parties for the actual costs of obtaining the expert's opinion. Under the law, the insurer/employer is responsible for paying the full cost the first time an individual health care provider submits a dispute, unless the Division determines that the provider's position is frivolous or based upon fraudulent representations. In any subsequent dispute involving that health care provider, whether the dispute is with our company or another insurer, the losing party—the health care provider or the insurer/employer—must pay the full cost of obtaining the expert's opinion to resolve the dispute.

Source for Additional Information

If you wish to request information on submitting a dispute to the Division, you should call the Division's Medical Cost Dispute Unit at (608) 267-9407, or you may write to them at the following address: Medical Cost Dispute Unit, Wisconsin Worker's Compensation Division, P.O. Box 7901, Madison, WI 53707-7901. You may obtain a Necessity of Treatment Dispute Resolution Request (WKC-9380) form from them. Information is also available from their Web site on the Internet at: http://www.dwd.state.wi.us/wc/medical/medical_cost_disputes.htm.

Very truly yours,

[Name of insurance company/self-insured employer/etc.]

[Name of claim representative]

☐ Please be advised that we intend to also dispute any additional bills for treatment that you submit on this claim, and that this notice should be considered to also apply to any such future bills.