



WEST VIRGINIA WORKERS' COMPENSATION

SELF-INSURANCE SELF-ADMINISTRATION TRAINING

**Application of West Virginia Workers' Compensation
Statutes and Regulations**

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WORKERS' COMPENSATION 101

Introduction:

To understand the West Virginia Workers' Compensation system requires not only a detailed understanding of the applicable statutes and regulations but also knowledge of how the system as a whole operates. The first step in understanding the peculiarities of the West Virginia Workers' Compensation System is to understand how the different parties fit into the system. As a Self-Insured Self Administering employer, the employer is now one of the most important parties in their workers' compensation claims. In addition to being the employer, the Self Insured employer is now the decision maker in all of its workers' compensation claims. The other parties include the injured worker, also known as the claimant, and the regulatory body which regulates the Workers' Compensation System, the Office of the Insurance Commissioner of West Virginia, known as the OIC.

Previously, prior to January 1, 2006, the employer insured its West Virginia Workers' Compensation liability through the state operated Workers' Compensation Fund operated by the West Virginia Workers' Compensation Commission. After January 1, 2006, The employer purchased insurance for its workers' compensation liability through BrickStreet Mutual Insurance Company. Under both the Workers' Compensation Commission and BrickStreet, a third-party (either the WCC or BrickStreet) made decisions in each of the employer's West Virginia workers' compensation claims and paid benefits according to those determinations. However, beginning very soon, the employer will be rendering decisions on all of the workers' compensation claims filed against it and paying benefits in accordance with those decisions. These decisions and the claim practices of the employer will be monitored and reviewed by the OIC.

Claims Process:

The West Virginia Workers' Compensation system was created by the West Virginia Legislature in 1913. The creation of this system was seen as a trade off between employer's and employees such that the employer's obtained immunity from civil liability for work place injuries and the employees received benefits for such work place injuries without the need to establish negligence or intent. Thus, the workers' compensation system is a **no-fault system**. West Virginia Code § 23-4-1(a) states that:

Subject to the provisions and limitations elsewhere in this chapter, the commission shall disburse the workers' compensation fund to the employees of employers subject to this chapter who have received personal injuries **in the course of and resulting from their covered employment...**

(Emphasis added). Thus, an employee who sustains an injury (or develops a disease) **in the course of and resulting from his or her employment** has sustained a

“compensable” injury for purposes of workers’ compensation benefits. In the case of an injury there must have been an **isolated fortuitous event** in the course of and resulting from the employment which gave rise to the injury. As noted, “injuries’ are not the only conditions which are compensable under the workers’ compensation system. The statute specifically provides provisions for occupational pneumoconiosis and occupational hearing loss. Further, the statute states:

. . . Except in the case of occupational pneumoconiosis, a disease shall be deemed to have been incurred in the course of or to have resulted from the employment only if it is apparent to the rational mind, upon consideration of all the circumstances (1) that there is a direct causal connection between the conditions under which work is performed and the occupational disease, (2) that it can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, (3) that it can be fairly traced to the employment as the proximate cause, (4) that it does not come from a hazard to which workmen would have been equally exposed outside of the employment, (5) that it is incidental to the character of the business and not independent of the relation of employer and employee, and (6) that it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction. . . .

W. Va. Code § 23-4-1(f) (2003). Therefore, there are four types of workers’ compensation claims – 1) Personal Injuries (PI); 2) Occupational Diseases (OD); 3) Occupational Pneumoconiosis (OP); and 4) Occupational Hearing Loss (HL).

When an employee sustains an injury in the course of and resulting from his or her employment the initial claim application is commonly known as a “**WC-1 Employees’ and Physicians’ Report of Injury**” form. Please note that there are separate and distinct forms for filing for Occupational Pneumoconiosis and Occupational Hearing Loss claims, however these are also known as WC-1 forms, either WC-1OP or WC-1HL.

Section I of the WC-1 form is completed by the injured worker (hereinafter “claimant”) and Section II is completed by the initial medical provider. The time limitation for filing an application for benefits (WC-1) is set forth in West Virginia Code § 23-4-15 and permits a claimant to file an application for benefits based on an **injury** for up to six (6) months after the date of injury. If the application is not filed within that six (6) month period the claim is jurisdictional barred. For Occupational Disease claims, and Occupational Hearing Loss claims, West Virginia Code § 23-4-15 states:

To entitle any employee to compensation for occupational disease other than occupational pneumoconiosis under the provisions of this section, the application for compensation shall be made on the form or forms prescribed by the commission and filed with the commission within three years from and after the day on which the employee was last exposed to the particular occupational hazard involved or within three years from and after the [date the] employees' occupational disease was made known to him or her by a physician or which he or she should reasonably have known, whichever last occurs, and unless filed within the three-year-period, the right to compensation under this chapter shall be forever barred, such time limitation being hereby declared to be a condition of the right and therefore jurisdictional...

W. Va. Code §23-4-15(c). Thus, the statute of limitations for an occupational disease claim is three years from the date of last exposure or the date the claimant knew or should have known that his or her occupational disease occurred in the course of and as a result of his or her employment.

Pursuant to West Virginia Code § 23-4-1(b) the employer has five (5) days from receipt of the claimant's completed WC-1 form to complete the "**WC-3 Employers' Report of Injury**" form. The employer, at this point, may question the compensability of a claim and provide evidence and argument as to why the claimant's application for benefits should be denied. While it may seem confusing, Self-Administering Self-Insured employers are still required to complete this form.

Once an application for benefits is received The Self-Insured employer, pursuant to West Virginia Code §23-4-1c, may either hold the claim compensable, reject the claimant's application for benefits or may hold the claim conditionally compensable pending the receipt of additional medical evidence or for the development of additional evidence to make a determination.

Following the decision on the claimant's application, if the claim is held compensable the claimant is entitled to such medical benefits as are medically necessary and reasonably required (see 85 C.S.R. §20), temporary total disability benefits for period in which the claimant is unable to return to work due to the compensable injury or condition, permanent partial disability benefits for any permanent impairment directly related to the compensable injury or disease (see 85 C.S.R. § 20 and AMA Guides to the Evaluation of Permanent Impairment, 4th Ed.) as well as vocational rehabilitation services which may be necessary to return to claimant to employment.

During the course of a claim, any order issued by the employer, which is not interlocutory in nature is protestable by either the claimant or the employer. West Virginia Code §23-5-1(b) states that:

Except with regard to interlocutory matters and those matters set forth in subsection (d) of this section, upon making any decision, upon making or refusing to make any award or upon modification or change with respect to findings or orders, as provided by section sixteen [§ 23-4-16], article four of this chapter, the commission shall give notice, in writing, to the employer, employee, claimant or dependent as the case may be, of its action. The notice shall state the time allowed for filing an objection to the finding. The action of the commission is final unless the employer, employee, claimant or dependent, shall, within thirty days after the receipt of the notice, object in writing, to the finding.

W. Va. Code § 23-5-1. Thus, any party has thirty (30) days to protest an order issued by the Insurer. However, West Virginia Code § 23-5-6 permits an additional 30 day period for filing a protest to the employers order based upon a request for “an extension of the time period showing good cause or excusable neglect, accompanied by the objection or appeal petition.”

Please note that there may be occasions when it is in The employer’s best interests to issue a decision and then protest that decision.

All protests to any order issued by the employer are filed with the Workers’ Compensation Office of Judges.

Litigation Process

Office of Judges (OOJ)

As noted above, all protests by any party, to an order issued by the employer are filed with the Office of Judges pursuant to West Virginia Code § 23-5-9. This statute sets forth the duties and obligations of the Office of Judges regarding the litigation of protests to an Insurer’s order. Further, pursuant to West Virginia Code § 23-5-8 the Chief Administrative Law Judge¹ is charged with promulgating rules of practice and procedure before the Office of Judges. These rules are contained in 93 C.S.R. §§ 1 and 2.

The Office of Judges, upon receipt of a protest by a party to a claim issues an “Acknowledgement and Automatic Time Frame Order” (ATFO’s) which acknowledges that the protest has been filed and sets forth the time frames for each party to adduce and submit evidence. These Time Frame Orders (TFO’s) can be either concurrent (for issues such as medical treatment or dual protests) with both parties time frames expiring at the same time or consecutive (for issues such as permanent partial disability awards) with the protesting parties time frame expiring first and the responding parties time frame expiring last. However, the Office of Judges liberally allows for the extension of the TFO’s upon

¹ Presently the Chief Administrative Law Judge is Timothy Leach.

a showing of “good cause” and further allows extensions for the submission of rebuttal evidence in concurrent and consecutive time frames.

The litigation process before the Office of Judges is best described as linear. While the majority of litigation tasks are similar, if not identical, to civil litigation, there is no “trial”. Further, neither the Rules of Civil Procedure nor the Administrative Procedures Act (APA) applies to the litigation of workers’ compensation claims.

The “trial” of the claim begins when the ATFO is entered and ends at the expiration of the stated time frames. During the applicable time frame each party develops and submits relevant evidence, including but not limited to, responses to discovery, medical records, other relevant records, affidavits, sworn statements, deposition transcripts, hearing transcripts, and physical evidence (photographs, videotapes, etc.). In contrast to civil litigation where discovery is developed prior to the “trial” and then submitted at “trial”, before the Office of Judges evidence is submitted as it is adduced blindly to the Office of Judges.² Thus, the Office of Judges record is created by the submission of evidence and includes only that evidence which has been submitted by a party.

Pursuant to the Office of Judges rules, any party may request a hearing on any issue to take testimony or present legal arguments. The practice, however, is that hearings are generally used for the taking of testimony of claimant’s, lay witnesses, and doctors, which could not otherwise be scheduled by deposition. Once a hearing is requested the Office of Judges sets the hearing on the next available docket at the hearing docket closest to the residence of the claimant at the time of the injury. The Office of Judges has three main offices – Charleston, Beckley and Fairmont. However, the Office of Judges also holds hearing dockets in the following locations: Elkins, Huntington, Keyser, Lewisburg, Logan, Madison, Martinsburg, Morgantown, Moundsville, Parkersburg, Pineville, Princeton, Ripley, Summersville, Weirton, Welch, Weston, Wheeling, and Williamson. These hearings are presided over by Hearing Examiners which can rule on motions and objections but are not attorneys. The hearings are set as “cattle calls”, thus, while the notice may state 9:00, your claim may not be the first called and may not be called until 10:00 or 11:00. The hearing transcript is provided to all parties and is a part of the record in a claim.

Additionally, any motions which a party wishes to file during the litigation of an issue are filed in the same manner with the Office of Judges. Please note that the Office of Judges rarely grants any dispositive motions, such as motions to dismiss based on jurisdictional issues, instead waiting for the final decision to rule on such motions. There are two schools of thought regarding the filing of dispositive motions. One posits that it is better to file the dispositive motion to make the record clear regarding the clients position and to obtain “two bites at the apple”. The down side to this is that if a motion is denied (which will be in an interlocutory order which is non-appealable), then a claimant

² Note that Administrative Law Judges are assigned randomly to decide claims so there is no way to know what judge will be deciding your claim. Further, the Office of Judges has continued the practice of using Non-Attorney Adjudicators (read Paralegal) to render decisions on issues.

can argue that the denial of the dispositive motion is *res judicata* and therefore the Administrative Law Judge can not rule on the issue in the final decision. The second school of thought posits that it is more cost effective to present any dispositive motions in the Closing Argument, thus the client is not paying for two separate motions on the same issue. Both approaches have their pros and cons.

Following the expiration of the last time frame on an issue, and within 10 days, any “Closing Arguments” must be filed with the Office of Judges for them to be considered by the individual assigned to render the decision. A “Closing Argument” is a statement of the issue in litigation, the relevant facts contained in the record, the law applicable to those facts, and the request for relief sought from the Office of Judges.

It should be noted that ALL evidence, motions, arguments or correspondence submitted to the Office of Judges MUST be accompanied by a document submission form. Further, the September 1, 2005, changes to the Office of Judges rules also eliminated automatic designations of the record. As of January 1, 2006, the Office of Judges will no longer have access to the “Claim File”. Thus, the only evidence that can or will be considered by the Office of Judges is that evidence which is actually submitted to the Office of Judges. While in the past documents such as the WC-123 form, the reopening application or the report upon which an order was based were automatically designated and reviewed by the adjudicator, now these documents must be submitted by a party for the Office of Judges to consider the same. However, once a document has been submitted into the Office of Judges file it may be designated on subsequent issues and does not need to be resubmitted.

Please note that the Office of Judges has implemented procedural rules to discourage the practice of protesting an issue and failing to submit evidence. (See 93 C.S.R. §1-10 *et al.*). This rule is known as the “No Evidence Rule” and is based on the premise that the protesting party carries the burden to establish that the Insurer erred in rendering its decision. Thus, if the protesting party fails to timely submit evidence in support of his or her protest the Office of Judges will affirm the order in litigation by rule. The protesting party may overcome this rule by timely submitting evidence or by submitting a “Closing Argument” within their time frame.

One of the most significant changes to the litigation process before the Office of Judges is the “Expedited” litigation process created in the 2005 amendments to the Workers’ Compensation statute. West Virginia Code § 23-4-1c (2005) addresses three separate issues which the Legislature has mandated the claimant, who has been denied benefits, be afforded an expedited adjudication process. These three issues include:

- 1) The claimant’s protest to an order rejecting the claimant’s application for benefits;
- 2) The claimant’s protest to an order which holds a claim compensable on a No Lost-Time basis (essentially a denial of initial temporary total disability benefits); and
- 3) The denial of authorization of medical benefits.

The Office of Judges, pursuant to the Legislative mandate to afford an expedited adjudication process, promulgated 93 C.S.R. § 1-9 *et al.* These regulations became effective on September 1, 2005. Essentially, when a claimant protests an order which falls into one of the above three classifications, the claimant has the option, within 15 days of receipt of the AATFO to “opt in” or elect to participate in the expedited hearing process. Thus, unless a claimant affirmatively “opts in” to the process the normal time frames and adjudication process apply.

However, if a claimant “opts in” to this process the time frames for the development of evidence are abbreviated and an expedited hearing is mandated. Once the claim is placed into the expedited process it can not be removed except by agreement of the parties for extraordinary good cause. Further, once notification is received by the Office of Judges that the claimant wishes to “opt in” a hearing will be scheduled at the next “Expedited Hearing Docket”, which should be between 25 and 45 days from receipt of the claimant’s election. The hearing is limited to a total of 30 minutes, 15 minutes for each side. At the conclusion of the hearing the time frames are extinguished and the claim is submitted for a decision.

Following a review of the evidentiary claim file developed during the litigation of an issue the Office of Judges will render a decision regarding the protest in issue. Thereafter, any party who disagrees with the decision of the Office of Judges may appeal that decision to the Workers’ Compensation Board of Review. If the Office of Judges reverses a decision which denied benefits and the employer appeals the statutes and regulations provide that any benefits payable are stayed until the Board of Review renders a decision. Please note, that the Notice of Appeal is filed with the Workers’ Compensation Board of Review.

Workers’ Compensation Board of Review

The Workers’ Compensation Board of Review is the only intermediate appellate court in the West Virginia Judicial system. The Board of Review, in its present incarnation, was established by the Legislature in the 2003 amendments to the Workers’ Compensation Statute. Prior to that the appellate body was know as the Workers’ Compensation Appeal Board.

The Board of Review is made up of three Judges who are appointed to six year terms by the Governor. Only two of the three can be from the same political party. Presently, the members include, W. Jack Stevens (a former Circuit Court Judge), Rita Hedrick-Helmick (wife of Senator Walt Helmick) and Robert G. Wolpert 9 a former clerk for the old WC Appeal Board). Mr. Wolpert’s term is set to expire in 2006.

Once a Notice of Appeal is filed with the Board of Review, the Board of Review acknowledges the appeal and allows the Appellant sixty (60) days from the date of the acknowledgement to file an Appellant’s brief and the Appellee thirty (30) days from receipt of the Appellant’s brief to file a response. If the Appellant is *pro se* there is no

requirement that he or she file a brief, however, the Appellee brief is due thirty (30) days from the date the Appellant's brief would have been due (or ninety (90) days from the date of the acknowledgment of the appeal). No reply briefs are permitted unless requested by the Board.

The Workers' Compensation Board of Review has promulgated rules of practice and procedure which are contained in 102 C.S.R. § 102-1 *et al.* These rules contain a description of the mandatory contents of the briefs. These include 1) Issue Presented; 2) Statement of Facts; 3) Legal Authorities; 4) Argument; and 5) Conclusion. Briefs are limited to 20 pages, however, if a brief exceeds the 20 page limit and Motion to Accept Brief in Excess of 20 Page Limit must be filed concurrent with the filing of the brief. The Board of Review discourages the inclusion of attachments or exhibits as they have access to the Office of Judges file. The only time attachments or exhibits should be attached to a Board of Review brief is when they are in support of a motion to Remand contained in the brief. Further, an original and one (1) copy should be served on the Board of Review and one (1) copy to each of the opposing parties.

Following the expiration of the briefing schedule and receipt of all briefs, the Board of Review will notify the parties of their right to present oral argument to the Board of Review. Once this notice is received a determination as to whether to present oral argument must be made and the form returned to the Board of Review within ten (10) days. If either party requests oral argument the Board of Review will set the claim for hearing and notify the parties of the hearing date and time.

Board of Review hearings are set as a "cattle call" although dockets are available outside the hearing room. The Board of Review's clerk will call all cases set for the docket to confirm that someone has appeared to argue. Claims can be submitted by agreement of the parties without oral argument at this time.

Arguments before the Board of Review have a reasonable time limit. The Appellant presents his or her argument first and responds to questions from the Board then the Appellee responds and answers questions from the Board. Following the argument the claim is submitted for decision and a written opinion is issued by the Board of Review.

Following the issuance of the Board of Review's order any party has thirty (30) days to petition the West Virginia Supreme Court of Appeals for review of the order.

West Virginia Supreme Court of Appeals

Review by the West Virginia Supreme Court of Appeal is by petition, not by right. A petition for appeal including the Issue Presented, a Statement of Facts, Statement of Errors by the Board of Review; Legal Authorities, Argument, and Conclusion, must be filed within thirty (30) from the date of the Board of Review order. Unlike Board of Review briefs, petitions for appeal or responses thereto must be accompanied by exhibits.

After the Petitioner files his or her petition the Respondent has thirty (30) days to file a Response to Petition.

If the Court accepts the petition a briefing schedule is entered and the parties further brief the issue. Thereafter, the Court will enter a Memorandum Order stating their decision, followed in thirty (30) days by a Mandate Order. A motion for reconsideration may be filed within thirty (30) days of the Memorandum Order, but not after the Mandate Order has been entered.

Self Insurance

Self-Insurance is a privilege and not a right. This privilege arises pursuant to West Virginia Code § 23-2-9 which states:

§ 23-2-9. Election of employer or employers' group to be self-insured and to provide own system of compensation; exceptions; catastrophe coverage; self administration; rules; penalties; regulation of self-insurers.

(a) Notwithstanding any provisions of this chapter to the contrary, the following types of employers or employers' groups may apply for permission to self-insure their workers' compensation risk including their risk of catastrophic injuries.

(b)

(1) Notwithstanding any provision in this chapter to the contrary, self-insured employers shall, effective the first day of July, two thousand four, administer their own claims. The executive director shall, pursuant to rules promulgated by the board of managers, regulate the administration of claims by employers granted permission to self-insure their obligations under this chapter. Such rules shall be promulgated at least thirty days prior to the first day of July, two thousand four. A self-insured employer shall comply with rules promulgated by the board of managers governing the self-administration of its claims.

(2) An employer or employers' group who self-insures its risk and self-administers its claims shall exercise all authority and responsibility granted to the commission in this chapter and provide notices of action taken to effect the purposes of this chapter to provide benefits to persons who have suffered injuries or diseases covered by this chapter. An employer or employers' group granted permission to self-insure and self-administer its obligations under this chapter shall at all times be bound and shall comply fully with all of the provisions of this chapter. **Furthermore, all of the provisions contained in article four [§§ 23-4-1 et seq.] of this chapter pertaining to disability and death benefits are binding on and shall be strictly adhered to by the self-insured employer in its administration of claims presented by employees of the self-insured employer. Violations of the provisions of this chapter and such rules relating to this chapter as may be**

approved by the board of managers may constitute sufficient grounds for the termination of the authority for any employer to self-insure its obligations under this chapter. Claim notices currently generated by the commission on behalf of self-insured employers must be generated and sent by the self-insured employer or its third-party administrator.

* * *

(l) Any employer subject to this chapter, who elects to carry the employer's own risk by being self-insured employer and who has complied with the requirements of this section and of any applicable rules, shall not be liable to respond in damages at common law or by statute for the injury or death of any employee, however occurring, after the election's approval and during the period that the employer is allowed to carry the employer's own risk.

(m) An employer may not hire any person or group to self-administer claims under this chapter as a third-party administrator unless the person or group has been determined to be qualified to be a third-party administrator by the commission pursuant to rules adopted by the board of managers. Any person or group whose status as a third-party administrator has been revoked, suspended or terminated by the commission shall immediately cease administration of claims and shall not administer claims unless subsequently authorized by the commission.

(n) All regulatory, oversight, and document gathering authority provided to the commission under section nine [§ 23-2-9], article two, chapter twenty-three shall transfer to the insurance commissioner and the industrial council upon termination of the commission.

As noted the Office of the Insurance Commissioner of West Virginia has regulatory oversight over Self-Insured Self-Administering employers. The regulations applicable to Self-Insurance Self-Administration are contained in 85 C.S.R. § 18-1 et seq. There are numerous sections which must be reviewed and complied with. These time frames and deadlines included in 85 C.S.R. § 18 will be discussed below as they apply to the various issues arising during claims management.

Notification of Self-Insurance Status:

85 C.S.R. § 18-15.2. Notifications.

a. Each new self-insured employer shall within **five (5) working days** notify, in writing, the following persons, entities or adjudicatory bodies involved in active claims

matters that that the self-insured employer is self-administering its claims.

1. Claimants;
 2. Claimant representatives;
 3. All parties to the claim;
 4. All adjudicatory bodies that are currently proceeding in the claim; and
 5. Vendors who are rendering services in the claim.
- b. Each self-insured employer shall within five (5) days notify its employees that it is self-administering its claims. This notice must be posted at each of the employer's places of business within the State.
- c. The self-insured employer is required to state in each notice, whether the notice is individually written or posted, that the self-insured employer, and not the commission, is the primary contact for submitting invoices, claims inquiries, legal notices, medical reports and other communications concerning the claim.

85 C.S.R. § 18-15.1 sets forth in general the duties of the self-insured employer and states:

Effective July 1, 2004, all self-insured employers shall administer their own claims. An injured worker, who is an employee of a self-insured employer, is entitled to all of the same benefits, as those afforded to injured workers whose claims are administered by the workers' compensation commission. These same benefits include the proper and timely payment of medical bills and compensation.

85 C.S.R. § 18-15.1. Additionally, as a Self-Insured Self-Administering employer you are required not only to process all applications and requests for benefits but also are the official repository of the claim file in every claim filed against you as the Self-insured Employer. Previously, the Workers' Compensation Commission was the official repository of all claim records. However, with the evolution to a private insurance system and the Self-Administration of claims by Self-Insured Employers there is no central repository for claims records. Accordingly, each Self-Insured Employer and each private carrier is required to keep copies of all claim records in claims filed against them. Regarding Self-Insured Employers the applicable regulations, 85 C.S.R. § 18-15.6 states:

Maintenance of Claim Records. For all actions taken on or after July 1, 2004, the self-insured employer is required to maintain a detailed claim record, either in an electronic or paper format, for each claim. The claim record shall include, but not be limited to:

- a. The completed report of injury as prescribed in the forms of the commission;
- b. Wage calculations used to determine claimant benefits;
- c. Dates that the claimant ceased work and returned to work as a result of the compensable injury;
- d. Health care invoices;
- e. Medical and vocational reports and summaries of psychiatric reports, if so restricted by the psychiatrist;
- f. Motions, applications, and claim correspondence;
- g. Rulings issued by the self-insured employer, including denial of benefit rulings; and
- h. Rulings issued by all adjudicatory bodies involved with the claim, including the office of judges, the board of review and the West Virginia Supreme Court of Appeals.

85 C.S.R. § 18-15.6. Further, 85 C.S.R. § 18-15.7 states:

15.7. Date stamp; Claims records. The self-insured employer is required to date stamp each report of injury, health care invoice, medical and vocational report, motion, application, claim correspondence, ruling issued by the self-insured employer and ruling issued by adjudicatory bodies on the date received or sent, as applicable.

As the official repository of the claim record the Self-Insured Employer is also charged with providing a copy of the claim file to the claimant upon request. 85 C.S.R § 18-15.9 states:

15.9. Requests for Claims Records by Injured Workers or Their Representatives. The self-insured employer shall provide a copy of the claim record to the claimant or his authorized representative within ten (10) working days of

the date the written request is received by the self-insured employer. The initial copy of the record will be provided at no cost by depositing the claims records, postage prepaid in the United States mail. Subsequent copies will be provided at a reasonable charge.

85 C.S.R. § 18-15.9.

Claims Management

As noted, beginning in January of 2004, Self-Insured Employers were permitted to Self-Administer their own claims. The former Workers' Compensation Commission promulgated rules to govern Self-Insured Employers who self-administered their own claims. These rules are contained in 85 C.S.R. § 18. Additionally, 85 C.S.R. § 1 contains regulations applicable to the management of claims.

Definitions:

85 C.S.R. §18-3.6. "Decision" means a written statement issued by the commission containing the commission's findings of facts and conclusions as to any issue presented to the commission under this rule. Such decisions shall include, but not be limited to, notices of delinquency and notices of default. Any purported "decision" which is not in writing shall have no legal effect under this rule. "Decision" does not include a written statement in the form of e-mail.

85 C.S.R. § 18-3.24. "Rule" or "ruled" in the context of claims administration by a self-insured employer means the issuance of a written order to the claimant advising the claimant of actions undertaken or to be undertaken in the administration of a claim and advising the claimant of his or her rights to contest the ruling.

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

Compensability

Personal Injury Claims - Traumatic

There are four types of claims recognized in West Virginia: injury claims, occupational disease claims, occupational hearing loss claims and occupational pneumoconiosis claims. As noted, West Virginia Code § 23-4-1 sets forth the standard for holding a claim compensable. Simply stated there must be an injury which occurs in the course of and resulting from employment. Additionally, West Virginia Code § 23-4-15 requires that an application for benefits based on an injury, and not a disease, be filed within six (6) months of the date of injury.

West Virginia Code § 23-4-1a states:

Every employee who sustains an injury subject to this chapter, or his or her representative, shall immediately on the occurrence of the injury or as soon thereafter 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, with like notice or a copy of the notice to the workers' compensation commission stating in ordinary language the name and address of the employer, the name and address of the employee, the time, place, nature and cause of the injury, and whether temporary total disability has resulted from the injury. The notice shall be given personally to the employer or any of the employer's agents, or may be sent by certified mail addressed to the employer at the employer's last known residence or place of business. The notice may be given to the workers' compensation commission by mail.

(Emphasis added). W. Va. Code 23-4-1a (2003). Further, West Virginia Code § 23-4-15(a) states:

To entitle any employee or dependent of a deceased employee to compensation under this chapter, other than for occupational pneumoconiosis or other occupational disease, **the application for compensation shall be made on the form or forms prescribed by the commission and, effective upon termination of the commission, the insurance commissioner, and filed with the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable**, within six months from and after the injury or death, as the case may be, and unless filed within the six month period, the right to compensation under this chapter is forever barred, such time limitation being hereby declared to be a condition of the right and hence jurisdictional, and all proofs of dependency in fatal cases must also be filed with the commission within six months from and after the death. In case the employee is mentally or physically incapable of filing the application, it may be filed by his or her attorney or by a member of his or her family.

(Emphasis added). W. Va. Code § 23-4-15(a)(2005). Read in *para materia* these sections appear to state that an employee is required to provide the employer written notice of an alleged injury or claim and further that an employee, as a condition precedent to consideration of entitlement to benefits, is required to file an application for benefits, in writing, on the forms prescribed by the commission.

Additionally, a review of the regulations applicable to "Claims Management and Administration" defines filing as: "'Filing' shall mean actual receipt by the Commission." 85 C.S.R. § 1-2.6. Further, 85 C.S.R. 1-3.1 states:

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.

(emphasis added). 85 C.S.R. § 1-3.1. Thus, it appears that a claimant is required to file an application for benefits before any action is required. However, please noted that 85 C.S.R. §18-15.1(b) states:

The self-insured employer shall report all occupational disease claims and permanent total disability applications to the commission within five (5) days of the claimant's report of injury or disease. Occupational disease claims and permanent total disability claims shall thereafter be administered as set forth in section 15.12

Once an application for benefits is received the Self-Insured Employer has three options:

- 1) Hold the claim compensable
- 2) Reject the application for benefits
- 3) Hold the claim conditionally compensable

Regarding orders holding a claim conditionally compensable 85 C.S.R § 18-15.5(a)(1) states:

The self-insured employer may enter an order conditionally approving the claimant's application if the self-insured employer finds that obtaining additional medical evidence or evaluations or other evidence related to the issue of compensability would aid the self-insured employer in making a correct final decision. **Benefits shall be paid during the period of conditional approval; however, if the final decision is one that rejects the claim, then any such payments shall be considered an overpayment. In the event that a self-insured employer conditionally approves a claim, the employer shall render a final decision concerning the compensability of the claim within ninety (90) days of the receipt of the claimant's notice of the occurrence of such injury.**

Additionally, the Self-Insured Employer, in evaluating an application for benefits, must consider the follow as set forth in West Virginia Code § 23-4-1c(a)(2):

In making a determination regarding the compensability of a newly filed claim or upon a filing for a reopening of a prior claim pursuant to the provisions of section sixteen [§ 23-4-16] of this article based upon an allegation of recurrence, reinjury, aggravation or progression of the previous compensable injury or in the case of a filing of a request for any other benefits under the provisions of this chapter, the commission, successor to the commission, or other private carrier or self-insured employer, whichever is applicable, shall consider the date of the filing of the claim for benefits for a determination of the following:

- (A) Whether the claimant had a scheduled shutdown beginning within one week of the date of the filing;
- (B) Whether the claimant received notice within sixty days of the filing that his or her employment position was to be eliminated, including, but not limited to, the claimant's worksite, a layoff or the elimination of the claimant's employment position;
- (C) Whether the claimant is receiving unemployment compensation benefits at the time of the filing;
- (D) Whether the claimant has received unemployment compensation benefits within sixty days of the filing

In the event of an affirmative finding upon any of these four factors, the finding shall be given probative weight in the overall determination of the compensability of the claim or of the merits of the reopening request.

W. Va. Code § 23-4-1c(a)(2) (2005) (emphasis added). Additionally, 85 C.S.R. § 1-3.1 states:

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; 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.

(emphasis added). 85 C.S.R. § 85-1-3.1.

While every claim is different there is some basic information that should be investigated:

- 1) Confirm employment status and job duties of claimant
- 2) Investigate whether there were any witnesses to alleged incident
- 3) Review any accident reports, investigation reports, photos, etc.
- 4) If there are no witnesses and the claimant failed to report the alleged injury a statement/affidavit from the supervisor may be beneficial
- 5) Investigate prior claims
- 6) Review medical records from initial treatment to compare to WC-1 allegations: confirm whether claimant's allegations are consistent
- 7) Obtain medical records to review for preexisting and/or noncompensable conditions
- 8) Contact manager or supervisor to determine claimant's status – rumors about activities;

85 C.S.R. § 18-15.5(a) states:

Initial Rulings; Injury and occupational disease claims. Those claims based upon injuries and non-allocable occupational diseases that are filed with the self-insured employer, upon properly executed, prescribed forms created under the provisions of W. Va. Code §23-4-1a, **shall be ruled upon within fifteen (15) working days from the date of receipt by the self-insured employer.**

(emphasis added). 85 C.S.R. § 18-15.5(a). Thus, once an application for benefits is received the Self-Insured Employer must render a decision within fifteen (15) working days.

Once a determination is made regarding the compensability of an application for benefits an order should be issued holding the claim compensable, rejecting the claim or holding the claim conditionally compensable. If the SI employer determines that an injury did not occur in the course of and as a result of covered employment the order rejecting the claimant's application for benefits should contain all bases for the rejection of the claim. All orders must contain language which permits the parties to file a protest with the Office of Judges.

The most common basis for the rejection of a claim is that the claimant's allegations reveal an aggravation of a prior injury. The Self-Insured Employer may also deny a claim as the claimant's allegations are not supported by the medical evidence submitted or the employer has submitted sufficient evidence that the injury did not occur. Less common are rejections based on the statute of limitations (remember an application must be filed within 6 months of the injury), horseplay, or simply there is no evidence that the claimant was injured at work.

Hearing Loss

Hearing loss claims are a form of occupational disease claim which is specifically addressed in the workers' compensation statute. There are really only two bases for the rejection of a hearing loss claim: 1) the claimant failed to file the application timely; or 2) there was no evidence of sufficient exposure to cause occupational hearing loss.

Statute of Limitation

As noted above, a claimant must file his application within three (3) years of his or her date of last exposure, the date he or she knew or should have known his hearing loss was caused by their employment; or within three (3) years of the date a physician informed the claimant that his or her hearing loss was caused by their employment. However, the West Virginia Supreme Court of Appeals clarified West Virginia Code § 23-4-15 by holding that one of two dates will trigger the running of the statute of limitations, whichever is latest. One date is the date of last exposure, and the other date is the "earlier of either the date the claimant was advised of the occupational disease by a physician or the date the claimant should reasonably have known of the existence of the occupational disease." Holdren v. Workers' Compensation Comm'r, 181 W. Va. 337, 340-41, 382 S.E.2d 531, 534-35 (1989).

To determine whether a valid statute of limitations argument exists, first confirm that the date of last exposure (DLE) is more than three (3) years prior to the date of the application. If the DLE is more than three years prior to the application (for example – a DLE of 1/12/2001 and the date the claimant signed the application is 12/22/2005), then a valid statute of limitations argument may exist. To establish the statute of limitations argument one or more of the following are required:

- 1) The WC-1HL or the claimant's medical records establish that he was diagnosed with occupational hearing loss more than three years prior to completing his application.
- 2) The claimant acknowledges in his interrogatory responses that he knew his hearing loss was related to his employment or that he was informed by a physician that his hearing loss was related to his employment more than three years prior to completing the application.
- 3) The claimant testifies that he knew that his hearing loss was caused by his employment when he last worked
- 4) A reasonable man would have known that his hearing loss was related to his employment given the type of exposure, the length of exposure and the symptoms.

No Harmful Exposure

The second basis to reject an occupational hearing loss claim is lack of harmful exposure. The first question to ask is whether the workplace environment was such that it could cause an occupational hearing loss (i.e. did the claimant work in an office or an underground mine). If there is a question regarding exposure, information regarding

noise studies done on the work place or facility should be obtained or the same should be considered.

If however, there is significant noise exposure in the workplace, or if the employer does not dispute that the exposure could cause an occupational hearing loss, obtain the claimant's work records to confirm that they had the requisite amount of exposure. West Virginia Code § 23-4-6b(g) states:

An application for benefits alleging a noise-induced hearing loss shall set forth the name of the employer or employers and the time worked for each. The commission shall allocate to and divide any charges resulting from the claim among the employers with whom the claimant sustained exposure to hazardous noise for as much as sixty days during the period of three years immediately preceding the date of last exposure.

W. Va. Code § 23-4-6b(g) (2005). Thus, for an employer to be held chargeable the claimant must have worked for the employer a minimum of sixty (60) days within the three years prior to the date of last exposure. If the claimant does not meet this minimum exposure requirement then the claim was properly rejected.

The only other basis to defend the rejection of a hearing loss claim is to establish that the claimant's hearing loss, if any, is not related to his or her employment but rather is related to noncompensable factors and conditions. To establish this requires a review of the claimant's medical records for conditions which may cause hearing loss, prior claims for prior head injuries which could have caused the hearing loss, and personal history to determine if the claimant's nonwork-related activities caused his or her hearing loss.

Occupational Disease

Occupational disease claims, such as Carpal Tunnel Syndrome, Cubital Tunnel Syndrome, repetitive stress disorders, toxic exposures etc., present a different set of issues for the Self-Insured Employer. The standard for holding a claim for an occupational disease is different than that for an occupational injury and is set forth by statute. West Virginia Code § 23-4-1 states:

“Where an employee files his application for workmen's compensation benefits, based on the occurrence of an occupational disease other than silicosis, to entitle him to an award, he must establish that the disease was contracted in the course of and resulted from the employment: it is not sufficient to establish that the employment resulted in an aggravation of a disease existing at the beginning of such employment.” Bannister v. State Workmen's Compensation Comm'r, 154 W. Va. 172, 174 S.E.2d 605 (1970) (Syl.pt 3).

. . . Except in the case of occupational pneumoconiosis, a disease shall be deemed to have been incurred in the course of or to have resulted from the employment only if it is apparent to the rational mind, upon consideration of all the circumstances (1) that there is a direct causal connection between the conditions under which work is performed and the occupational disease, (2) that it can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, (3) that it can be fairly traced to the employment as the proximate cause, (4) that it does not come from a hazard to which workmen would have been equally exposed outside of the employment, (5) that it is incidental to the character of the business and not independent of the relation of employer and employee, and (6) that it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction. . . .

W. Va. Code § 23-4-1 (2003). (Emphasis added). Thus, the claimant is required to meet the six factor test set forth above and establish a causal connection between employment and the occupational disease.

Initially, the claim should be reviewed to determine if the application was filed timely. Like hearing loss claims, the application for benefits must be filed within 3 years of the claimant's date of last exposure, the date the claimant knew or should have known the condition was caused by employment; or within three years of the date a physician informed the claimant the condition was caused by employment. The statute of limitation argument in these claims is similar to those in hearing loss claims. If the possibility for a statute of limitations argument exists be sure to analyze it carefully.

The fine line that must be walked by the claims adjuster is that to establish a statute of limitations argument you must acknowledge that the condition is compensable and that the claimant knew or should have known that the condition he or she suffered from when he or she last work was related to their employment. The safest course in these claims is to reject the claim based on the lack of a causal connection between the condition and the employment – not that the claimant failed to file the application timely.

In an occupational disease claim the following is some initial information which should be investigated:

- 1) Was there a physician review of the medical evidence upon which the claim was denied.
- 2) Was there any actual exposure which could cause the occupational disease – may need statement from supervisor that there was no exposure or only minimal exposure

- 3) Review the claimant's medical records for evidence of alternative noncompensable causes for the disease
- 4) Did a physician actually relate the claimant's condition to his/her employment (review WC-1 and medical evidence submitted with application)

Mental-Mental Claims

West Virginia Code § 23-4-1f states that:

For the purposes of this chapter, no alleged injury or disease shall be recognized as a compensable injury or disease which was solely caused by nonphysical means and which did not result in any physical injury or disease to the person claiming benefits. It is the purpose of this section to clarify that so-called mental-mental claims are not compensable under this chapter.

W. Va. Code § 23-4-1f (2005). There is no allowance for a "mental-mental" claim, and an application for benefits based on a purely psychiatric conditions should be rejected.

Secondary Conditions:

In general, the inclusion of secondary conditions is within the discretion of the Self-Insured Employer. 85 C.S.R. § 20-9.7 states:

The Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, shall use the ICD-9-CM coding system to report injured worker conditions in work-related injuries and occupational illnesses. Standard coding conventions shall be followed in reporting diagnosis. Payment will be denied for diagnosis judged, in the sole discretion of the Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, to not be causally related to the compensable injury.

Psychiatric Conditions

Psychiatric conditions are routinely included as compensable conditions in injury claims and often in occupational disease claims. Therefore, a claim where the alleged injury is solely a psychiatric condition is rare (and generally will be accompanied by some allegation of an actual physical injury). However, the issue of the compensability of a psychiatric condition will arise when a physician requests to include a psychiatric condition as a secondary condition. The following are a list of regulations that every adjuster should be aware of:

- 1) **85 C.S.R. § 20-12.2** – To be included as a compensable component of an injury a psychiatric condition must manifest itself with six (6) months after the injury or a significant complication based on credible medical evidence. Gone

are the days where a claimant could have a psychiatric condition added years after an injury.

- 2) **85 C.S.R. 20-12.5** –The Claims Administrator or Self-Insured employer is not responsible for continued treatment of a chronic psychiatric condition. Once a claimant has reached his or her maximum degree of medical improvement from a compensable injury (both physiologically and psychiatrically) treatment for a psychiatric condition may be terminated. This represents the first time in the history of West Virginia Workers' Compensation that continued psychiatric treatment may be terminated.
- 3) **85 C.S.R. § 20-9.1** – Psychiatric treatment requires prior review and authorization before services are rendered and reimbursement is made. Now a claimant or treating physician who seeks to obtain psychiatric services must request and obtain prior authorization before any such services will be covered.
- 4) **85 C.S.R. § 20-49** – Multi-Disciplinary Pain Management treatment must include a psychiatric or psychological evaluation as part of the process.
- 5) **85 C.S.R. § 20-50.59** – Implantable Devices require psychiatric or psychological screening prior to the procedure being performed.
- 6) **85 C.S.R. § 20-53** – Long Term Opioid Therapy requires, in some instances, are required to undergo psychiatric or psychological evaluation to determine the appropriateness of such treatment. Further, a claimant on has been on opioids without improvement is required to undergo a psychological evaluation.
- 7) **85 C.S.R. § 20-5.9** – requires Independent Medical Evaluators to be Board Certified.
- 8) **85 C.S.R. § 20-64.6** – Adopted psychiatric disability ranges which are required to be adhered to by the IME physician in rating permanent impairment.
- 9) In cases with traumatic brain injuries the evaluator is to employee the use of the AMA Guides to the Evaluation of Permanent Impairment, 4th ed., Chapter 4 and not the psychiatric impairment ratings. Evaluators are not to combine the two.
- 10) Regulations adopted a list of psychiatric conditions which can not be held compensable in a workers' compensation claim.

Temporary Total Disability (TTD)

Temporary total disability benefits are paid to a claimant who has sustained a compensable injury for the period in which the claimant is recovering from his or her injury and is unable to return to work. The purpose of these benefits is wage replacement for lost wages during a period of inability to work. Prior to July 1, 2003, a claimant was entitled to up to 208 weeks (4 years) of TTD benefits. However, the 2003 legislation capped this benefit at 104 weeks (2 years). TTD benefits are awarded based on medical evidence that the claimant remains temporarily and totally disabled. (See W. Va. Code § 23-4-1c). These benefits can not be granted prospectively for more than 90 days. TTD benefits are terminated based on West Virginia Code § 23-4-7a(e) which states:

Notwithstanding any provision in subsection (c) of this section, the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall enter a notice suspending the payment of temporary total disability benefits but providing a reasonable period of time during which the claimant may submit evidence justifying the continued payment of temporary total disability benefits when:

- (1) The physician or physicians selected by the commission conclude that the claimant has reached his or her maximum degree of medical improvement;
- (2) When the authorized treating physician advises the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, that the claimant has reached his or her maximum degree of improvement or that he or she is ready for disability evaluation and when the authorized treating physician has not made any recommendation with respect to a permanent disability award as provided in subsection (c) of this section;
- (3) When other evidence submitted to the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, justifies a finding that the claimant has reached his or her maximum degree of improvement; or
- (4) When other evidence submitted or otherwise obtained justifies a finding that the claimant has engaged or is engaged in abuse, including but not limited to, physical activities inconsistent with his or her compensable workers' compensation injury.

In all cases, a finding by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, that the claimant has reached his or her maximum degree of improvement terminates the claimant's entitlement to temporary total disability benefits regardless of whether the claimant has been released to return to work. Under no circumstances shall a claimant be entitled to receive temporary total disability benefits either beyond the date the claimant is released to return to work or beyond the date he or she actually returns to work.

W. Va. Code § 23-4-7a(e) (2005). Thus, to entitle a claimant to temporary total disability benefits the claimant must submit medical evidence that he or she continues to be temporarily and totally disabled. Regarding the time frame in which a request for temporary total disability benefits must be ruled upon 85 C.S.R. § 18-15.5(c)(1) states:

1. Awards of temporary total disability benefits. Written medical reports submitted upon properly executed, prescribed forms and providing proper and sufficient evidence that claimants are entitled to awards of temporary total disability benefits **shall be acted upon by issuance of orders granting awards of benefits within fifteen (15) days from the date of receipt by the self-insured employer** or the date of issuance of a compensability ruling in the claim. Payment pursuant to such awards shall be issued in accordance with the provisions of West Virginia Code article four, chapter twenty-three.

(emphasis added). 85 C.S.R. § 18-15.5(c)(1). As noted, the request must be “acted upon” which is significantly different than “ruled upon” and allows the Self-Insured Employer more latitude to consider and evaluate the facts and evidence, obtain more evidence and in the end issue an order which is more accurate and correct.

When a claimant is off and receiving temporary total disability benefits the Self-Insured employer is required, after 120 days of temporary total disability benefits, to refer the claimant for an independent medical evaluation. West Virginia Code § 23-4-7a(f) states:

Notwithstanding the anticipated period of disability established pursuant to the provisions of subsection (b) of this section, whenever in any claim temporary total disability continues longer than one hundred twenty days from the date of injury (or from the date of the last preceding examination and evaluation pursuant to the provisions of this subsection or pursuant to the directions of the commission under other provisions of this chapter), the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall refer the claimant to a physician or physicians of the commission's selection for examination and evaluation in accordance with the provisions of subsection (d) of this section and the provisions of subsection (e) of this section are fully applicable: Provided, 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 an amputation necessitating a prosthetic appliance.

W. Va. Code § 23-47a(f). Further, 85 C.S.R. § 18-15.5(c)(4) states:

4. The self-insured employer shall make referrals of claimants to physicians for independent medical examinations and evaluations as required by West Virginia Code within twenty (20) days of the end of the one hundred twenty (120) day period of temporary total disability, unless from the record the self-insured employer has a reasonable belief that the period of temporary total disability exceeds one hundred twenty (120) days.

Initial TTD benefits

Pursuant to West Virginia Code § 23-4-5:

If the period of disability does not last longer than three days from the day the employee leaves work as the result of the injury, no award shall be allowed, except the disbursements provided for in the next two preceding sections, but if the period of disability lasts longer than seven days from the day the employee leaves work as a result of the injury, an award shall be allowed for the first three days of such disability.

W. Va. Code § 23-4-5. Essentially, a claimant is entitled to TTD benefits, from the date of injury, if he or she misses more than seven (7) days. However, if the claimant misses no work or less than three (3) days then the claimant is not entitled to any temporary total disability benefits, even though the claim was held compensable. Thus, there are two possible orders which can be issued initially regarding temporary total disability benefits:

- 1) No-Lost Time – holds claim compensable but does not grant TTD benefits
- 2) Holds claim compensable and grants TTD benefits for period supported by medical evidence

Please note the following contained in 85 C.S.R. § 1-6 et seq.:

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

6.1. To qualify for temporary total disability benefits, the injured worker must have missed more than three (3) 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.

6.2. If an individual retires, he or she is disqualified from

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

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

85 C.S.R. §1-6.

Further, 85 C.S.R. § 18-15.5(i) states:

1. Self-insured employers shall make the initial temporary total disability payments to claimants in lost-time claims that are ruled compensable within fifteen (15) days of its ruling.

2. Self-insured employers shall make continuous bi-weekly temporary total disability payments to claimants for the extent of their temporary total disability as defined by the provisions of article four, chapter twenty-three of the West Virginia Code and the rules of the commission.

Please note that litigation regarding this issue will arise most commonly when the Self-Insured Employer holds a claim compensable on a no-lost time basis. This is essentially a denial of temporary total disability benefits. The basis for this order will most likely be that there was no evidence that the claimant missed any work or the physician who completed Section II of the WC-1 form indicated that the claimant would miss less than three days of work or no work.

This issue falls into the Expedited litigation process. In prosecuting a protest to the denial of initial TTD benefits the claimant may attempt to establish that the denial was unreasonable and thus the claimant is entitled to attorney's fees as provided by statute. (See W. Va. Code § 23-2C-21 (2005) and 93 C.S.R. § 1-19 *et seq.*).

Be cautious with this issue as a claimant may not be protesting the denial of TTD benefits *per se* but rather is protesting the conditions held compensable. For example the Self-Insured Employer may hold a claim compensable on a no-lost time basis for a lumbar sprain and the claimant protests the order and alleges that the cervical or thoracic spine are compensable conditions in the claim.

Closure of a claim for TTD benefits

Temporary total disability benefits are terminated when the treating physician concludes that the claimant has reached his or her maximum degree of medical improvement (MMI), when the Insurers Independent Medical Examiner determines that the claimant has reached his or her maximum degree of medical improvement; when the Insurer receives information (medical or otherwise) which indicates that the claimant has reached his or her maximum degree of medical improvement; when evidence of abuse is received by the Insurer (video tape evidence, photographic evidence, statements, etc.), or when the claimant is either released to return to work (RTW) or has actually returned to work. Additionally, TTD benefits may be terminated if the claimant is incarcerated as West Virginia Code § 23-4-1e specifically prohibits the payment of TTD benefits during periods of incarceration.

Further, 85 C.S.R. § 18-15.5(c) states in relevant part:

2. Cessation of temporary total disability. Written medical or other information providing proper and sufficient evidence that claimants have ceased to be temporarily and totally disabled or have returned to work shall be acted upon by issuance of notices advising the parties that benefit payments shall be suspended pending final disposition. The self-insured employer shall issue such notices within five (5) working days from the date of receipt of incoming correspondence.

3. Notice of closing claim. After the thirty (30) day notice period provided in suspension notices has expired and review of claims reveals that sufficient medical evidence to support a further award of temporary total disability benefits has not been received, the self-insured employer shall issue an order within ten (10) working days from the end of the aforesaid notice period advising the parties that the claims have been closed upon a temporary total disability basis. Failure to issue the order in a timely

fashion under this provision does not act as a bar to the issuance of the order by the self-insured employer.

85 C.S.R. §18-15.5(c)2 and 3.

As noted above, the Self-Insured Employer can close a claim for temporary total disability benefits for any of the reasons set forth in West Virginia Code § 23-4-7a(e). Other bases exist for the closure of the claim in the applicable regulations, such as failing to attend an Independent Medical Evaluation (IME) or failing to comply with the treating physician's treatment plan.

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

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

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

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

Calculation of TTD benefits:

Pursuant to West Virginia Code § 23-4-6(b), temporary total disability benefits are calculated as "a maximum weekly benefit to be computed on the basis of sixty-six

and two-thirds percent of the average weekly wage earnings, wherever earned, of the injured employee, at the date of injury, not to exceed one hundred percent of the average weekly wage in West Virginia: Provided, That in no event shall an award of temporary total disability be subject to the annual adjustments resulting from changes in the average weekly wage in West Virginia.” Further, “the minimum weekly benefits paid under this subdivision shall not be less than thirty-three and one-third percent of the average weekly wage in West Virginia, except as provided in sections six-d [§23-4-6d] and nine [§23-4-9] of this article. In no event, however, shall the minimum weekly benefits exceed the level of benefits determined by use of the applicable federal minimum hourly wage...” (W. Va. Code § 23-5-6(b)).

For the fiscal year 2007, the following **minimum** temporary total disability rates apply:

State Average Weekly Wage	\$195.78 per week
Federal Minimum Wage	\$144.20 per week

For the fiscal year 2007, the following **maximum** temporary total disability benefit rate applies:

State Average Weekly Wage	\$587.35 per week
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Please note that West Virginia Code § 23-4-14 explains the “Computation of Benefits”. This section states in relevant part that:

On or after the first day of July, one thousand nine hundred ninety-four, the expression “average weekly wage earnings, wherever earned, of the injured person, at the date of injury”, within the meaning of this chapter, shall be computed based upon the daily rate of pay at the time of the injury or upon the weekly average derived from the best quarter of wages out of the preceding four quarters of wages as reported to the commission pursuant to subsection (b), section two [§23-2-2], article two of this chapter, whichever is most favorable to the injured employee, except for the purpose of computing temporary total disability benefits for part-time employees pursuant to the provisions of section six-d [§ 23-4-6d] of this article.

W. Va. Code § 23-4-14(2). Additionally, the website of the West Virginia Office of the Insurance Commissioner contains a program for calculating temporary total disability benefits. (See www.wvinsurance.org). Temporary total disability benefits are limited by statute to not exceed one hundred four (104) weeks of benefits or two (2) years. (See W. Va. Code § 23-4-6(c)). Previously, these benefits were allowed for up to two hundred eight (208) weeks or four (4) years.

Reopening for TTD benefits

Pursuant to West Virginia Code §§ 23-4-16, 23-5-2 and 23-5-3, when a claimant seeks to reopen his or her claim, the claimant has the burden of proof to establish a progression or aggravation of his or her compensable injury. See also Harper v. State Workmen's Compensation Comm'r, 160 W. Va. 364, 234 S.E.2d 779 (1977) (Syl.pt 1). West Virginia Code §§ 23-5-2 and 23-5-3, set forth the requirements for filing an application for reopening and the standard which must be met before a claim can be reopened. Read in *pari materia* these statutes require that a claimant establish an aggravation or progression of the compensable condition. A claimant need only submit evidence of a *prima facie* cause for the reopening of a claim.

85 C.S.R. §18-15.5(e)(1) states that:

1. The self-insured employer shall rule upon petitions for reopening of claims upon a temporary total disability basis within thirty (30) days from the date of receipt.

85 C.S.R. § 18-15.5(e)(1). Thus, a ruling on a petition to reopen a claim for temporary total disability benefits must be issued within thirty (30) days from receipt of the petition.

West Virginia Code § 23-4-16 sets forth the time limitations for filing an application to reopen a claim stating in relevant part:

The power and jurisdiction of the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, over each case is continuing and the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, may, in accordance with the provisions of this section and after due notice to the employer, make modifications or changes with respect to former findings or orders that are justified. Upon and after the second day of February, one thousand nine hundred ninety-five, the period in which a claimant may request a modification, change or reopening of a prior award that was entered either prior to or after that date shall be determined by the following subdivisions of this subsection. Any request that is made beyond that period shall be refused.

(1) Except as provided in section twenty-two 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. During that time period, only two requests may be filed.

(2) Except as stated below, in any claim in which an award of permanent disability was made, any request must be made within five years of the date of the initial award. During that time period, only two requests may be filed.

W. Va. Code § 23-4-16 (2005). Thus, if a claimant requests a reopening of his or her claim within the time limits proscribed, and establishes an aggravation or progression of his or her compensable the Self-Insured Employer should reopen the claim.

If the reopening is to be denied based on the statute of limitations the claim file must be reviewed to determine whether the claim was closed without entry of a permanent partial disability (PPD) award. If so, was the request to reopen filed within five (5) years of the order closing the claim. Also, the closure order must be reviewed to determine if it contained the mandatory language set forth in West Virginia Code § 23-4-22 notifying the claimant of his or her right to reopen the claim. If the request to reopen was filed within five (5) years of the closure order, was this the claimant's first or second request. If the claimant had previously filed two reopening requests (and no award had been entered) then the legal argument stands and little if any evidentiary development is necessary. If, however, a PPD award has been entered then the statute of limitations is calculated five (5) years from the date of the PPD award. Please note that the Office of Judges historically has viewed this statute as allowing the claimant an unlimited number of reopenings for temporary total disability benefits.

If the reopening request was timely filed then the denial should be based on documentation which would include medical evidence showing that the claimant's condition had not been aggravated or progressed, evidence establishing that the claimant suffered a subsequent intervening injury (compensable or noncompensable), or evidence that the claimant's present medical condition is the result of a noncompensable condition and not the compensable injury.

Medical Treatment issues

As noted above, a claimant who sustained a compensable injury or disease is entitled medical benefits which are medically necessary and reasonably required to treat the compensable condition. (See W. Va. Code § 23-4-3). A ruling on a request for medical treatment must be issued within fifteen (15) working days from the date of receipt of the request by the Self-Insured employer. 85 C.S.R. §18-15.5(b) states:

1. Medical Treatment. The self-insured employer shall rule upon requests for authorization of medical treatment within fifteen (15) working days from the date of receipt by the self-insured employer.

2. Appliances, Devices, and Supplies. The self-insured employer shall rule upon requests for authorization for the purchase of prosthetic or other appliances, devices or medical supplies within fifteen (15) working days from the date of receipt by the self-insured employer.

85 C.S.R. § 18-15.5(b).

These issues have become more common since the Legislature abolished the liberality rule and adopted a preponderance of the evidence rule. Prior to the 2003 amendments to the Workers' Compensation statute, and under the direction of former Chief Administrative Law Judge Robert Smith, there existed an unwritten rule or policy at the Office of Judges and the Commission known as the "Treating Physicians" rule which stated that the treating physician was the health care provider in the best position to know the treatment needs of the claimant and thus the treating physician's opinion was afforded great deference. However, following the 2003 amendments the Commission amended and readopted medical treatment guidelines which are contained in 85 C.S.R. § 20-1 *et seq.* known as "Rule 20". Rule 20 contains detailed Guidelines regarding the treatment of numerous conditions and incorporated by reference "The Disability Advisor" known also as the Pressley Reed Guidelines. It is likely that the majority of treatment issues encountered will be based on the requested treatment being outside the aforementioned guidelines. However, some denials will be based on reasoning such as the treatment is not related to a compensable condition or is treatment for a noncompensable condition.

Medical treatment issues range from the denial of an authorization for medication to the denial of surgical treatment. These issues may also involve the denial of a referral to a consulting physician (i.e. surgeon, chiropractor, psychologist, psychiatrist, etc), the denial of diagnostic testing (i.e. MRI, EMG/NCS, bone scan, CT, CT myelogram, etc), the denial of physical therapy, the denial of chiropractic treatment, the denial of psychiatric treatment and the denial of durable medical goods (i.e. braces, prosthetics, hearing aids, etc.). Thus, there is a plethora of "treatments" that may be denied, therefore it is imperative to determine what was denied and why.

The claimant and his treating physician in requesting medical treatment in a claim must establish that the requested medical treatment is medically necessary and reasonably required to treat his or her compensable condition.

It should be noted that the denial of medical treatment falls under the Expedited hearing process mandated by the Legislature, thus, the claimant can elect or "opt in" to this process and the litigation of the issue will be abbreviated. To render an appropriate decision on a request for medical treatment the following is some initial information which should be investigated

- 1) Identify the treatment modality requested.

- 2) Identify the compensable conditions in the claim and determine whether the treatment is related to those compensable conditions or some other noncompensable condition
- 3) Review and identify applicable treatment guidelines
- 4) Review claim file to determine if treatment had previously been granted or denied
- 5) Review medical records and IME reports to determine if a prior physician had concluded that the claimant did not require any further treatment
- 6) Review medical records to determine if treatment is related to noncompensable condition (i.e. arthritis) or a prior injury.

In the majority of treatment issues the only evidence the claimant will submit is a request from the treating physician. The Rule 20 Guidelines contain requirements for the information which must be included in a request for medical treatment. Please note that a medical treatment issue can have as much impact on a claim as any other issue. For example in a claim for a lumbosacral sprain, where an MRI of the cervical spine is denied, a ruling by the Office of Judges which reverses the order and authorizes the cervical MRI can be argued to have the effect of including the cervical spine as compensable and thus the claimant is entitled to treatment and benefits related to that condition including additional medical benefits, temporary total disability benefits and permanent partial disability benefits.

Additionally, while not common at this point, in the future an issue which will be presented regarding medical treatment is a denial of treatment based on the applicable statute of limitations. Prior to the 1995 amendments to the Workers' Compensation statute a claimant was entitled to lifetime medical treatment for a compensable injury. However, in 1995, the Legislature enacted a statute of limitations on medical treatment. This statute of limitations is contained in West Virginia Code § 23-4-16 and states:

With the exception of the items set forth in subsection (d), section three [§ 23-4-3] of this article, in any claim in which medical or any type of rehabilitation service has not been rendered or durable medical goods or other supplies have not been received for a period of five years, no request for additional medical or any type of rehabilitation benefits shall be granted nor shall any medical or any type of rehabilitation benefits or any type of goods or supplies be paid for by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, if they were provided without a prior request. For exclusive purposes of this subdivision, medical services and rehabilitation services shall not include any encounter in which significant treatment was not performed.

W. Va. Code § 23-4-16(a)(4) (2005). Thus, in a claim where a claimant has not received "significant" treatment within the five years prior to the most request for treatment, the

claim is barred for additional medical benefits. Presently, the term “significant treatment” has not been definitively defined, however, a reasonable interpretation of “significant treatment” would not include office visits where no treatment was provided.

Permanent Partial Disability (PPD)

Permanent partial disability awards are granted to an injured worker to compensate the injured worker for permanent impairment which resulted from a compensable injury. A claimant can not be awarded a permanent partial disability award until he or she has reached their maximum degree of medical improvement from a compensable injury. In 1995, the West Virginia Legislature by enacting amendments to the Workers’ Compensation Statute and the subsequent regulatory changes converted the West Virginia Workers’ Compensation system from a disability system to an impairment system. The significance of this change was that prior to the 1995 amendments physicians could consider social, economic, and geographical factors in determining the amount of a permanent partial disability award. However, the legislative changes abolished such considerations and after May 12, 1995, permanent partial disability awards were based exclusively on the amount of whole person impairment an individual sustained. By regulation, the Commission adopted the AMA Guides to Permanent Impairment 4th Ed., as the standard for rating permanent whole person impairment. (See 85 C.S.R. § 20-65). While a 5th edition of the AMA Guides has been published and the authors are now working on a 6th edition, by regulation the 4th edition must be used. The only exceptions to the use of the AMA Guides 4th Ed., is for rating impairment in occupational pneumoconiosis claims, occupational hearing loss claims, psychiatric permanent impairment and those injuries which are governed by the statutory awards set forth in West Virginia Code § 23-4-6(f).

The initial permanent partial disability award can be based on one of two physician’s reports pursuant to West Virginia Code § 23-4-7a. If the treating physician recommends a permanent partial disability award of 15% or less the Self-Insured Employer has a mandatory duty to enter an award based on the treating physician’s recommendation. However, if the treating physician recommends an award in excess of 15% the Self-Insured Employer must refer the claimant to a physician of its choice for a permanent partial disability evaluation. When the Self-Insured Employers’ IME physician finds that the claimant suffers from permanent impairment the Self-Insured Employer is required to enter an order based on that physician’s report. 85 C.S.R. § 18-15.5(d)(1) states:

1. The self-insured employer shall act upon permanent disability evaluation reports received from physicians to whom claimants have been referred by the self-insured in claims based upon injuries and occupational diseases other than occupational pneumoconiosis within fifteen (15) working days from the date of receipt.

85 C.S.R § 18-15.5(d)(1). Further, payments of permanent partial disability awards are required to be made within fifteen (15) days from the date of the award. See 85 C.S.R. § 18-15.5(d)(2).

The amount of permanent partial disability benefits a claimant is entitled to is the subject of much litigation since it could represent a large cash payment to the claimant and assists the claimant in reaching the 50% threshold to apply for permanent total disability benefits.

To minimize the amount of litigation related to permanent partial disability issues and increase the accuracy of awards which are granted the following is some initial information which should be investigated:

- 1) What are the compensable conditions in this claim
- 2) Was the claimant's request for a permanent partial disability rating timely (see below)
- 3) Whether the claimant received a prior award in the instant claim which was properly deducted
- 4) Whether the claimant had any prior injuries to the same body part and if so was the claimant previously granted any awards for that body part.
- 5) Whether the claimant suffers from a noncompensable condition to the compensable body part and if so was any noncompensable impairment excluded from the impairment rating
- 6) Whether the claimant sustained a subsequent intervening injury to the same body part

It should be noted that prior to the 1986 changes to West Virginia Code § 23-4-9b, a preexisting impairment could not be deducted from a permanent partial disability award unless it had previously been rated. See Gallardo v. Workers' Compensation Comm'r, 179 W. Va. 756, 761, 373 S.E.2d 177, 182 (1988). However, presently preexisting impairments must be excluded from a permanent partial disability rating. West Virginia Code § 23-4-9b states:

Where an employee has a definitely ascertainable impairment resulting from an occupational or a nonoccupational injury, disease, or any other cause, whether or not disabling, and such employee shall thereafter receive an injury in the course of and resulting from his employment . . ., such impairment, and the effect thereof, and an aggravation thereof, shall not be taken into consideration in fixing the amount of compensation allowed by reason of such injury, and such compensation shall be awarded only in the amount that would have been allowable had such employee not had such preexisting impairment. Nothing in this section shall be construed to require that the degree of such preexisting impairment be

definitely ascertained or rated prior to the injury received in the course of and resulting from such employee's employment or that benefits must have been granted or paid for such preexisting impairment. The degree of such preexisting impairment may be established at any time by competent medical or other evidence. . . ."

W. Va. Code § 23-4-9b (2005). Thus, it is imperative that the claimant's prior injury and medical history be investigated to determine if the claimant suffers from preexisting impairment which can not be calculated in the permanent partial disability award and must be specifically excluded from such award.

When referring a claimant for an independent medical evaluation remember to provide as much information (i.e. medical records) as possible to the evaluating physician and make all requests in the referral letter as specific as possible. A good referral letter will result in a detailed and more accurate IME report from the evaluating physician.

Calculation of PPD Benefits:

Permanent partial disability benefits are benefits paid to injured workers for permanent impairment related to a compensable injury. With the exception of occupational pneumoconiosis, occupational hearing loss, psychiatric impairment ratings and the statutory awards set forth in West Virginia Code § 23-4-6(f) permanent partial disability "shall be determined exclusively by the degree of whole body medical impairment that a claimant has suffered." (See W. Va. Code § 23-4-6(i)). West Virginia has adopted by legislative rule the American Medical Association Guide to the Evaluation of Permanent Impairment, 4th ed. as the required basis for determining whole body medical impairment. (See 85 C.S.R. §20-64 and 65 et al). Additionally, 85 C.S.R. § 20 ("Rule 20") contains tables of ranges for impairments related to the lumbar, thoracic, and cervical spine, carpal tunnel syndrome (maximum of 12% PPD) and psychiatric impairment. As noted, occupational pneumoconiosis (OP) and occupational hearing loss (HL) have separate methods for rating impairment. OP impairment is determined by the Occupational Pneumoconiosis Board (See W. Va. Code § 23-4-6a) and hearing loss impairment is calculated pursuant to West Virginia Code § 23-4-6b. Additionally, West Virginia Code § 23-4-6(f) provides statutory awards, or mandatory awards for injuries such as amputations.

Permanent partial disability rates are calculated pursuant to West Virginia Code § 23-4-6(e)(1) which states:

For all awards made on or after the effective date of the amendment and reenactment of this section during the year two thousand three, if the injury causes permanent disability less than permanent total disability, the percentage of disability to total disability shall be determined and the award computed on the basis of four weeks' compensation for each percent of disability

determined at the maximum or minimum benefits rates as follows: Sixty-six and two-thirds percent of the average weekly wage earnings, wherever earned, of the injured employee at the date of injury, not to exceed seventy percent of the average weekly wage in West Virginia: Provided, That in no event shall an award for permanent partial disability be subject to annual adjustments resulting from changes in the average weekly wage in West Virginia:

...

As you can see from the attached chart, the present **maximum permanent partial disability** award is calculated as:

Weekly Benefit Rate	\$411.15
Each 1% of PPD award	\$1644.60

The minimum benefit rate is calculated at the same rate as temporary total disability benefits pursuant to West Virginia Code § 23-4-6(b). (See W. Va. Code § 23-4-6(e)(3).

Statute of Limitations

The statute of limitations on permanent partial disability awards has been a significant litigation issue for the past decade, since the 1995 amendments required that a minimum threshold of prior permanent partial disability awards be met to permit an individual to even apply for permanent total disability benefits. Upon receiving a claimant's protest to a permanent partial disability award, or denial of a permanent partial disability award, an inquiry into whether his or her request for a permanent partial disability evaluation was timely should be made. If the request was within five (5) years of the date of injury then no statute of limitations issue is present. However, if the request was more than five (5) years after the date of injury then this issue should be investigated. For example as of January 2006, any claim with a date of injury prior to December 31, 2000, should be investigated for a potential statute of limitations argument. (To help identify such claims look at the State claim Number. Any claim with a claim number beginning 2000 has a date of injury or date of last exposure prior to July 1, 2000. Any claim with a claim number beginning 2001 has a date of injury or date of last exposure prior to July 1, 2002.).

The applicable statute of limitations is contained in West Virginia Code § 23-4-16. As noted above West Virginia Code § 23-4-16 sets forth the time limitations for filing an application to reopen a claim stating in relevant part:

The power and jurisdiction of the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, over each case is continuing and the commission, successor to the commission, other private carrier or self-insured employer,

whichever is applicable, may, in accordance with the provisions of this section and after due notice to the employer, make modifications or changes with respect to former findings or orders that are justified. Upon and after the second day of February, one thousand nine hundred ninety-five, the period in which a claimant may request a modification, change or reopening of a prior award that was entered either prior to or after that date shall be determined by the following subdivisions of this subsection. Any request that is made beyond that period shall be refused.

(1) Except as provided in section twenty-two 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. During that time period, only two requests may be filed.

(2) Except as stated below, in any claim in which an award of permanent disability was made, any request must be made within five years of the date of the initial award. During that time period, only two requests may be filed.

W. Va. Code § 23-4-16 (2005). Thus, in this instance, to request a permanent partial disability evaluation and possible award in any claim in which no permanent partial disability award was granted such request must be made with five (5) years of the date the claim was closed for temporary total disability benefits. To request a permanent partial disability evaluation and possible award in a claim where a permanent partial disability award had been granted such request must be made with five (5) years of the date of the initial award. Both of these time limitations are subject to the “two request within five years” stipulation.

The statute of limitations has remained essentially unchanged since the 1995 amendments to the Workers’ Compensation Statute and thus most claims that will likely be encountered will fall under this version. However, prior to 1995, every time a claimant was granted an additional permanent partial disability award the five (5) year statute of limitations began over. For example in a 1988 claim (Claim No. 8800xxxxx with a date of injury of 1/1/1988), a claimant may have been awarded a 5% PPD award in 1992, thus the statute of limitations expired in 1997. However if the claimant timely requested a reopening in 1996 and received an additional 2% award in 1996, the five year period began again and the claimant would have until 2001 to request an additional reopening. If the claimant again timely requested a reopening in 2000 and was granted an additional 3% award in 2001, then the claimant would have until 2006 to request another reopening. Another significant difference in the pre-1995 claims was that the statute calculated the 5 years to run from the date of last payment of benefits (not the date the award was granted) and if a protest was later resolved in favor of the claimant and an additional award was granted by the OOH, Board of Review or Supreme Court, the five

years began again on the date of last payment for that award. Thus, it is likely that permanent partial disability issues will arise in older claims which we may be requested to defend. Further, in pre-1987 claims, if the claimant was never granted an award and his or her claim was never closed for TTD benefits, that claim remains eligible to be reopened for PPD benefits. These claims are litigated frequently when a claimant is attempting to bolster his or her PPD total to reach the minimum PTD threshold.

Thus, every claim should be reviewed to determine if a statute of limitations argument exists.

Statutory Awards

As noted above West Virginia Code § 23-4-6(f) sets forth statutory awards for certain injuries or types of injuries, such as amputations, and sets forth specific permanent partial disability awards which must be granted. Be aware that issues regarding statutory awards may arise and the claimant almost always seeks to have an award greater than that allowed by statute entered. The common argument is that the statutory awards are minimums not maximums and thus an award greater than that allowed by statute is appropriate. Depending on the facts these claims could go either way as there is no definitive statement on whether the statutory awards are minimums or maximums.

Spinal Injuries

By far, the largest number of claims are filed for spinal injuries (i.e lumbar sprain/strain, thoracic sprain/strain and cervical sprain/strain). Thus, historically permanent partial disability awards for spinal injuries have been the most fervently litigated. In the past, regardless of the limitations set forth in the AMA Guides claimant's have protested almost all permanent partial disability awards and submitted reports from physicians such as Dr. Clifford Carlson, Dr. Bruce Guberman or Dr. Victor Poletajev, who have rated simple lumbar impairments up to as much as 50%. Prior to 2003, and for orders entered prior to July 1, 2003, the Office of Judges had applied and continues to apply the "rule of liberality" and consistently granted large permanent partial disability awards for even the simplest of back sprains. However, the 2003 amendments as well as the subsequently promulgated regulations have brought such liberal awards to an end. To understand why the 2003 amendments and subsequent regulations are so drastic a change in this area requires an understanding of the system prior to 2003.

As noted above, prior to 1995 West Virginia was a disability state, meaning that physicians rated permanent impairment based on what they believed the claimant's "disability" resulting from the injury was. The 1995 amendments changed West Virginia from a "disability" state to an "impairment" state. After 1995, all permanent partial disability award were to be made in accordance with the AMA Guides as discussed above. With relation to spinal injuries, the AMA Guides provided two (2) distinct methods to rate permanent impairment – the Range of Motion (ROM) Model and the Diagnosis-Related Estimates (DRE) Model. The DRE model was the model favored by the authors

of the AMA Guides and was a departure from the prior three editions of the AMA Guides. Under the DRE model, the physician when evaluating a spinal injury placed the claimant into one of seven (7) categories based on the severity of the injury and its permanent restrictions. This model arrived at significantly lower awards than had been historically granted. The ROM model was the method which had been used in the prior three editions of the AMA Guides. The physician employing the ROM model first placed the claimant in a category from Table 75 (which is similar to the DRE categories) and then made additions for range of motion deficits and for neurological deficits. This method arrived at significantly greater impairment ratings and allowed a larger variance in evaluator opinions. The Office of Judges, under former CALJ Robert Smith issued a “policy” stating that the DRE was inconsistent with various section of the Workers’ Compensation Act and thus was unreliable. The employer community challenged this “policy” and the West Virginia Supreme Court of Appeals held in Repass that the DRE model could not be used as a basis for impairment ratings.

In response to this decision, the Legislature in its 2003 amendments to the Workers’ Compensation act included language requiring the promulgations of ranges of impairments for spinal injuries. The Commission thereafter adopted ranges of impairments for spinal injuries which are contained in 85 C.S.R. § 20 Tables 85-20 C, D, and E. These Tables created five (5) categories each for the lumbar spine, thoracic spine and cervical spine and set forth ranges of impairment (if one looks closely at these categories and the DRE categories in the AMA Guides 5th ed., they would find that they are photo copies of those tables with the title changed).

Thus, presently, spinal injuries must be rated under the Tables set forth in 85 C.S.R. § 20. To date there has been no significant challenge to the validity of these Tables and certainly no definitive determination from the West Virginia Supreme Court of Appeals. Therefore, the number of claims in litigation solely on the amount of permanent partial spinal impairment has decreased.

Carpal Tunnel Syndrome

Carpal tunnel syndrome (CTS) may be considered an occupational disease in some claims. As an occupational disease the claimant and his or her treating physician are required to submit evidence which essentially establishes a causal connection between the claimant’s job duties and the development of carpal tunnel syndrome. Further, in compensable CTS claims treatment modalities and length of TTD should be closely evaluated. Also, be aware that BrickStreet has adopted a policy which precludes surgery in some CTS cases based on EMG/NCS findings. This is something which should be evaluated and considered.

Like any other permanent partial disability issue (with the exception of OP, HL, and psychiatric impairment) an evaluating physician is required to rate the claimant’s permanent impairment in accordance with the AMA Guides 4th ed. Like spinal injuries, the AMA Guides provides two method with which to rate permanent impairment related to carpal tunnel syndrome. The first, and preferred method, is to estimate the permanent

sensory and motor loss of both upper extremities pursuant to Table 11, 12, 13, and 15 of the AMA Guides and arrive at a whole person impairment rating. The alternative method (and unfortunately the most commonly used) is to place the claimant in one of three categories contained in Table 16 (mild, moderate or severe) which is the entrapment neuropathy table and blindly follow the impairment ratings given. Please note that there is no correlation between EMG/NCS results (which are expressed as mild, moderate and severe CTS) and the categories contained in Table 16.

Prior to the 2005 amendments to the Workers' Compensation statute most CTS claims resulted in a 12% permanent partial disability award (6% for each upper extremity when placed in the mild category of Table 16). However, the Legislature specifically addressed carpal tunnel syndrome claims in the amendments and the Commission subsequently adopted limits on permanent partial disability awards for carpal tunnel syndrome. 85 C.S.R. § 20-64.5 states:

Carpal Tunnel Syndrome Impairment: An injured worker who can otherwise show entitlement to a permanent partial disability award for carpal tunnel syndrome shall be eligible to receive a permanent partial disability award of 0% - 6% in each affected hand.

85 C.S.R. § 20-64.5. Therefore, presently a claimant can receive no more than a 12% award for bilateral carpal tunnel syndrome. However, there remains the aforementioned arguments and an additional argument, if a rating is based on Table 16, that the West Virginia Supreme Court of Appeals decision in Repass precludes the awarding of benefits based on Table 16 as that table, like the DRE, conflicts with several other statutory provisions.

Upper Extremities and Lower Extremities and the rest

The remaining permanent partial disability issues that may be encountered involve the upper extremities (shoulder, elbow, hand, and fingers), the lower extremities (hips, thighs, knees, ankles, feet, and toes), any other system that could be injured, including psychiatric conditions. The upper and lower extremities are addressed in separate chapters of the AMA Guides and each of these body parts has corresponding Tables and charts to rate permanent impairment. Further, there are separate chapters dealing with the cardiovascular, pulmonary, neurological and all other systems of the body. However, as noted above, the rating methodology for occupational pneumoconiosis, occupational hearing loss and psychiatric impairment is set forth specifically in 85 C.S.R. § 20. To properly administer claims requires at least a minimal knowledge of the AMA Guides, the regulatory guidelines, and how to properly evaluate permanent impairment.

Vocational Rehabilitation

Vocational rehabilitation, as the name implies, includes a myriad of benefits granted to assist an injured worker to return to the workforce. It is difficult to define where vocational rehabilitation benefits begin as Brickstreet and Self-Insured Employers refer injured workers for vocational rehabilitation services as soon as possible. This confusion is directly related to the 2003 and 2005 amendments to the Workers' Compensation statute. A reasonable beginning point to understand the vocational rehabilitation process is the purpose of vocational rehabilitation. West Virginia Code § 23-4-9 states:

The Legislature hereby finds that it is the goal of the workers' compensation program to assist employees to return to suitable gainful employment after an injury. In order to encourage workers to return to employment and to encourage and assist employers in providing suitable employment to injured employees, it is a priority of the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, to achieve early identification of individuals likely to need rehabilitation services and to assess the rehabilitation needs of these injured employees. It is the goal of rehabilitation to return injured employees to employment which is comparable in work and pay so that which the individual performed prior to the injury. If a return to comparable work is not possible, the goal of rehabilitation is to return the individual to alternative suitable employment, using all possible alternatives of job modification, restructuring, reassignment and training so that the individual will return to productivity with his or her employer or, if necessary, with another employer. The legislature further finds that it is the shared responsibility of the employer, the employee, the physician and the commission to cooperate in the development of a rehabilitation process designed to promote reemployment for the injured employee.

W. Va. Code § 23-4-9(a)(2005). Thus, the Legislature has clearly stated that the goal of the workers' compensation system is to return an injured employee to employment and that is the shared responsibility of all parties to cooperate in this process.

The Commission promulgated rules to effectuate this legislative purpose which are contained in to 85 C.S.R. § 15-1 *et seq.* The most recent modifications to this rule became effective on October 1, 2005. To understand how the rehabilitation process works it is imperative that a clear understanding of the goals be obtained. The "Rehabilitation Hierarchy" which is set forth in 85 C.S.R. § 15-4.1 states:

Vendors of vocational rehabilitation services and qualified rehabilitation professionals must utilize the following

priorities. No higher numbered priority may be utilized unless the Commission, Insurance Commissioner, self-insured employer or private carrier, whichever is applicable, has determined all lower numbered priorities are unlikely to result in placement of the injured worker into suitable gainful employment. If a lower numbered priority is clearly inappropriate for the injured worker, the next higher numbered priority must be considered. The rehabilitation plan must explicitly state the reasons and rationale for the rejection of any lower numbered priority. The priorities are as follows:

1. Return to the same employer and pre-injury job;
2. Return to the same employer and pre-injury job with modification;
3. Return to the same employer in a different position;
4. return to the same employer in a different position with on-the-job-training
5. Employment by a new employer without retraining
6. Employment by a new employer with on-the-job-training
7. Return to work following enrollment of the injured working in a retraining program which consists of a goal-oriented period of formal retraining designed to lead to suitable gainful employment in the labor market.

85 C.S. R. § 15-4.

All litigation of vocational rehabilitation issues will revolve around where the claimant is in the above hierarchy. Litigation regarding vocational rehabilitation issues will arise when the claimant protests either the denial of some form of vocational rehabilitation services or protests the authorization of some form a vocational rehabilitation which he does not agree with. These issues will include claimant's protests to orders denying vocational rehabilitation services, protests to the type of services being rendered, protests to the denial of rehabilitation TTD benefits, etc.

These are difficult issues to litigate and require a complete and thorough understanding of the claim history including medical treatment and rehabilitation services offered as well as an understanding of the claimant's pre-injury job duties, the employers' work environment and facility, the employer's willingness and ability to provide accommodations, and the claimant's physical and mental capabilities.

Permanent Total Disability

These issues, with the exception of novel occupational disease claims or toxic exposure claims, are the most difficult and time consuming from all perspectives.

However, due to the 2003 and 2005 amendments to the Workers' Compensation statute as well as the West Virginia Supreme Court of Appeals decision in Wampler Foods going forward permanent total disability issues will be increasingly rare.

Presently, permanent total disability benefits are granted to injured workers' who meet the eligibility criteria and are determined to be unable to return to any form of gainful employment due to their compensable injuries and diseases. Prior to 1995, a claimant could apply to be considered for permanent total disability benefits at any time in any claim, regardless of the amount of prior permanent partial disability benefit they had been granted. Once the claimant applied for permanent total disability consideration the Commission would refer the claimant for appropriate evaluations, including vocational rehabilitation evaluations, and benefits were granted when a determination was made that the claimant could not return to suitable gainful employment. These benefits were for the remainder of the claimant's life.

In 1995 the Legislature attempted to limit the number of permanent total disability awards granted by amending the Workers' Compensation statute to create a three step process for consideration of permanent total disability applications. The first step required a claimant to establish that he had previously been granted in excess of 50% in prior permanent partial disability awards. Without meeting this initial requirement a claimant was not even eligible to apply for permanent total disability benefits. Once a claimant established that he had previously been granted 50% or more in prior permanent partial disability benefits the claim was then referred to the newly created Interdisciplinary Examining Board (IEB). The charge of the IEB was determine whether the claimant met the second threshold requirement of having at least 50% in whole person impairment due to all of his or her compensable injuries and diseases. If the claimant was found to have 50% or more in whole person impairment then the IEB made a recommendation to the Commission, based on its evaluation of the medical and vocational rehabilitation evidence in the claim file, as to whether the claimant should be granted a permanent total disability award or not. However, the IEB employed the old Posey/Cardwell standards to determine the claimant's entitlement to benefits. The Commission, once it received the IEB's recommendation, was required to enter an order effectuating that recommendation: either grant or deny permanent total disability benefits. Another change made in 1995 was to limit the length of time which a claimant could receive permanent total disability benefits. Instead of putting a specific age limit, the Legislature chose to terminate PTD benefits at the age the claimant was eligible to receive Old Age Social Security benefits.

Due to several West Virginia Supreme Court of Appeals decisions, these amendments were never fully implemented as the Court found that the date of injury established the controlling law. Thus, there was a mass filing for PTD benefits in claims with dates of injury prior to May 12, 1995 (the effective date of SB 250). However, recently in the Beirne decision the West Virginia Supreme Court of Appeals upheld the constitutionality of the statute which terminated PTD benefits when a claimant reached the eligibility for Old Age Social Security Retirement benefits.

In 1999, the legislature revisited the workers' compensation issue and modified the statute again. This time, the Legislature reduced the minimum threshold requirements from 50% to 40% for the first two steps of the PTD process. The Legislature made this change retroactive and thus all applications for PTD benefits in claims with dates of injury from May 12, 1995 forward were required to meet only the 40% threshold.

In 2003, the Legislature again revisited the workers' compensation issue and again changed the PTD requirements. In SB 2013 the Legislature again modified the minimum threshold for PTD consideration, raising both thresholds to 50% for all applications filed after its effective date. Additionally, the Legislature essentially abolished the Posey/Cardwell standard and statutorily created the analysis for permanent total disability determinations. These were further fleshed out in the subsequent regulations. Additionally, (as the Beirne case had not yet been decided) the Legislature included a provision which mandated that all PTD awards terminate when the claimant reached the age of 70.

Therefore, presently, the PTD application process (contained in West Virginia Code § 23-4-6(n)) remains a three step process.

Step 1. - To be eligible to apply for permanent total disability consideration a claimant must have been awarded a total of prior permanent partial disability awards in excess of 50% or suffered a single occupational injury or disease which resulted in a finding by the Self-Insured Employer that the claimant had suffered a medical impairment of 50% or the claimant has sustained a 35% statutory disability pursuant to West Virginia Code § 23-4-6(f).

Step 2. - Once a determination is made that the claimant met the first threshold, the claim is referred to the "Reviewing Body" (formerly known as the IEB) to be reevaluated to determine if the claimant suffered a whole body medical impairment of 50% or more from either a single occupational injury or disease or a combination of occupational injuries and disease or has sustained a 35% statutory disability pursuant to West Virginia Code § 23-4-6(f).

Step 3. - Once a determination is made that the claimant met both of the statutory thresholds West Virginia Code § 23-4-6(n)(2) governs the determination of entitlement and states:

For all awards made on or after the effective date of the amendment and reenactment of this section during the year two thousand three, disability which renders the injured employee unable to engage in substantial gainful activity in which he or she previously engaged with some regularity and over a substantial period of time shall be considered in determining the issue of total disability. The comparability of preinjury income to post-disability income will not be a

factor in determining permanent total disability. Geographic availability of gainful employment within a driving distance of seventy-five miles from the residence of the employee or within the distance from the residence of the employee to his or her preinjury employment, whichever is greater, will be a factor in determining permanent total disability. For any permanent total disability award made after the amendment and reenactment of this section in the year two thousand three, permanent total disability benefits shall cease at age seventy years. In addition, the vocational standards adopted pursuant to subsection (m) section seven, article three of this chapter shall be considered once they are effective.

W. Va. Code § 23-4-6(n)(2) (2005).

Additionally, the statute provides for statutory PTD awards in specific claims which are identified in West Virginia Code § 23-4-6(m) and include the loss of both eyes or the sight thereof; the loss of both hands or the use thereof; the loss of both feet or the use thereof; and the loss of one hand and one foot or the use thereof. Further, West Virginia Code § 23-4-6(n)(2) creates a rebuttable presumption of permanent total disability in a claimant whose prior permanent partial disability awards total 85% or more and meets the first two thresholds.

Calculation of PTD Benefits

Permanent total disability benefits are awarded to an injured worker who meets the eligibility criteria and is determined by a reviewing board not to be able to return to any employment within a 75 mile radius of his residence. These benefits are extremely difficult to obtain at this point. The benefits rate for permanent total disability awards is set forth by statutes as:

The claimant shall be paid benefits so as not to exceed a maximum benefit of sixty-six and two-thirds percent of the claimant's average weekly wage earnings, wherever earned, at the time of the date of injury not to exceed one hundred percent of the average weekly wage in West Virginia. The minimum weekly benefits paid under this section shall be as is provided for in subdivision (b) of this section.

Thus, according to the chart attached hereto, the present maximum permanent total disability benefits are:

Weekly **\$587.35**

Monthly

\$2552.18