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2003 SENATE BILL 339

December 5, 2003 – Introduced by COMMITTEE ON LABOR, SMALL BUSINESS DEVELOPMENT AND CONSUMER AFFAIRS. Referred to Committee on Labor, Small Business Development and Consumer Affairs.

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

Analysis by the Legislative Reference Bureau

This bill makes various changes relating to the worker's compensation law, as administered by the Department of Workforce Development (DWD).

Payment of benefits

Current law requires a party that has been ordered to pay an award of worker's compensation to pay the award within 21 days after DWD mails a copy of the order to the party's last–known address, unless *any* party files a petition for review of the decision. This bill requires a party that has been ordered to pay an award of worker's

compensation to pay the award within those 21 days, unless *that* party files a petition for review of the decision.

Current law requires worker's compensation for permanent disability that results from an injury for which the employer or insurer concedes liability and that is based on a minimum permanent disability rating promulgated by DWD by rule to begin within 30 days after the end of the employee's healing period or within 30 days after the employer or insurer receives a medical report that provides a permanent disability rating, whichever is later. Current law also requires worker's compensation for permanent disability that results from an injury for which the employer or insurer does not concede liability or that is based on a permanent disability rating that is above a minimum permanent disability rating promulgated by DWD by rule to begin within the later of those 30–day periods, unless the employer or insurer requests the employee to undergo an independent medical examination, in which case that compensation must begin within 30 days after the employer or insurer receives a report of the examination or within 90 days after the date of the request for examination, whichever is earlier.

This bill eliminates those payment requirements and instead requires worker's compensation for permanent disability to begin as follows:

1. Within 30 days after the end of the employee's healing period, if the employer or insurer concedes liability for the injury and if the extent of the permanent disability can be determined based on a minimum permanent disability rating promulgated by DWD by rule.

2. Within 30 days after the employer or insurer receives a medical report that provides a basis for a permanent disability rating, if the employer or insurer concedes liability for the injury, but the extent of the permanent disability cannot be determined without a medical report that provides the basis for a permanent disability rating.

3. According to rules promulgated by DWD in cases in which the employer or insurer concedes liability for the injury but disputes the extent of permanent disability.

Under current law, DWD may direct an employer or an employer's insurer to pay unaccrued compensation or death benefits to an injured employee or the employee's dependents in advance if DWD determines that the advance payment is in the best interest of the injured employee or the employee's dependents. This bill specifies that DWD may direct advance payment of death benefits or of unaccrued compensation *for permanent disability*.

Reasonableness of fees and necessity of treatment disputes

Under current law, DWD has jurisdiction to resolve a dispute between a health service provider and an insurer or self–insured employer over the reasonableness of any health service fee charged by the health service provider for services provided to an injured employee who claims worker's compensation benefits or over the necessity of any treatment provided to the employee. This bill prohibits a health service provider from submitting a fee dispute or a dispute over necessity of treatment to DWD before all treatment by the health service provider for the employee's injury has ended if the amount in controversy, whether based on a single

charge or a combination of charges for one or more days of service, is less than $25. After all treatment has ended, a health service provider may submit any fee dispute or dispute over necessity of treatment to DWD, regardless of the amount in controversy.

Under current law, DWD is required to determine the reasonableness of a disputed fee by comparing the disputed fee to the mean fee for the procedure for which the disputed fee was charged, as shown by data from a database certified by DWD. If the disputed fee is at or below the mean fee, plus 1.5 standard deviations from that mean, DWD shall determine that the disputed fee is reasonable and order the fee to be paid. If the disputed fee is above the mean fee, plus 1.5 standard deviations from that mean, DWD shall determine that the disputed fee is unreasonable and order that a reasonable fee be paid, unless the health service provider proves that a higher fee is justified. This bill lowers the standard deviations used to determine the reasonableness of a disputed health service fee to 1.4 standard deviations from the mean.

Under current law, DWD may set aside, reverse, or modify a determination as to the reasonableness of a health service fee charged by a health service provider for services provided to an injured employee who claims worker's compensation benefits or as to the necessity of any treatment provided to such an employee within 30 days after the determination. This bill permits DWD to set aside, reverse, or modify a reasonableness of fee or necessity of treatment determination within 60 days after the determination on the grounds of mistake.

Supplemental benefits; disability or death payments

Under current law, temporary and permanent disability benefits are subject to maximum weekly compensation rates specified in statute. Currently, an injured employee who is receiving the maximum weekly benefit in effect at the time of the injury for permanent total disability or continuous temporary total disability resulting from an injury that occurred before January 1, 1978, is entitled to receive supplemental benefits in an amount that, when added to the employee's regular benefits, equals $202. This bill makes an employee who is injured prior to May 13, 1980, eligible for those supplemental benefits. The bill also increases the supplemental benefit amount for a week of disability occurring after January 1, 2004, to an amount that, when added to the employee's regular benefits, equals $233.

Work injury supplemental benefit fund

Under current law, if an otherwise meritorious claim is barred by the statute of limitations, if the status or existence of the employer or insurer cannot be determined, or if there is otherwise no adequate remedy, DWD, in lieu of worker's compensation benefits, may direct payment from the work injury supplemental benefit fund of such compensation and such medical expenses as would otherwise be due to or on behalf of the injured employee. The work injury supplemental benefit fund consists of moneys that an employer or insurer is required to pay into the state treasury in cases of injuries resulting in death or in the loss or total impairment of a hand, arm, foot, leg, or eye. Specifically, current law requires an employer to pay into the state treasury $5,000 in each case of injury resulting in death and $7,000 in

each case of injury resulting in the loss or total impairment of a hand, arm, foot, leg, or eye. This bill increases those amounts to $10,000.

Examinations and treatment

Under current law, whenever an employee claims worker's compensation, the employee must, on the request of his or her employer or the employer's worker's compensation carrier, submit to reasonable examinations by physicians, chiropractors, psychologists, dentists, or podiatrists (practitioners) provided and paid for by the employer or insurer. Currently, an employee is entitled to have a practitioner provided by himself or herself present at the examination and to receive a copy of all reports of the examination. Also, under current law, if two or more practitioners disagree as to the extent of an injured employee's temporary disability, the end of the employee's healing period, the employee's ability to return to work, or the necessity of further treatment or for a particular type of treatment, DWD may appoint another practitioner to examine the employee and render an opinion. In addition, under current law, a certified report of a practitioner who has examined or treated an injured employee is admissible as evidence of the diagnosis, the necessity of treatment, and the cause and extent of disability of the injured employee, except that a certified report of a dentist is admissible as evidence of the diagnosis and the necessity of treatment, but not of the cause and extent of disability, of the injured employee. Furthermore, under current law, if the testimony presented at a hearing indicates a dispute or creates a doubt as to the extent or cause of an employee's disability or death, DWD may direct that the injured employee be examined, that an autopsy be performed, or that an opinion be obtained by an impartial, competent practitioner. Finally, under current law, subject to certain exceptions, when an employer has notice of an employee's injury and its relationship to the employee's employment, the employer must offer to the employee his or her choice of any practitioner licensed to practice in this state and practicing in this state for treatment of the injury.

This bill includes physician assistants and advanced practice nurse prescribers among the practitioners to which the provisions of current law relating to examination and treatment of an injured employee apply, except as follows:

1. The bill does not permit DWD to appoint a physician assistant or an advanced practice nurse prescriber to examine an injured employee and render an opinion, if two or more practitioners disagree as to the extent of the employee's temporary disability, the end of the employee's healing period, the employee's ability to return to work, or the necessity of further treatment or for a particular type of treatment.

2. The bill does not permit DWD to direct that an injured employee be examined by, that an autopsy be performed by, or that an opinion be obtained from a physician assistant or an advanced practice nurse prescriber, if the testimony at a hearing indicates a dispute or creates a doubt as to the extent or cause of an employee's disability or death.

3. The bill provides that a certified report of a physician assistant or an advanced practice nurse prescriber who has examined or treated an injured

employee is admissible as evidence of the diagnosis and necessity of treatment, but not of the cause and extent of disability, of the injured employee.

Under current law, a physician assistant is a person licensed to provide medical care with physician supervision and direction, and an advanced practice nurse prescriber is an advanced practice nurse who is certified to prescribe drugs.

Uninsured employer payments

Under current law, if an employee of an employer that is not insured or self–insured as required by the worker's compensation law suffers an injury for which the employer is liable under that law, DWD or a reinsurer retained by DWD must pay to the injured employee or the employee's dependents benefits in an amount equal to the worker's compensation that is owed by the uninsured employer, and the uninsured employer must reimburse DWD for the amount of benefits paid, less any amounts that the employee repays DWD from any compensation recovered from the uninsured employer or a third party. This bill requires an uninsured employer, in addition, to reimburse DWD for any expenses paid by DWD in administering the employee's claim.

Program administration

Current law requires employers that are subject to the worker's compensation law to keep records of all accidents causing death or disability of an employee while performing services growing out of and incidental to the employee's employment; requires insurers and self–insured employers to keep records of all payments made under the worker's compensation law; and requires reports based on those records to be furnished to DWD at the times and in the manner that DWD may require by rule or general order. An employer or insurer that fails to keep those records or to make those reports is subject to a forfeiture of not less than $10 nor more than $100 for each offense. This bill permits DWD to waive or reduce a forfeiture imposed for failure to keep those records or to make those reports if the employer or insurer requests a waiver or reduction of the forfeiture within 45 days after notice of the forfeiture is mailed to the employer or insurance company and shows that the violation was due to mistake or an absence of information.

Under current law, if an insurer cancels or terminates a worker's compensation insurance policy, the insurer must provide notice of the cancellation or termination to DWD or, if DWD so provides by rule, to the Wisconsin Compensation Rating Bureau (WCRB), which is a rate service organization licensed by the Commissioner of Insurance to establish worker's compensation premium rates. Currently, notice of cancellation or termination of a worker's compensation insurance policy may be served personally on DWD at its office in Madison or sent to DWD or WCRB by certified mail or facsimile machine transmission. This bill permits that notice, in addition, to be send to DWD or WCRB by electronic mail or by any electronic, magnetic, or other medium approved by DWD.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

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

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

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

102.13 **(1)** (b) (intro.) An employer or insurer who requests that an employee submit to reasonable examination under par. (a) or (am) shall tender to the employee, before the examination, all necessary expenses including transportation expenses. The employee is entitled to have a physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist provided by himself or herself present at the examination and to receive a copy of all reports of the examination that are prepared by the examining physician, chiropractor, psychologist, podiatrist, dentist, physician assistant, advanced practice nurse

prescriber, or vocational expert immediately upon receipt of those reports by the employer or worker's compensation insurer. The employee is also entitled to have a translator provided by himself or herself present at the examination if the employee has difficulty speaking or understanding the English language. The employer's or insurer's written request for examination shall notify the employee of all of the following:

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

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

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

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

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

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

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

102.13 **(1)** (d) 1. Any physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, or vocational expert who is

present at any examination under par. (a) or (am) may be required to testify as to the results ~~thereof~~ of the examination.

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

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

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

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

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

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

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

102.13 **(2)** (a) An employee who reports an injury alleged to be work–related or files an application for hearing waives any physician–patient,

psychologist–patient or chiropractor–patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding ss. 51.30 and 146.82 and any other law, any physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, worker's compensation insurer, or department or its representative, provide that person with any information or written material reasonably related to any injury for which the employee claims compensation.

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

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

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

102.16 **(2)** (a) ~~The~~ Except as provided in this paragraph, the department has jurisdiction under this subsection, sub. (1m) (a), and s. 102.17 to resolve a dispute between a health service provider and an insurer or self–insured employer over the reasonableness of a fee charged by the health service provider for health services

provided to an injured employee who claims benefits under this chapter. A health service provider may not submit a fee dispute to the department under this subsection before all treatment by the health service provider of the employee's injury has ended if the amount in controversy, whether based on a single charge or a combination of charges for one or more days of service, is less than $25. After all treatment by a health service provider of an employee's injury has ended, the health service provider may submit any fee dispute to the department, regardless of the amount in controversy. The department shall deny payment of a health service fee that the department determines under this subsection, sub. (1m) (a), or s. 102.18 (1) (b) to be unreasonable.

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

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

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

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

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

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

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

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

treatment, unless that determination is set aside, reversed or modified by the department under s. 102.18 (3) or by the commission under s. 102.18 (3) or (4) or is set aside on judicial review under s. 102.23.

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

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

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

102.17 **(1)** (d) 1. The contents of certified medical and surgical reports by physicians, podiatrists, surgeons, dentists, psychologists, physician assistants, advanced practice nurse prescribers, and chiropractors licensed in and practicing in this state, and of certified reports by experts concerning loss of earning capacity under s. 102.44 (2) and (3), presented by a party for compensation constitute prima facie evidence as to the matter contained in ~~them~~ those reports, subject to any rules and limitations the department prescribes. Certified reports of physicians, podiatrists, surgeons, dentists, psychologists, physician assistants, advanced practice nurse prescribers, and chiropractors, wherever licensed and practicing, who have examined or treated the claimant, and of experts, if the practitioner or expert

consents to ~~subject himself or herself~~ being subjected to cross–examination also constitute prima facie evidence as to the matter contained in ~~them~~ those reports. Certified reports of physicians, podiatrists, surgeons, psychologists, and chiropractors are admissible as evidence of the diagnosis, necessity of the treatment, and cause and extent of the disability. Certified reports by doctors of dentistry, physician assistants, and advanced practice nurse prescribers are admissible as evidence of the diagnosis and necessity ~~for~~ of treatment but not of the cause and extent of disability. Any physician, podiatrist, surgeon, dentist, psychologist, chiropractor, physician assistant, advanced practice nurse prescriber, or expert who knowingly makes a false statement of fact or opinion in such a certified report may be fined or imprisoned, or both, under s. 943.395.

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

3. The department may, by rule, establish the qualifications of and the form used for certified reports submitted by experts who provide information concerning loss of earning capacity under s. 102.44 (2) and (3). The department may not admit

into evidence a certified report of a practitioner or other expert or a record of a hospital or sanatorium that was not filed with the department and all parties in interest at least 15 days before the date of the hearing, unless the department is satisfied that there is good cause for the failure to file the report.

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

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

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

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

from a hearing, the default of a party, or a compromise or stipulation confirmed by the department.

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

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

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

102.31 **(2)** (a) No party to a contract of insurance may cancel ~~it~~ the contract within the contract period or terminate or not renew ~~it~~ the contract upon the expiration date until a notice in writing is given to the other party fixing the proposed date of cancellation or declaring that the party intends to terminate or does not intend to renew the policy upon expiration. Except as provided in par. (b), when an insurance company does not renew a policy upon expiration, the nonrenewal is not effective until 60 days after the insurance company has given written notice of the nonrenewal to the insured employer and the department. Cancellation or termination of a policy by an insurance company for any reason other than nonrenewal is not effective until 30 days after the insurance company has given written notice of the cancellation or termination to the insured employer and the department. Notice to the department may be given ~~either~~ by personal service of the notice upon the department at its office in Madison ~~or,~~ by sending the notice by ~~facsimile machine transmission or~~ certified mail addressed to the department at its office in Madison, or by transmitting the notice to the department at its office in Madison by facsimile machine transmission, electronic mail, or any electronic,

magnetic, or other medium approved by the department. The department may provide by rule that the notice of cancellation or termination be given ~~by certified mail or facsimile machine transmission~~ to the Wisconsin compensation rating bureau rather than to the department and that the notice of cancellation or termination be given to the Wisconsin compensation rating bureau by certified mail, facsimile machine transmission, electronic mail, or other medium approved by the department after consultation with the Wisconsin compensation rating bureau. Whenever the Wisconsin compensation rating bureau receives such a notice of cancellation or termination it shall immediately notify the department of the notice of cancellation or termination.

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

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

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

(c) Subject to par. (d), if the employer or the employer's insurer concedes liability for an injury that results in permanent disability, but the extent of the permanent disability cannot be determined without a medical report that provides

the basis for a minimum permanent disability rating, compensation for permanent disability shall begin within 30 days after the employer or the employer's insurer receives a medical report that provides a basis for a permanent disability rating~~, whichever is later. Compensation for permanent disability that results from an injury for which the employer or the employer's insurer does not concede liability or that is based on a permanent disability rating that is above a minimum permanent disability rating promulgated by the department by rule shall begin within the later of those 30–day periods unless within the later of those 30–day periods the employer or insurer notifies the employee that the employer or insurer is requesting an examination under s. 102.13 (1) (a), in which case compensation for permanent disability shall begin within 30 days after the employer or insurer receives the report of the examination or within 90 days after the date of the request for the examination, whichever is earlier~~.

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

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

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

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

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

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

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

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

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

a 2nd choice of attending practitioner on notice to the employer or its insurance carrier. Any further choice shall be by mutual agreement. Partners and clinics are ~~deemed~~ considered to be one practitioner. Treatment by a practitioner on referral from another practitioner is ~~deemed~~ considered to be treatment by one practitioner.

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

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

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

102.44 **(1)** (a) If such employee is receiving the maximum weekly benefits in effect at the time of the injury, the supplemental benefit for a week of disability occurring after January 1, ~~2002~~ 2004, shall be an amount which, when added to the regular benefit established for the case, shall equal ~~$202~~ $233.

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

102.44 **(1)** (b) If such employee is receiving a weekly benefit which is less than the maximum benefit which was in effect on the date of the injury, the supplemental benefit for a week of disability occurring after January 1, ~~2002~~ 2004, shall be an amount sufficient to bring the total weekly benefits to the same proportion of ~~$202~~

$233 as the employee's weekly benefit bears to the maximum in effect on the date of injury.

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

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

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

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

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

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

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

102.82 **(1)** An uninsured employer shall reimburse the department for any payment made under s. 102.81 (1) to or on behalf of an employee of the uninsured employer or to an employee's dependents and for any expenses paid by the department in administering the claim of the employee or dependents, less amounts repaid by the employee or dependents under s. 102.81 (4) (b). The reimbursement

owed under this subsection is due within 30 days after the date on which the department notifies the uninsured employer that the reimbursement is owed. Interest shall accrue on amounts not paid when due at the rate of 1% per month.

SECTION 34. Initial applicability.

(1) FEE DISPUTES AND NECESSITY OF TREATMENT DISPUTES.

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

(b) The treatment of section 102.16 (2) (f) and (2m) (e) of the statutes first applies to fee dispute and necessity of treatment dispute determinations made by the department of workforce development 30 days before the effective date of this paragraph.

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

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

SECTION 35. Effective date.

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

(END)