LRB-3006

2003 DRAFTING REQUEST

Bill

Received: **07/21/2003**

Received By: **gmalaise**

Wanted: **Soon**

Identical to LRB:

For: **Workforce Development 7-6704**

By/Representing: **Jim O'Malley**

This file may be shown to any legislator: **NO**

Drafter: **gmalaise**

May Contact:

Addl. Drafters:

Subject: **Employ Priv - worker's comp**

Extra Copies:

Submit via email: **YES**

Requester's email: **jim.o'malley@dwd.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Worker's compensation changes

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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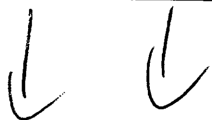

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/?	gmalaise	/1 wlj 7/25					

FE Sent For:

<END>

Malaise, Gordon

From: O'Malley, Jim
Sent: Thursday, July 17, 2003 12:53 PM
To: Malaise, Gordon
Subject: CHAPTER 102 WC AGREED UPON BILL

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2003 Management Proposals - Su...

Legislative ɔroposals from the..

I am forwarding the legislative changes that the Worker's Compensation Advisory Council (WCAC) has ageed upon to date. Attached are the Department's proposals and a proposal to amend s. 102.31(2)(a) from the Worker's Compensation Rating Bureau.

Most of the legislative changes are in the attachment on the left. The amendment to s. 102.32(6) (Department's Proposal 7) is in the middle attachment. The amendment to s. 102.31(2)(a) is in the attachment on the right.

Department's Proposals 1-5 are approved.

Department's Proposal 6 to amend s. 102.31(3) was not approved.This should not be included in the bill.

Department's Proposal 7 to amend s. 102.32(6) is on the middle attachment.The current language of this section has caused a great deal of controversy. We are asking you to adopt the language that is drafted in the attachment.

Department's Proposal 8 is approved.

Department's Proposal 9 to amend s. 102.35(1) was approved in part.The WCAC did not agree to increase the forfeiture amounts to $100 to $500. The WCAC agreed to amend s. 102.35(1) to provide the statutory authority for the Department to rescind forfeitures. We thought that s. 102.35(1)(b) should be created to give authority to rescind forfeitures.

Department's Proposal 16 to amend s. 102.81(1) was approved. This proposal appears out of order because it came up late.

The proposal to amend s. 102.31(2)(a) is on the attachment on the left. This was approved by the WCAC. We did not draft any suggested language for this amendment. Currently WC insurers are required to send cancellation notices to the Rating Bureau by certified or registered mail or by fax. The intention of the amendment is to allow electronic submission of cancellations by insurers to the Rating Bureau by a wide variety of methods but not limited to tapes, cartridges, e-mail, EDI or any other type of technology. You may wish to review DWD 80.02(3m) of the Wisconsin Administrative Code to view the language permitting insurers/employers to report by electronic means.

I will provide you with any other amendments as soon as the WCAC agrees to these. The next meeting is on July 28, 2003 and the " Agreed Upon Bill" should be completed by then.

If you have any questions please feel free to contact me at 267-6704. Thank you for your help.

WORKER'S COMPENSATION DIVISION

PROPOSED STATUTORY AND REGULATORY CHANGES 2003-2004 Revised 5/30/03

	SECTION	TOPIC	PROPOSAL	RATIONALE	STATUS
1.	102.16 (2)(a)	Reasonableness of Fee Disputes	Amend §102.16(2)(a) as follows: (2)(a) 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 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 before treatment to the employee has ended for the injury must involve a minimum $25 amount based on a single charge or a combination of charges for one or more dates of service. There shall be no minimum threshold amount for a dispute between a health service provider and an insurer or self-insured employer after treatment for the injury provided to the employee by the health service provider has ended. 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…	There is an increasing number of reasonableness of fee disputes being submitted which involve very small amounts. Some disputes are for only several dollars. This proposal will limit disputes which are relatively small (under $25 unless treatment has ended) and will contribute to a more cost-effective use of staff time in processing reasonableness of fee disputes. 102.16 (1m)? } those subject 102.18 (1)(b)? } to $25 limit? VO /P2	4/22/03 WCAC requested draft language allowing a provider to submit a dispute regardless of the amount if treatment has ended. 5/13/03 Draft language completed. Approved by WCAC.
2.	102.16(2m) (a)	Necessity of Treatment Disputes	Amend §102.16(2m)(a) as follows: (2m)(a) The department has jurisdiction under this subsection, sub. (1m)(b) and s. 102.17 to	This proposal will limit necessity of treatment disputes, which are relatively small. The proposal will also contribute to a more cost-effective use of staff processing necessity of treatment disputes.	4/22/03 WCAC requested draft language

Approved

Approved

			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 dispute between a health service provider and an insurer or self-insured employer over the necessity of treatment provided to an injured employee by the health service provider before treatment to the employee has ended for the injury must involve a minimum $25 amount based on a single charge or a combination of charges for one or more dates of service. There shall be no minimum threshold amount for a dispute between a health service provider and an insurer or self-insured employer after treatment for the injury provided to the employee by the health service provider has ended. 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…		allowing a provider to submit a dispute regardless of the amount if treatment has ended. 5/13/03 Draft language completed. Approved by WCAC.
Approved 3.	102.16(2)(f)	Reasonableness of Fee Disputes = w/in 60 days if mistake	Amend §102.16(2)(f) as follows: (f) The department may set aside, reverse or modify a determination under this subsection within 30 days after the date of the determination. Thereafter, the department may within 30 days, set aside, reverse or modify a determination under this subsection 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.	This amendment is proposed to provide additional time for department staff to correct mistakes in reasonableness of fee determinations. Currently, some mistakes are not discovered until more than 30 days after the determination has been issued. The additional 30 days will give department staff the authority and opportunity to correct mistakes in determinations. Newly discovered evidence? 102.18(4) No	4/22/03 WCAC requested language change to allow modification within 60 days rather than 90 days originally proposed. 5/13/03 Draft language completed. Approved by WCAC.

4	102.16(2m)(e)	Necessity of Treatment Disputes	Amend §102.16(2m)(e) as follows: (e) The department may set aside, reverse or modify a determination under this subsection within 30 days after the date of the determination. Thereafter, the department may within 30 days, set aside, reverse or modify a determination under this subsection 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.	This amendment is proposed to provide additional time for department staff to correct mistakes in necessity of treatment determinations. Currently, some mistakes are not discovered until more than 30 days after the determination has been issued. The additional 60 days will give department staff the authority and opportunity to correct mistakes in determinations.	4/22/03 WCAC requested language change to allow modification within 60 days rather than 90 days originally proposed. 5/13/03 Draft language completed. Approved by WCAC.
6	102.18(1)(e)	Payment After an Award	Amend to read: (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 a 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.	Clarify that in cases where orders awarding a portion of the benefits claimed, and the order is appealed by the employee the insurance carrier or self-insured employer is required to pay the undisputed/uncontested amount within 21 days rather than after the appeal is resolved.	4/22/03 Approved by WCAC.

Not approved

6.	102.31(3)	Penalties	Amend to read: (3) The department may examine from time to time the books and records of any insurer insuring liability or compensation for an employer in this state. The department may require an insurer to designate one mailing address for use by the department and to respond to correspondence from the department within 30 days. Any insurer that refuses or fails to answer correspondence from the department or to allow the department to examine its books and records is subject to enforcement proceedings under s. 601.64 <u>and penalties under s. 102.35(1)</u>.	Under the current law the only enforcement tool available to the department for failure to answer correspondence is under s.601.64 through the Office of the Commissioner of Insurance (OCI). This amendment will add monetary penalties under s. 102.35(1) Stats. as an incentive and sanction for failure to respond to correspondence from the department.	4/22/03 WCAC action on proposal pending. 5/13/03. WCAC still pending.
7.	102.32(6)	Accrual and payment of permanent partial disability	Amend to read: (6) 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 the employer or the employer's insurer concedes liability and that is based on a minimum permanent disability rating promulgated by the department by rule shall begin within 30 days after the end of the employee's healing period or within 30 days after he employer or the employer's insurer receives a medical report that provides 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<u>s</u> liability 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	The purpose of this amendment is to correct erroneous language used in the previous amendment. The intention for initially amending this section was for cases disputed on the extent of disability to allow insurance carriers and self-insured employers an additional 30 days to give notice of scheduling an employee for an examination under s. 102.13(1)(a) and a 90 day limit beyond the date to begin payment of any compensation for permanent partial disability which is due.	4/22/03 WCAC requested that language be changed to reflect changes proposed by Attorney Lehner & Attorney Weir. 5/13/03 Proposed changes attached to this document. 5/13/03. WCAC approved proposed statutory and rule language.

See management proposal

			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~~ <u>later</u>. 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.		
8.	102.32(6m)	Advance payments of unaccrued compensation	Amend to read: (6m) The department may direct an advance on a payment of unaccrued compensation <u>for permanent disability</u> 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%.	This amendment is to clarify that advance payments of unaccrued compensation can only be considered on permanent disability or death benefits.	4/22/03 Approved by WCAC.

Approved

9.	102.35(1)	Penalties	Amend to read: 102.35 Penalties (1)(a) 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 or fails to respond to correspondence from the department as specified in s. 102.31(3) shall forfeit to the state not less than $10100 nor more than $100500 for each offense. (b) Forfeitures may be rescinded by the department upon timely request from the employer, self-insured employer or insurance carrier due to mistake or absence of information. Requests for rescission of forfeitures must be made within the time period provided by the department for this purpose.	Under the current law, the only enforcement tool available to the department for failures to answer correspondence is through the Office of the Commissioner of Insurance (OCI) under s. 601.64. These changes will add the monetary penalties under s. 102.35(1) as an alternative or additional enforcement tool to referrals to OCI for missing reports for failure to respond to departmental correspondence. The changes also increase the minimum and maximum of the forfeiture penalty provisions under s. 102.35(1). They have not been changed since 1931. Both the OCI as well as the insurance carriers have recommended that the department not use the enforcement proceedings in s.601.64 for failure to submit required reports and correspondence. Also the current law only provides for issuing forfeitures. This proposal provides that employers and insurers can request rescission of the forfeitures and the authority for the department to rescind them.	4/22/03 WCAC requested that proposal include language for a graduated penalty for repeated failure to provide reports. 5/13/03 Proposed alternative language change attached to this document. WCAC action pending.
10.	80.02(2)(b)	Reporting requirements for WKC-13 and to the employee	Amend to read: (b) A supplementary report with the information required by form WKC-13 on or before the 30th day following the day on which the injury in par. (a) occurred or on or before the 30th day following the day the injury was reported to the department, if the injury was not required to be reported under par. (a).	Under the current rule, insurers are required to submit supplemental reports only if the reported injury meets the definition of lost time under DWD 80.02(1)(a). However, insurers report many claims even though they do not meet that definition and insurers then fail to notify the department or submit a subsequent report. This causes the department to have to follow-up with them to get the outcome of the claims which are often denied claims or " no-lost-time" claims not meeting the DWD 80.02(1)(a) definition. These changes will make it a requirement to submit a supplemental report for all claims reported whether or not they meet the lost-time definition. It does not require the reporting of no lost time or denied claims, just the filing of a supplemental report when any claim is reported.	4/22/03 Approved by WCAC. 5/13/03 Draft language completed. WCAC approved.

Rules	11.	80.02(g)2	Reporting requirements to the department and employee	Amend to read: 2. A decision to deny liability for payment of compensation for reported claims after a concession of liability is made, giving the reason for the denial and advising the employee of the right to a hearing before the department.	Under the current rule insurers and self-insured employers are required to provide copies of notices to deny claims to the department. The rule is inconsistent with the requirement to report only compensable claims under DWD 80.02(1)(a). However, if a claim is initially reported and paid and later denied, the insurer or self-insured employer is still required to provide notice to the employee and the department.	4/22/03 Approved by WCAC.
Rules	12.	80.02(2)(h)	Reporting requirements	Amend DWD 80.02 (2) Title and create 80.02(2m) as follows: (2) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES; REPORTS. (2m) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES; NOTICE TO EMPLOYEE. For all injuries under sub. (1)(a), self-insured employers and insurance companies shall provide written notice to the employee: (a) Within 14 days of the date of an alleged injury under sub. (1) (a): either a decision to deny liability for payment of compensation, giving the specific reason for the denial and advising the employee of the right to a hearing before the department; or an explanation that the claim is not paid because the insurance carrier or self-insured employer is still investigating the claim. This notice shall specify the information needed to complete the investigation. If notice from the employee to	Under the current DWD 80.02(2)(h) insurers and self-insured employers are required to provide copies of notices to deny or investigate claims to the department. The rule is inconsistent with the requirement to report only compensable injuries under DWD 80.02(1)(a). If the insurer or self-insured employer initially sends out a notice of investigation, the insurer or self-insured employer has ~~45~~ 30 days thereafter to either pay benefits or deny the claim.	4/22/03 WCAC requested draft language to include 30 rather than 45 days for completion of investigation and that insurer/self-insurer must specify the information needed to complete the investigation. 5/13/03 Draft completed. WCAC requested changes to language. Changes to be

			the insured employer or from the insured employer to its insurance carrier was not made within 7 days of the date of the alleged injury, the insurance carrier shall provide the decision or explanation of non-payment within 14 days of receiving notice of the alleged injury from any source. (b) Within 30 days of providing an explanation of non-payment for an alleged injury due to an ongoing investigation, the carrier or self-insured employer must either begin making payments of compensation or give notice of a decision to deny liability for payment of compensation, giving the specific reason for the denial and advising the employee of the right to a hearing before the department.		submitted electronically to WCAC.
13.	80.02(3m)	Reporting by electronic, magnetic or other media	Amend rule and renumber. 80.02(3m) REPORTING BY ELECTRONIC, MAGNETIC OR OTHER MEDIA. ~~(a)~~1(a) An employer . . . (b) The authorization shall be in writing . . . 2 (a) The department may require an employer, self-insured employer or insurer to submit all or selected information in reports or amendments to reports required to be filed with the department in sub. (1) or (2) via electronic, magnetic, or other media satisfactory to the department. The department may require an employer, self-insured employer or insurer to use electronic, magnetic or other reporting media after considering the extent to which it will help the employer, self-insured employer or insurer	Under the current rule, insurers may request to report electronically but are not required to do so. This change allows the department discretion to require electronic reporting when it believes it will help the employer or insurer to meet the reporting requirements. These changes will help the department to effectively enforce reporting requirements and create efficiencies in the reporting process. Electronic reporting has been available to insurers and is used by many. However, some insurers fail to use it and fail to effectively submit required reports. This change gives latitude and discretion to the department to require electronic reporting for its interests in efficiency and effectiveness of monitoring claims. This will reduce some frictional costs between insurers and the department including additional correspondence. There is no anticipated unusual workload increase or effect on staffing. This should help reduce workload	4/22/03 WCAC requested draft language allowing for waiver upon showing of good cause. 5/13/03 Draft language completed. WCAC approved.

Rule

			meet or exceed the applicable reporting requirements and performance standards in subs. (1) to (3). (b) The directive requiring reporting by electronic, magnetic or other media shall be in writing and set forth terms and conditions including a deadline for compliance. (c) An employer, self-insured employer or insurer can request a waiver within 60 days of the date of the department's directive requiring reporting by electronic, magnetic or other media. The department shall, within its discretion, grant the waiver if the department is satisfied that the employer, self-insured employer or insurer has established good cause.	for insurers and for the department.	
14.	80.72(3)(a)	Reasonableness of fee determinations	Amend rule as follows: (a) In a case where liability or the extent of disability is in dispute, an insurer or self-insured employer must provide written notice of the dispute to the health care provider within 30 days after receiving a completed bill which clearly identifies the provider's name, address and phone number; the patient – employee, the date of service and the health service procedure, unless there is good cause for delay in providing notice. In a case where liability for the extent of disability is not in issue, and a health care provider charges a fee which an insurer or self-insurer refuses to pay because . . .	There is an increasing number of reasonableness of fee disputes being submitted in which insurers and self-insured employers are raising liability as a defense to take the case out of the dispute resolution process. The liability defense is being raised after the answer is submitted. This proposal will require liability to be raised earlier in the process, unless there is good cause for not raising the issue earlier.	4/22/03 Approved by WCAC. 5/13/03 Draft language completed. WCAC approved.

Rules

15.	80.73(3)(a)	Necessity of treatment disputes	Amend rule as follows: (a) <u>In a case where liability or the extent of liability is in dispute, an insurer or self-insured employer must provide written notice of the dispute to the health care provider within 60 days after receiving a bill which documents the treatment provided to the worker, unless there is good cause for delay in providing notice.</u> An insurer or self-insurer which refuses to pay for treatment rendered to an injured worker because it disputes that the treatment is necessary shall, in a case where liability or the extent of liability is not an issue, give the provider . . .	There is an increasing number of necessity of treatment disputes being submitted in which insurers and self-insured employers are raising liability as a defense to take the case out of the dispute resolution process. The liability defense is being raised after the answer is submitted and in some cases after the determination is issued. This proposal will require liability to be raised earlier in the process, unless there is good cause for not raising this issue earlier.	4/22/03 Approved by WCAC. 5/13/03 Draft language completed. WCAC approved.
16.	102.82(1)	Uninsured employer payments	Amend to read: **(1)** An uninsured employer shall reimburse the department for any payment made under s. 102.81(1) to <u>or on behalf of</u> an employee of the uninsured or to an employee's dependents <u>and for expenses paid by the department in administering the claim</u>, 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 on paid when due at the rate of 1% per month.	The Uninsured Employers Fund (UEF) is authorized to retain a third party administrator to process, investigate and pay claims under s. 102.81(2), Stats. In processing and investigating claims the third party administrator incurs expenses for claims administration. Examples of these expenses are payments required for medical records, examinations under s. 102.13(1), Stats., police and court records/reports, contractors and managed care services. Managed care fees include expenses for services such as medical case management, vocational rehabilitation management, utilization review services, light duty/return-to-work programs, prospective injury management services, automated state fee scheduling and hospital bill audit services. These are important ancillary claims services, which are necessary for effective worker's compensation claims administration. Utilizing these services will result in overall reduced costs to the UEF and the amount employers are required to reimburse to the department. The department's policy of assessing an uninsured	5/30/03 New proposal by the department.

Rule

Approved

				employer for UEF claim administration expenses was recently questioned. Currently there is no specific statutory authority in s. 102.82(1), Stats. which requires uninsured employers to reimburse the department for claims administration expenses. This proposal will specifically require uninsured employers to reimburse the department for claims administration expenses. The department is advancing this proposal to protect the Fund against depletion as much as reasonably possible.	
[illegible].	DWD 80.62(7)(a)(3)	Uninsured employers fund	Amend to read: 3. To seek reimbursement from employers under s. 102.82(1), Stats., for payments made from the fund to or on behalf of employees, ~~or~~ their dependents, and claims administration expenses.	Same rationale as # 16 above. This rule will go along with the statutory changes to §102.82(1). This proposal will specifically require uninsured employers to reimburse the department for claims administration expenses.	5/30/03 New proposal by the department.

Rule

2003 Management Proposals to Amend the WCA — Supplementary Proposal to Amend § 102.32(6)

	Statute	Topic	Proposal
	102.32(6)	Accrual and payment of permanent partial disability	The Department's proposal number 7 attempts to fix some statutory language from the last set of amendments. Even with the proposed change, the statute would still not carry out the original intent, insofar as it is intelligible. First, the statute was amended to provide for making payment of PPD benefits on conceded claims when one of the minimum ratings under DWD 80.32 would apply. Such payment is to begin within 30 days after the end of healing. As drafted, it provides for payment to begin within 30 days after the end of healing *or* within 30 days after the employer/insurer receives a medical report that provides a PPD rating, whichever is *later*. Thus, even when a minimum rating under DWD 80.32 would clearly apply, the employer/insurer does not have to begin payment within 30 days after the end of healing if it has not yet received a medical report with a PPD rating. Since the medical report would be *later*, the PPD payments would not have to begin until 30 days after the medical report is received. The following proposed language would implement the intent of the statute: Compensation for permanent disability that results from an injury for which the employer or the employer's insurer concedes liability and that is based on a minimum permanent disability rating promulgated by the department by rule shall begin within 30 days after the end of the employee's healing period, or within 30 days after the employer or the employer's insurer receives a medical report that first provides a basis for such a minimum permanent disability rating, whichever is later. Thus, for a conceded injury, the payment of PPD based upon a minimum rating under DWD 80.32 would have to begin within 30 days after the end of healing whenever a minimum rating would automatically apply. (E.g., the employee has back surgery with a removal of disc material at one level, for a minimum rating of 5% PTD.) Alternatively, in other cases the PPD payments would have to begin within 30 days after a medical report was submitted that first provided information making it clear that a minimum rating under DWD 80.32 would apply. (E.g., a shoulder injury where the physician provides information as to the degrees of limitation of active elevation in flexion and abduction under DWD 80.32(7).)

			The third sentence of section 102.32(6) also needs to be amended since it is presently unintelligible, even with the Department's proposed change. The intended effect of the statute is too complex to be incorporated into a statute, because of the limitations inherent in statutory drafting. The intent of the statute would be more effectively carried out in the form of an administrative rule. Proposed language for the administrative would be: **DWD 80.xx**: Payment of permanent disability where the ~~degree of permanancy~~ extent of disability is disputed. Where injury is conceded, but the employer or the employer's insurer disputes the extent of permanent disability, payment of permanent disability shall begin: (1) Within 30 days of a report that provides the permanent disability rating, in the amount of the permanancy set forth in the report; or (2) Within 30 days after the employer or insurer receives a report from an examination performed under s. 102.13(1)(a), in the amount of the permanent disability found as a result of that medical examination, if any. If such an examination had not previously been performed, the employer or employer's insurer must give notice of a request for such an examination within 30 days of ~~a~~ receiving a report that establishes the permanent disability under ~~(a)~~ (1), and in the event that a report from the examination is not available within 90 days of the request for the examination, the employer and insurer shall begin payment of the permanent disability set forth in the report under ~~(a)~~ (1). Therefore, the third sentence of sec. 102.32(6) should be repealed and replaced with the foregoing administrative rule.

Legislative Proposals from the Public and Legislators for Possible Consideration in 2003 - 2004

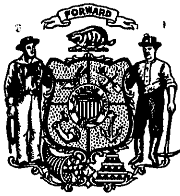
Statute	Topic	Proposal	Source	Date
No current statute	Low interest loan program for injured employees	Creation of a low interest loan program for individuals who are experiencing financial hardship while waiting for a decision on eligibility for worker's compensation or social security benefits. This would be set up like a farmer's FSA loan with the loan in a managed account. The program would provide loans up to $10,000 at a flat interest rate of 2 to 5 percent. To qualify for the loan the individual must agree to pay off the loan first from the proceeds of a worker's compensation settlement or a social security disability lump sum payment before the funds are distributed to the individual. Interest would apply only to the amount used. If benefits are not paid the individual is responsible for the amount of the loan used with interest to be repaid in monthly installments over a five (5) year period.	Gregory W. Stebler	4/24/02
102.31 (2) DWD 80.65 Approved	Insurer filing cancellation notices to the WCRB	Currently the language in s. 102.31 (2), Stats. and DWD 80.65 provides that insurers are required to send cancellation notices to the Wisconsin Compensation Rating Bureau (WCRB) by certified or registered mail or by facsimile. With changes in technology the WCRB requests that this be expanded to allow for electronic submissions. Electronic submission will include but is not limited to tapes, cartridges, e-mail and EDI with the goal to have the electronic submission methods generic to not be limited by type of technology. The WCRB and the WCD would determine the acceptable electronic submission methods and notify insurers. Electronic submissions would apply only to the insurers obligation for filing with the WCRB and WCD and will not impact the requirements for insurers to notify employers. – "electronic, magnetic, or other medium satisfactory to bureau"	Ralph Herrmann President of the WCRB	6/10/02

102.076 (1)	Election by corporate officer to not be subject to Chapter 102	Amend s. 102.076(1), Stats., to permit corporate officers who elected to not be subject to Chapter 102 to once again become subject (eligible for benefits) with 30 days notice. Under current law if the corporate officer elected not to be subject the election is effective for the period of the policy and may not be reversed during the period of the policy. The amendment is proposed because of concern about corporate officers who elected not to be subject and may be left without coverage for work-related injuries during the policy period.	Dennis Mackeben, Branch Manager Brown & Brown Insurance	6/14/02	
102.43	Three day waiting period	A constituent of Senator Baumgart's believes the current law on the three day waiting period encourages people to remain off work longer than necessary so they will be eligible for benefits.	Senator Baumgart	8/8/02	

102.13 (2)	Require use of department's medical authorization form	Require insurance carriers and self – insured employers to use the department's medical record release authorization form, Voluntary and Informed Consent for Disclosure of Health Care (WKC- 9488) for obtaining employees' medical records from health care providers. Currently some authorizations are used which omit language advising employees they are entitled to receive at no cost a copy of the medical records obtained through the use of the authorization. Under this proposal employees will be advised about receiving copies of the reports obtained by the authorization.	Attorney John B. Edmondson	8/26/02	
102.22 628.45	12 percent interest on overdue payments	Require payment of interest at the rate of 12% per year on all overdue payments owed by the insurance carriers. The 12% interest will apply to the payments made 30 days after they are due.	Attorney John B. Edmondson	8/7/02 10/4/02	

102.17 (1) 102.18(1) (bp) 102.57	Scheduling Hearings, Bad Faith, Safety Violations WC handbook and appointments with health care providers	1. Hearings should be scheduled faster with 3-6 months as the maximum time. 2. Increase the maximum penalties for bad faith under s. 102.18 (1)(bp), Stats. and 15% increased compensation under s.102.57, Stats., from $15,000 to $50,000. 3. All injured employees must be provided with a WC Handbook which explains rights and responsibilities. 4. Prohibit caseworkers employed by employers and insurance carriers from attending appointments with employees and health care providers.	Paul Koehler	10/9/02	
102.43 80.(47)	Liability for compensation for temporary disability after discharge for misconduct	DWD 80.47 provides that an employer is liable for temporary total disability benefits while an employee is subject to temporary limitations, unless the employer offers suitable work within the temporary limitations. The decision in Brakebush Bros., Inc. v. LIRC, 210 Wis. 2d 623, (1997), held that termination for misconduct during a period of temporary limitations does not bar a claim for temporary disability benefits. S.102.43, Stats. and DWD 80.47 should be amended to provide that an employer is not liable for temporary disability benefits if the employer demonstrates that an offer of suitable employment was terminated because of the employee's misconduct.	Senator Lazich	11/27/02	

102.01 (2)(g)2	Date of injury for occupational disease claims	Change law on the date of injury for occupational disease claims to permit a later date other than the date of first lost time to allow higher wage for compensation payments.	Lori Linde letter Testimony at Public Hearing	11/20/02 12/11/02	
80.73 (3)	Definition of liability for necessity of treatment disputes	Define liability or extent of liability for disputes involving necessity of treatment under s. 102.16 (2m) Stats., and DWD 80.73.	Russell A. Leonard Executive Director WAC	12/02	



State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–3006/?
GMM...:...:...

AN ACT ...; **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 without a medical report that provides the basis for a permanent disability rating.

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

3. Within 30 days after the employer or insurer receives a report of an independent medical examination of the employee or, if the employer or insurer does not receive such a report within 90 days after requesting the examination, within 90 days after the request for the examination, if the employer or insurer concedes liability for the injury but disputes the permanent disability rating provided in a medical report that provides the basis for that rating.

Under current law, DWD may direct an employer or an employer's insurer to pay unaccrued compensation to an injured employee in advance if DWD determines that the advance payment is in the best interest of the injured employee. This bill specifies that DWD may direct advance payment only 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 such an 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 may set aside, reverse, or modify a determination as to the reasonable 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 such a determination within 60 days after the determination on the grounds of mistake.

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 3rd 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 such times and in such manner as 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 a time period to be established by DWD by rule 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 the WCRB by certified mail or facsimile machine transmission. This bill permits that notice, in addition, to be send to DWD or the WCRB by electronic mail or by any other 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:

1 **SECTION 1.** 102.16 (1m) (a) of the statutes is amended to read:

2 102.16 **(1m)** (a) ~~If~~ Subject to sub. (2) (a), if an insurer or self–insured employer

3 concedes by compromise under sub. (1) or stipulation under s. 102.18 (1) (a) that the

4 insurer or self–insured employer is liable under this chapter for any health services

1 provided to an injured employee by a health service provider, but disputes the
2 reasonableness of the fee charged by the health service provider, the department
3 may include in its order confirming the compromise or stipulation a determination
4 as to the reasonableness of the fee or the department may notify, or direct the insurer
5 or self–insured employer to notify, the health service provider under sub. (2) (b) that
6 the reasonableness of the fee is in dispute.

History: 1975 c. 147, 200; 1977 c. 195; 1981 c. 92, 314; 1983 a. 98; 1985 a. 83; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38; 1999 a. 14, 185; 2001 a. 37.

7 **SECTION 2.** 102.16 (1m) (b) of the statutes is amended to read:

8 102.16 **(1m)** (b) ~~If~~ Subject to sub. (2m) (a), if an insurer or self–insured employer
9 concedes by compromise under sub. (1) or stipulation under s. 102.18 (1) (a) that the
10 insurer or self–insured employer is liable under this chapter for any treatment
11 provided to an injured employee by a health service provider, but disputes the
12 necessity of the treatment, the department may include in its order confirming the
13 compromise or stipulation a determination as to the necessity of the treatment or the
14 department may notify, or direct the insurer or self–insured employer to notify, the
15 health service provider under sub. (2m) (b) that the necessity of the treatment is in
16 dispute.

History: 1975 c. 147, 200; 1977 c. 195; 1981 c. 92, 314; 1983 a. 98; 1985 a. 83; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38; 1999 a. 14, 185; 2001 a. 37.

17 **SECTION 3.** 102.16 (2) (a) of the statutes is amended to read:

18 102.16 **(2)** (a) ~~The~~ Except as provided in this paragraph, the department has
19 jurisdiction under this subsection, sub. (1m) (a), and s. 102.17 to resolve a dispute
20 between a health service provider and an insurer or self–insured employer over the
21 reasonableness of a fee charged by the health service provider for health services
22 provided to an injured employee who claims benefits under this chapter. A health
23 service provider may not submit a fee dispute to the department under this

1 subsection, sub. (1m) (a), or s. 102.17 before all treatment by the health service
2 provider of the employee's injury has ended if the amount in controversy, whether
3 based on a single charge or a combination of charges for one or more days of service,
4 is less than $25. After all treatment by a health service provider of an employee's
5 injury has ended, the health service provider may submit any fee dispute to the
6 department, regardless of the amount in controversy. The department shall deny
7 payment of a health service fee that the department determines under this
8 subsection, sub. (1m) (a), or s. 102.18 (1) (b) to be unreasonable.

9 (am) A health service provider and an insurer or self–insured employer that
10 are parties to a fee dispute under this subsection are bound by the department's
11 determination under this subsection on the reasonableness of the disputed fee,
12 unless that determination is set aside on judicial review as provided in par. (f). A
13 health service provider and an insurer or self–insured employer that are parties to
14 a fee dispute under sub. (1m) (a) are bound by the department's determination under
15 sub. (1m) (a) on the reasonableness of the disputed fee, unless that determination is
16 set aside or modified by the department under sub. (1). An insurer or self–insured
17 employer that is a party to a fee dispute under s. 102.17 and a health service provider
18 are bound by the department's determination under s. 102.18 (1) (b) on the
19 reasonableness of the disputed fee, unless that determination is set aside, reversed,
20 or modified by the department under s. 102.18 (3) or by the commission under s.
21 102.18 (3) or (4) or is set aside on judicial review under s. 102.23.

History: 1975 c. 147, 200; 1977 c. 195; 1981 c. 92, 314; 1983 a. 98; 1985 a. 83; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38; 1999 a. 14, 185; 2001 a. 37.

22 **SECTION 4.** 102.16 (2) (f) of the statutes is amended to read:

23 102.16 **(2)** (f) ~~The~~ Within 30 days after a determination under this subsection,
24 the department may set aside, reverse, or modify ~~a determination under this~~

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

History: 1975 c. 147, 200; 1977 c. 195; 1981 c. 92, 314; 1983 a. 98; 1985 a. 83; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38; 1999 a. 14, 185; 2001 a. 37.

8 **SECTION 5.** 102.16 (2m) (a) of the statutes is amended to read:

9 102.16 **(2m)** (a) ~~The~~ Except as provided in this paragraph, the department has
10 jurisdiction under this subsection, sub. (1m) (b), and s. 102.17 to resolve a dispute
11 between a health service provider and an insurer or self–insured employer over the
12 necessity of treatment provided for an injured employee who claims benefits under
13 this chapter. A health service provider may not submit a dispute over necessity of
14 treatment to the department under this subsection, sub. (1m) (b), or s. 102.17 before
15 all treatment by the health service provider of the employee's injury has ended if the
16 amount in controversy, whether based on a single charge or a combination of charges
17 for one or more days of service, is less than $25. After all treatment by a health
18 service provider of an employee's injury has ended, the health service provider may
19 submit any dispute over necessity of treatment to the department, regardless of the
20 amount in controversy. The department shall deny payment for any treatment that
21 the department determines under this subsection, sub. (1m) (b), or s. 102.18 (1) (b)
22 to be unnecessary. A health service provider and an insurer or self–insured employer
23 that are parties to a dispute under this subsection over the necessity of treatment are
24 bound by the department's determination under this subsection on the necessity of

¶ (am)

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.

History: 1975 c. 147, 200; 1977 c. 195; 1981 c. 92, 314; 1983 a. 98; 1985 a. 83; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38; 1999 a. 14, 185; 2001 a. 37.

SECTION 6. 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.

History: 1975 c. 147, 200; 1977 c. 195; 1981 c. 92, 314; 1983 a. 98; 1985 a. 83; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38; 1999 a. 14, 185; 2001 a. 37.

SECTION 7. 102.18 (1) (bg) 1. of the statutes is amended to read:

1 102.18 **(1)** (bg) 1. ~~If~~ <u>Subject to s. 102.16 (2) (a), if</u> the department finds under
2 par. (b) that an insurer or self–insured employer is liable under this chapter for any
3 health services provided to an injured employee by a health service provider, but that
4 the reasonableness of the fee charged by the health service provider is in dispute, the
5 department may include in its order under par. (b) a determination as to the
6 reasonableness of the fee or the department may notify, or direct the insurer or
7 self–insured employer to notify, the health service provider under s. 102.16 (2) (b)
8 that the reasonableness of the fee is in dispute.

History: 1971 c. 148; 1973 c. 150; 1975 c. 147; 1977 c. 29, 195; 1979 c. 89, 278, 355; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1987 a. 179; 1989 a. 64; 1997 a. 38; 1999 a. 14; 2001 a. 37.

9 **SECTION 8.** 102.18 (1) (bg) 2. of the statutes is amended to read:

10 102.18 **(1)** (bg) 2. ~~If~~ <u>Subject to s. 102.16 (2m) (a), if</u> the department finds under
11 par. (b) that an employer or insurance carrier is liable under this chapter for any
12 treatment provided to an injured employee by a health service provider, but that the
13 necessity of the treatment is in dispute, the department may include in its order
14 under par. (b) a determination as to the necessity of the treatment or the department
15 may notify, or direct the employer or insurance carrier to notify, the health service
16 provider under s. 102.16 (2m) (b) that the necessity of the treatment is in dispute.

History: 1971 c. 148; 1973 c. 150; 1975 c. 147; 1977 c. 29, 195; 1979 c. 89, 278, 355; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1987 a. 179; 1989 a. 64; 1997 a. 38; 1999 a. 14; 2001 a. 37.

17 **SECTION 9.** 102.18 (1) (e) of the statutes is amended to read:

18 102.18 **(1)** (e) Except as provided in s. 102.21, if the department orders a party
19 to pay an award of compensation, the party shall pay the award no later than 21 days
20 after the date on which the order is mailed to the last–known address of the party,
21 unless ~~a~~ <u>the</u> party files a petition for review under sub. (3). This paragraph applies
22 to all awards of compensation ordered by the department, whether the award results

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

History: 1971 c. 148; 1973 c. 150; 1975 c. 147; 1977 c. 29, 195; 1979 c. 89, 278, 355; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1987 a. 179; 1989 a. 64; 1997 a. 38; 1999 a. 14; 2001 a. 37.

3 **SECTION 10.** 102.31 (2) (a) of the statutes is amended to read:

4 102.31 **(2)** (a) No party to a contract of insurance may cancel ~~it~~ the contract
5 within the contract period or terminate or not renew ~~it~~ the contract upon the
6 expiration date until a notice in writing is given to the other party fixing the proposed
7 date of cancellation or declaring that the party intends to terminate or does not
8 intend to renew the policy upon expiration. Except as provided in par. (b), when an
9 insurance company does not renew a policy upon expiration, the nonrenewal is not
10 effective until 60 days after the insurance company has given written notice of the
11 nonrenewal to the insured employer and the department. Cancellation or
12 termination of a policy by an insurance company for any reason other than
13 nonrenewal is not effective until 30 days after the insurance company has given
14 written notice of the cancellation or termination to the insured employer and the
15 department. Notice to the department may be given ~~either~~ by personal service of the
16 notice upon the department at its office in Madison ~~or~~, by sending the notice by
17 ~~facsimile machine transmission or~~ certified mail addressed to the department at its
18 office in Madison, or by transmitting the notice to the department at its office in
19 Madison by facsimile machine transmission, electronic mail, or any other electronic,
20 magnetic, or other medium approved by the department. The department may
21 provide by rule that the notice of cancellation or termination be given ~~by certified~~
22 ~~mail or facsimile machine transmission~~ to the Wisconsin compensation rating
23 bureau rather than to the department and that the notice of cancellation or
24 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.

History: 1971 c. 260, 307; 1975 c. 39; 1975 c. 147 ss. 26, 54; 1975 c. 199, 371; 1977 c. 29, 195; 1979 c. 278; 1981 c. 92; 1983 a. 189 s. 329 (25); 1985 a. 29, 83; 1987 a. 179; 1989 a. 64, 332; 1993 a. 81, 112; 2001 a. 37.

SECTION 11. 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. (c), 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 without a medical report the provides the basis for that rating, 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 disputes the extent of the permanent disability, or if the extent of the permanent disability cannot be determined without a medical report that provides the basis for a minimum permanent disability rating promulgated by the department by rule, compensation for permanent disability shall begin within 30 days after the employer or the employer's insurer receives a medical report that provides 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.

History: 1977 c. 195; 1979 c. 278; 1983 a. 98, 368, 538; 1991 a. 221; 1993 a. 492; 2001 a. 37.

SECTION 12. 102.32 (6) (d) of the statutes is created to read:

102.32 **(6)** (d) If the employer or the employer's insurer concedes liability for an injury that results in permanent disability, but disputes the permanent disability rating provided in a medical report submitted under par. (c), the employer or insurer may, within 30 days after receiving the medical report, request the employee to submit to an examination under s. 102.13 (1) (a), unless such an examination has previously been performed. Compensation for permanent disability shall begin within 30 days after the employer or insurer receives the report of the examination, except that, if the employer or insurer does not receive a report of the examination

1 within 90 days after the request for the examination, compensation for permanent
2 disability shall begin within 90 days after the request for examination.

3 **SECTION 13.** 102.32 (6m) of the statutes is amended to read:

4 102.32 **(6m)** The department may direct an advance on a payment of unaccrued
5 compensation <u>for permanent disability</u> or death benefits if the department
6 determines that the advance payment is in the best interest of the injured employee
7 or the employee's dependents. In directing the advance, the department shall give
8 the employer or the employer's insurer an interest credit against its liability. The
9 credit shall be computed at 7%.

History: 1977 c. 195; 1979 c. 278; 1983 a. 98, 368, 538; 1991 a. 221; 1993 a. 492; 2001 a. 37.

10 **SECTION 14.** 102.35 (1) of the statutes is amended to read:

11 102.35 **(1)** Every employer and every insurance company that fails to keep the
12 records or to make the reports required by this chapter or that knowingly falsifies
13 such records or makes false reports shall forfeit to the state not less than $10 nor
14 more than $100 for each offense. <u>The department may waive or reduce a forfeiture</u>
15 <u>imposed under this subsection if the employer or insurance company that violated</u>
16 <u>this subsection requests a waiver or reduction of the forfeiture within the time period</u>
17 <u>established by the department under this subsection and shows that the violation</u>
18 <u>was due to mistake or an absence of information. The department shall promulgate</u>
19 <u>a rule establishing the time period within which a waiver or reduction under this</u>
20 <u>subsection may be requested.</u>

History: 1975 c. 147; 1977 c. 29, 195.

21 **SECTION 15.** 102.81 (1) (a) of the statutes is amended to read:

22 102.81 **(1)** (a) If an employee of an uninsured employer, other than an employee
23 who is eligible to receive alternative benefits under s. 102.28 (3), suffers an injury for
24 which the uninsured employer is liable under s. 102.03, the department or the

1 department's reinsurer shall pay to or on behalf of the injured employee or to the
2 employee's dependents an amount equal to the compensation owed them by the
3 uninsured employer under this chapter except penalties and interest due under ss.
4 102.16 (3), 102.18 (1) (b) and (bp), 102.22 (1), 102.35 (3), 102.57, and 102.60.

History: 1989 a. 64; 1995 a. 117.

5 **SECTION 16.** 102.82 (1) of the statutes is amended to read:

6 102.82 **(1)** An uninsured employer shall reimburse the department for any
7 payment made under s. 102.81 (1) to or on behalf of an employee of the uninsured
8 employer or to an employee's dependents and for any expenses paid by the
9 department in administering the claim of the employee or dependents, less amounts
10 repaid by the employee or dependents under s. 102.81 (4) (b). The reimbursement
11 owed under this subsection is due within 30 days after the date on which the
12 department notifies the uninsured employer that the reimbursement is owed.
13 Interest shall accrue on amounts not paid when due at the rate of 1% per month.

History: 1989 a. 64, 359; 1991 a. 85; 1993 a. 81; 1995 a. 27 s. 9130 (4); 1997 a. 3, 38.

14 **SECTION 17. Initial applicability.**

15 (1) FEE DISPUTES AND NECESSITY OF TREATMENT DISPUTES.

16 (a) The treatment of sections 102.16 (1m) (a) and (b) and (2) (a) and (am) and
17 102.18 (1) (bg) 1. and 2. of the statutes first applies to fee disputes and necessity of
18 treatment disputes submitted to the department of workforce development on the
19 effective date of this paragraph.

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

1 (2) PAYMENT OF AWARDS. The treatment of section 102.18 (1) (e) of the statutes
2 first applies to orders awarding worker's compensation mailed to a party on the
3 effective date of this subsection.
4 (3) PERMANENT DISABILITY PAYMENTS. The renumbering and amendment of
5 section 102.32 (6) of the statutes, the creation of section 102.32 (6) (d) of the statutes,
6 and the treatment of sections 102.32 (6m) of the statutes first apply to compensation
7 for permanent disability that becomes due on the effective date of this subsection.
8 **SECTION 18. Effective date.**
9 (1) This act takes effect on January 1, 2004, or on the day after publication,
10 whichever is later.
11 **(END)**

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–3006/P1dn
GMM.../...:...
WLJ

Jim:

In reviewing this draft, please note all of the following:

1. *Fee dispute and necessity of treatment dispute jurisdictional limit.* The draft clarifies that the $25 threshold for fee disputes and necessity of treatment disputes applies not only to disputes under s. 102.16 (2) and (2m) but also to disputes under s. 102.16 (1m) and 102.18 (1) (bg). If the council wants the threshold to apply only to disputes under s. 102.16 (2) and (2m), the treatment of ss. 102.16 (1m) and 102.18 (1) (bg) can come out.

2. *Setting aside fee dispute and necessity of treatment dispute determinations.* A comparable provision, s. 102.18 (4) (c), grants LIRC an extended time period in which it may set aside a determination not only on the grounds of mistake but also on the grounds of newly discovered evidence. Would the council be interested in granting DWD an extended time period within which it may set aside a fee dispute or necessity of treatment dispute determination on the grounds of newly discovered evidence?

3. *Waiver of penalties.* The submitted language would permit DWD to rescind a penalty on the grounds of mistake or absence of information. "Rescind," however, usually applies to rescission of a contract or repeal of a statute. See *Black's Law Dictionary.* Accordingly, this draft permits DWD to waive or reduce a penalty. See also s. 102.85 (2m) and (2p), which permits DWD to waive, not rescind, penalties.

4. *Permanent disability payments.* The drafting instructions express the opinion that the provisions relating to permanent disability payments set forth in those instructions are too complex for statutory drafting. With all due respect, I disagree. Accordingly, this draft includes statutory provisions relating to permanent disability payments. Basically, the draft breaks down the universe of permanent disability payments into the following cases:

a. Cases in which the extent of disability can be determined from the minimum disability ratings promulgated by rule without a medical report that provides the basis for a disability rating.

b. Cases in which the extent of disability cannot be determined without a medical report that provides the basis for a minimum disability rating or in which the employer disputes the extent of disability.

c. Cases in which the employer disputes the medical report and requests an independent medical examination.

Please review these provisions carefully to ensure that they express the council's intent. If you have any questions about the draft, please do not to contact me directly at the phone number or e–mail address listed below.

Gordon M. Malaise
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Drafter's Note
from the
Legislative Reference Bureau

LRB–3006/P1dn
GMM:wlj:pg

July 25, 2003

Jim:

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a. Cases in which the extent of disability can be determined from the minimum disability ratings promulgated by rule without a medical report that provides the basis for a disability rating.

b. Cases in which the extent of disability cannot be determined without a medical report that provides the basis for a minimum disability rating or in which the employer disputes the extent of disability.

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Please review these provisions carefully to ensure that they express the council's intent. If you have any questions about the draft, please do not hesitate to contact me directly at the phone number or e–mail address listed below.

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