Chapter Ind 80

WORKER'S COMPENSATION

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Ind 80.01 Definitions. (1) "Act," "compensation act" or "worker's compensation act" means ch. 102, Stats.

(2) "Department" means the department of industry, labor and human relations.

(3) "Commission" means the labor and industry review commission.

History: 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82.

Ind 80.02 Reports. (1) EMPLOYERS. Employers covered by the provisions of ch. 102, Stats., shall, within one day after the death of an employe due to an accident or industrial disease, make a brief report of this occurrence to the department by telegraph, telephone or by letter. They shall also make a report on a form WC-12 on or before the fourth day

after the accident or beginning of a disability from occupational disease upon every accident or disease causing death or a disability which exists beyond the third day after the employe leaves work as a result of the accident or disease. (s. 102.43, Stats.)

(2) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES. Pursuant to s. 102.38, Stats., for injuries which require the first report of injury set forth in (1), self-insured employers and insurance companies shall:

(a) Make a supplementary report on a form WC-13 on or before the fourteenth day following that on which the injury occurred, a copy of the WC-12 shall be attached to the initial WC-13, and if the wage is less than the maximum wage as defined by s. 102.11 (1), Stats., submit with the form WC-13, wage information on form WC-13a. If wage information is not available at the time the WC-13 is submitted, a notation should be made on the form WC-13 that a form WC-13a will be submitted at a later date. If an employe restricts his or her availability on the labor market to part-time employment and is not actively employed full time elsewhere, a statement confirming this intention must accompany the WC-13a. This statement is not required if the employe is under the age of 16.

(b) Make a report within 7 days from the date that payments are stopped for any reason. If any payments are stopped for a reason other than the employe's return to work, an explanation of such cessation must be provided to the department and the employe. The self-insured employer or insurance carrier shall advise the employe as to what the employe must do to reinstate payments.

(c) Make a report to the department on form WC-13 with a copy to the employe if payment of compensation is changed from temporary total disability or temporary partial disability to a permanent disability basis. Similar report shall be made if temporary disability benefits are reinstated.

(d) Notify the department and the employe immediately if liability for payment of compensation is denied, giving the reason for such denial. The notice shall advise the employe of the right to a hearing before the department.

(e) Make a final report on a form WC-13 when final payment of compensation has been made. A practitioner's report is necessary if temporary disability exceeds 3 weeks or if permanent disability has resulted. Copies of the final WC-13 form and the final practitioner's report must be sent to the employe.

(f) Notify the department and the employe if the employe fails to return to a practitioner for final examination. The notice shall also advise the employe that in order to determine permanent disability, if any, the final examination is necessary.

(g) Submit a final receipt as proof of payment of any increased compensation due to an injured employe.

(h) File a current form WC-13 indicating all payments to date and the periods of time for which these payments were made when submitting a stipulation or compromise, or at the time of hearing.

Ind 80.68 Payment of benefits under s. 102.59, Stats. (1) Payment of benefits under s. 102.59, Stats., shall initially be made to the individual entitled to the benefits at such time as payments of primary compensation by the employer cease to be made or would have been made had there been no payment under s. 102.32 (6) unless the preexisting disability and the disability for which primary compensation is being paid combine to result in permanent total disability.

(2) Payments received by an employe or dependent from an account in a financial institution or from an annuity policy where such account or annuity policy are established through settlement of the claim for primary compensation, shall be considered payments by the employer or insurance carrier.

(3) Payments under s. 102.59 shall be on a periodic basis but subject to s. 102.32 (6) and (7), Stats.

Note: This rule is adopted to insure the solvency of the work injury supplemental benefit and to insure the protection of dependents as of the date of death of the employe with the preexisting disability.

History: Cr. Register, September, 1986, No. 369, eff. 10-1-86.

Ind 80.70 Malice or bad faith. (1) An employer who unreasonably refuses or unreasonably fails to report an alleged injury to its insurance company providing worker's compensation coverage, shall be deemed to have acted with malice or bad faith.

(2) An insurance company or self-insured employer who, without credible evidence which demonstrates that the claim for the payments is fairly debatable, unreasonably fails to make payment of compensation or reasonable and necessary medical expenses, or after having commenced those payments, unreasonably suspends or terminates them, shall be deemed to have acted with malice or in bad faith.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

Ind 80.72 Health service fee dispute resolution process. (1) PURPOSE. The purpose of this section is to establish the procedures and requirements for resolving a dispute under s. 102.16 (2), Stats., between a health service provider and an insurer or self-insured employer over the reasonableness of a fee charged by the health service provider relating to the examination or treatment of an injured worker, and to specify the standards that health service fee data bases must meet for certification by the department.

(2) DEFINITIONS. In this section:

(a) "ADA" means American dental association.

(b) "Applicant" means the person requesting certification of a data base.

(c) "Certified" means approved by the department for use in determining the reasonableness of fees.

(d) "CPT code" means the American medical association's 1992 physicians' current procedural terminology.

Note: This volume is on file in the offices of the secretary of state and the revisor of statutes, and in the worker's compensation division of the department, GEF I, room 161, 201 E. Washington Ave., Madison, Wisconsin. Copies can be obtained from local textbook stores or from

the American medical association, order department: OP054192, P.O. Box 10950, Chicago, IL 60601.

(e) "Data base" means a list of fees for procedures compiled and sorted by CPT code, ICD-9-CM code, ADA code, DRG code, or other similar coding which is systematically collected, assembled, and updated, and which does not include procedures charged under medicare.

(f) "DRG" means a diagnostic related group established by the federal health care financing administration.

(g) "Dispute" means a disagreement between a health service provider and an insurer or self-insured employer over the reasonableness of a fee charged by a health service provider where the insurer or self-insured employer refuses to pay part or all of the fee.

(h) "Fee" or "health service fee" means the amount charged for a procedure by a health service provider.

(i) "Formula amount" means the mean fee for a procedure plus 1.5 standard deviations from that mean as shown by data from a certified data base.

(j) "ICD-9-CM" means the commission on professional and hospital activities' international classification of diseases, 9th revision, clinical modification.

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(k) "Procedure" or "health service procedure" means any treatment of an injured worker under s. 102.42, Stats.

(l) "Provider" or "health service provider" includes a physician, podiatrist, psychologist, optometrist, chiropractor, dentist, physician's assistant, therapist, medical technician, or hospital.

(m) "Self-insurer" means an employer who has been granted an exemption from the duty to insure under s. 102.28 (2), Stats.

(3) JUSTIFICATION OF DISPUTED FEES. (a) In a case where liability or the extent of disability is not in issue, and a health care provider charges a fee which an insurer or self-insurer refuses to pay because it is more than the formula amount, the insurer or self-insurer shall, except as provided in sub. (6) (b), mail or deliver written notice to the provider within 30 days after receiving a completed bill which clearly identifies the provider's name, address and phone number; the patient-employe; the date of service; the health service procedure; and the amount charged for each procedure. The notice from the insurer or self-insurer to the provider shall specify:

1. The name of the patient-employe and the employer;

2. The date of the procedure in dispute;

3. The amount charged for the procedure;

4. The CPT code, ADA code, ICD-9-CM code, DRG code or other certified code for the procedure;

5. The formula amount for the procedure and the certified data base from which that amount was determined;

6. The amount of the fee that is in dispute beyond the formula amount;

7. The provider's obligation under par. (c), if the fee is beyond the formula amount, to provide the insurer or self-insurer with a written justification for the higher fee, at least 20 days prior to submitting the dispute to the department. The notice must clearly explain that the only justification for a fee more than the formula amount is that the service provided in this particular case is more difficult or more complicated than in the usual case; and

8. The insurer's or self-insurer's obligation under par. (d) to respond within 15 days of receiving the provider's written justification for charging a fee beyond the formula amount.

9. That pursuant to s. 102.16 (2) (b), Stats., once the notice required by this subsection is received by a provider, a health service provider may not collect the disputed fee from, or bring an action for collection of the disputed fee against, the employe who received the services for which the fee was charged.

(b) If the provider and the insurer or self-insurer agree on the facts in sub. (3) (a) 1 to 6, the provider may submit the dispute to the department at any time. If the provider believes there is a factual error in the notice provided by the insurer or self-insurer, it must raise the issue as provided in par. (c).

(c) If, after receiving notice from the insurer or self-insurer, the provider believes a fee beyond the formula amount is justified, or if it does not agree with the factual information provided in the notice under par. (a), then, at least 20 days prior to submitting a dispute to the department, the provider must submit a written justification to the insurer or self-insurer noting the factual error or explaining the extent to which the service provided in the disputed case was more difficult or more complicated than in the usual case, or both.

(d) If the provider submits a written justification under par. (c), the insurer or self-insurer has 15 days after receiving the notice to notify the provider that it accepts the provider's explanation or to explain its continuing refusal to pay the fee. If the insurer or self-insurer accepts the provider's justification, the fee must be paid in full, or in an amount mutually agreed to by the provider and insurer or self-insurer, within 30 days from the date the insurer or self-insurer received written justification under par. (c).

(e) If only a portion of the fee is in dispute, the insurer or self-insurer shall, within the 30-day notice period specified in par.(a), pay the remainder of the fee which is not in dispute.

(4) SUBMITTING DISPUTED FEES. (a) For the department to determine whether or not a fee is reasonable under s. 102.16 (2), Stats., a provider shall file a written request to the department to resolve the dispute within 6 months after an insurer or self-insurer first refuses to pay as provided in sub. (3) (a), and provide a copy of the request and all attachments to the insurer or self-insured employer.

(b) A request by a provider shall include copies of all correspondence in its possession related to the fee dispute.

(c) The department shall notify the insurer or self-insurer when a request to settle the dispute is submitted that the insurer or self-insurer has 20 days to file an answer or a default judgment will be ordered.

(d) The insurer or self-insurer shall file an answer with the department, and send a copy to the provider, within 20 days from the date of the department's notice of dispute. The answer shall include:

1. Copies of any prior correspondence relating to the fee dispute which the provider has not already filed.

2. Information from a certified data base on fees charged by other providers for comparable services or procedures which clearly demonstrates that the fee in dispute is beyond the formula amount for the service or procedure.

3. An explanation of why the service provided in the disputed case is not more difficult or complicated than in the usual case.

(e) The department shall examine the material submitted by all parties and issue its order resolving the dispute within 90 days after receiving the material submitted under par. (d). The department shall send a copy of the order to the provider, the insurer or self-insurer and the employee. If the fee dispute involves a claim for which an application for hearing is filed under s. 102.17, Stats., or an injury for which the insurer or self-insurer disputes the cause of the injury, the extent of disability, or other issues which could result in an application for hearing being filed, the department may delay resolution of the fee dispute until a hearing is held or an order is issued resolving the dispute between the injured employe and the insurer or self-insurer.

(f) The department may develop and require the use of forms to facilitate the exchange of information.

(5) DEPARTMENT INITIATIVE. The department may initiate resolution of a fee dispute when requested to do so by an injured worker, an insurer or a self-insurer. The department shall direct the parties to follow the process provided for in subs. (3) and (4), except where the department specifically determines that extraordinary circumstances justify some modification to expedite or facilitate a fair resolution of the dispute.

(6) INTEREST ON LATE PAYMENT. (a) Except as provided in par. (b), in addition to any amount paid or awarded in a fee dispute, where an insurer or self-insurer fails to respond as required in subs. (3) and (4) or as directed under sub. (5), the insurer or self-insurer shall pay simple interest on the payment or award to the provider at an annual rate of 12 percent, to be computed by the insurer or self-insurer, from the date that the insurer or self-insurer first missed a deadline for response, to the date of actual payment to the provider.

(b) If the insurer or self-insurer notifies the provider within 30 days of receiving a completed bill under sub. (3) (a), that it needs additional documentation from the provider regarding the bill or treatment, the insurer or self-insurer shall have 30 days from the date it receives the provider's response to this request for additional documentation to comply with the notice requirement in sub. (3) (a). Examples of additional

documentation include requests for a narrative description of services provided or medical reports.

(c) For the purpose of calculating the extent to which any claim is overdue, the date of actual payment is the date on which a draft or other valid instrument which is equivalent to payment is postmarked in the U.S. mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(7) CERTIFICATION OF DATA BASES. (a) Before the department may certify a data base under s. 102.16 (2), Stats., and sub. (8), it shall determine that all of the following apply:

1. The fees in the data base accurately reflect the amounts charged by providers for procedures rather than the amounts paid to or collected by providers, and do not include any medicare charges.

2. The information in the data base is compiled and sorted by CPT code, ICD-9-CM code, ADA code, DRG code or other similar coding accepted by the department.

3. The information in the data base is compiled and sorted into economically similar regions within the state, with the fee based on the location at which the service was provided.

4. The information in the data base can be presented in a way which clearly indicates the formula amount for each procedure.

5. The applicant authorizes and assists the department to audit or investigate the accuracy of any statements made in the application for certification by any reasonable method including, if the applicant did not collect or compile the data itself, providing a means for the department to audit or investigate the process used by the person who collected or compiled the data.

6. The information in the data base is up-dated and published or distributed by other methods at least every 6 months.

(b) Before the department may certify a data base under s. 102.16 (2), Stats., it shall consider all of the following:

1. The coverage of the data base, including the number of CPT codes, ICD-9-CM codes or DRGs for which there are data; the number of data entries for each code or DRG; the number of different providers contributing to a code or DRG entry; and the extent to which reliable data exist for injuries most commonly associated with worker's compensation claims;

2. The sources from which the data are collected, including the number of different providers, insurers or self-insurers;

3. The age of the data, and the frequency of the updates in the data;

4. The method by which the data are compiled, including the method by which mistakes in charges are identified and corrected prior to entry and the extent to which this occurs; and the conditions under which charges reported to the applicant may be excluded and the extent to which this occurs;

5. The extent to which the data are representative of the entire geographic area for which certification is sought;

6. The length of time the applicant has been in business and doing business in Wisconsin;

7. The length of time the data base has been in existence;

8. Whether the data base has been certified by any organization or government agency.

(8) APPLICATION FOR CERTIFICATION; DECERTIFICATION. (a) To obtain certification from the department, an applicant shall submit a complete description of the items covered in sub. (7) to the department. The department may require the submission of other information which it deems relevant.

(b) The applicant shall clearly identify any trade secrets under s. 19.36 (5), Stats. The department shall treat any information marked as trade secrets as confidential and shall use it solely for the purpose of certification and shall take appropriate steps to prevent its release.

(c) Notwithstanding par. (b), the department may create a technical advisory group consisting of individuals with special expertise from both the public and private sectors to assist the department in reviewing and evaluating an application.

(d) The department shall certify a data base for one year at a time. The department may extend the one-year certification period while an application for renewal is under review by the department.

(e) If the department determines that an applicant has misrepresented a material fact in its application or that it no longer meets the requirements in sub. (7), the department may decertify a data base after providing the applicant with notice of the basis for decertification and an opportunity to respond.

(9) APPLICABILITY. This section first applies to health service procedures provided on July 1, 1992 and shall take effect on July 1, 1992.

History: Cr. Register, June, 1992, No. 438, eff. 7-1-92.

Ind 80.73 Health service necessity of treatment dispute resolution process. (1) PURPOSE. The purpose of this section is to establish the procedures and requirements for resolving a dispute under s. 102.16 (2m), Stats., between a health service provider and an insurer or self-insurer over the necessity of treatment rendered by a provider to an injured worker.

(2) DEFINITIONS. In this section:

(a) "Dispute" means a disagreement between a provider and an insurer or self-insurer over the necessity of treatment rendered to an injured worker where the insurer or self-insurer refuses to pay part or all of the provider's bill.

(b) "Expert" means a person licensed to practice in the same health care profession as the individual health service provider whose treatment is under review, and who provides an opinion on the necessity of treatment rendered to an injured worker for an impartial health care services review organization or as a member of an independent panel established by the department.

(c) "Licensed to practice in the same health care profession" means licensed to practice as a physician, psychologist, chiropractor, podiatrist or dentist.

(d) "Provider" includes a hospital, physician, psychologist, chiropractor, podiatrist, or dentist, or another licensed medical practitioner who provides treatment ordered by a physician, psychologist, chiropractor, podiatrist or dentist whose order of treatment is subject to review.

(e) "Review organization" or "impartial health care services review organization" means a public or private entity not owned or operated by, or regularly doing medical reviews for, any insurer, self-insurer, or provider, and which, for a fee, can provide expert opinions regarding the necessity of treatment provided to an injured worker.

(f) "Self-insurer" means an employer who has been granted an exemption from the duty to insure under s. 102.28 (2), Stats.

(g) "Treatment" means any procedure intended to cure and relieve an injured worker from the effects of an injury under s. 102.42, Stats.

(3) NOTICE TO THE PROVIDER. (a) An insurer or self-insurer which refuses to pay for treatment rendered to an injured worker because it disputes that the treatment is necessary shall, in a case where liability or the extent of liability is not an issue, give the provider written notice within 60 days of receiving a bill which documents the treatment provided to the worker. The notice shall specify:

1. The name of the patient-employe;

2. The name of the employer on the date of injury;

3. The date of the treatment in dispute;

4. The amount charged for the treatment and the amount in dispute;

5. The reason that the insurer or self-insurer believes the treatment was unnecessary, including the organization and credentials of any person who provides supporting medical documentation;

6. The provider's right to initiate an independent review by the department within 9 months under sub. (6), including a description of how costs will be assessed under sub.(8);

7. The address to use in directing correspondence to the insurer or self-insurer regarding the dispute; and

8. That pursuant to s. 102.16 (2m) (b), Stats., once the notice required by this subsection is received by a provider, the provider may not collect a fee for the disputed treatment from, or bring an action for collection of the fee for that disputed treatment against, the employe who received the treatment.

(b) At the request of an insurer or self-insurer, the department may extend the 60-day period in par. (a) where the insurer or self-insurer is unable to obtain the supporting medical documentation within the 60-day period, or where the department determines other extraordinary circumstances justify an extension.

(c) Except as provided in par. (b), if an insurer or self-insurer provides the notice after the 60-day period, the provider may immediately request

the department to issue a default order requiring the insurer or self-insurer to pay the full amount in dispute.

(4) NOTICE TO THE INSURER OR SELF-INSURER. After receiving notice from the insurer or self-insurer under sub. (3) and, except as provided in sub. (3) (b) and (c), at least 30 days prior to submitting a dispute to the department, the provider shall explain to the insurer or self-insurer in writing why the treatment was necessary to cure and relieve the effects of the injury, including a diagnosis of the condition for which treatment was provided.

(5) RESPONSE BY THE INSURER OR SELF-INSURER. (a) Within 30 days from the date on which the provider sent or delivered notice under sub. (4), an insurer or self-insurer shall notify the provider whether or not it accepts the provider's explanation regarding necessity of treatment.

(b) If the insurer or self-insurer accepts the provider's explanation, the provider's fee must be paid in full, or in an amount mutually agreed to by the provider and insurer or self-insurer, within the 30-day period specified in par. (a). In the case of late payment, the insurer or self-insurer shall pay simple interest on the amount mutually agreed upon at the annual rate of 12 percent, from the day after the 30-day period lapses to the date of actual payment to the provider.

(6) SUBMITTING DISPUTES TO THE DEPARTMENT. (a) For the department to determine whether or not treatment was necessary under s. 102.16 (2m), Stats., a provider shall, after the 30-day notice period in sub. (4) has elapsed, apply to the department in writing to resolve the dispute. The provider shall apply to the department within 9 months from the date it receives notice under sub. (3) from the insurer or self-insurer refusing to pay the provider's bill.

(b) The provider's application to the department shall include copies of all correspondence related to the dispute.

(c) At the time it files the application with the department, the provider shall send or deliver to the insurer or self-insurer which is refusing to pay for the treatment in dispute a copy of all materials submitted to the department.

(d) When an application to resolve a dispute is submitted, the department shall notify the insurer or self-insurer that it has 20 days to either pay the bill in full for the treatment in dispute or to file an answer under par. (e) for the department to use in the review process in sub. (7).

(e) The answer shall include copies of any prior correspondence relating to the dispute which the provider has not already filed, and any other material which responds to the provider's application. The answer shall include the name of the organization, and credentials of any individual, whose review of the case has been relied upon in reaching the decision to deny payment.

(f) The department may develop and require the use of forms to facilitate the exchange of information. For information regarding forms contact the worker's compensation division, medical cost dispute unit, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707.

(7) REVIEW PROCESS. (a) After the 20-day period in sub. (6) (d) for the insurer or self-insurer to answer has passed, the department shall provide

a copy of all materials in its possession relating to a dispute to an impartial health care services review organization, or to an expert from a panel of experts established by the department, to obtain an expert written opinion on the necessity of treatment in dispute.

(b) In all cases where the dispute involves a Wisconsin provider, the expert reviewer shall be licensed to practice in Wisconsin.

(c) When necessary to provide a fair and informed decision, the expert may contact the provider, insurer or self-insurer for clarification of issues raised in the written materials. Where the contact is in writing, the expert shall provide all parties to the dispute with a copy of the request for clarification and a copy of any responses received. Where the contact is by phone, the expert shall arrange a conference call giving all parties an opportunity to participate simultaneously.

(d) Within 90 days of receiving the material from the department under par. (a), the review organization or panel shall provide the department with the expert's written opinion regarding the necessity of treatment, including a recommendation regarding how much of the provider's bill the insurer or self-insurer should pay, if any. At the same time that it provides an opinion to the department, the review organization or panel on which the expert serves shall send a copy of the opinion to the provider and the insurer or self-insurer which are parties to the dispute.

(e) The provider, insurer or self-insurer shall have 30 days from the date the expert's opinion is received by the department under par. (d) to present written evidence to the department that the expert's opinion is in error. Unless the department receives clear and convincing written evidence that the opinion is in error, the department shall adopt the written opinion of the expert as the department's determination on the issues covered in the written opinion.

(f) If the necessity of treatment dispute involves a claim for which an application for hearing is filed under s. 102.17, Stats., or an injury for which the insurer or self-insurer disputes the cause of the injury, the extent of the disability, or other issues which could result in an application for hearing being filed, the department may delay resolution of the necessity of treatment dispute until a hearing is held or an order is issued resolving the dispute between the injured employe and the insurer or self-insurer.

(8) PAYMENT OF COSTS. (a) The department shall charge the insurer or self-insurer the full cost of obtaining the written opinion of the expert for the first dispute involving the necessity of treatment rendered by an individual provider, unless the department determines the provider's position in the dispute is frivolous or based on fraudulent representations.

(b) In a subsequent dispute involving the same provider, the department shall charge the full cost of obtaining the expert's opinion to the losing party.

(c) Any time prior to the department's order determining the necessity of treatment, the department shall dismiss the application if the provider and insurer or self-insurer mutually agree on the necessity of treatment and the payment of any costs incurred by the department related to obtaining the expert opinion.

(9) DEPARTMENT INITIATIVE. In addition to the provider's right to submit a dispute to the department under sub. (6), the department may initiate resolution of a dispute on necessity of treatment when requested to do so by an injured worker, an insurer or a self-insurer. The department shall notify the insurer or self-insurer of its intention to initiate the dispute resolution process and shall direct them to provide information necessary to resolve the dispute. The department shall allow up to 60 days for the parties to respond, but may extend the response period at the request of either party.

(10) EXPERT PANELS. The department may establish one or more panels of experts in one or more treating disciplines, and may set the terms and conditions for membership on any panel. In making appointments to a panel the department shall consider:

(a) An individual's training and experience, including:

1. The number of years of practice in a particular discipline;

2. The extent to which the individual currently derives his or her income from an active practice in a particular discipline; and,

3. Certification by boards or other organizations;

(b) The recommendation of organizations that regulate or promote professional standards in the discipline for which the panel is being created; and,

(c) Any other factors that the department may determine are relevant to an individual's ability to serve fairly and impartially as a member of an expert panel.

(11) APPLICABILITY. This section first applies to health services provided on January 1, 1992, and shall take effect on July 1, 1992.

History: Emerg. cr. eff. 1-1-92; cr. Register, June, 1992, No. 438, eff. 7-1-92.