

## Chapter DWD 80

### WORKER'S COMPENSATION

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**Note:** Chapter Ind 80 was renumbered chapter DWD 80 under s. 13.93 (2m) (b) 1., Stats., Register, July, 1996, No. 487.

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

**(2)** "Department" means the department of workforce development.

**(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; correction in (2) made under s. 13.93 (2m) (b) 6., Stats., July, 1996, No. 487.

**DWD 80.02 Reports. (1) EMPLOYERS.** An employer covered by the provisions of ch. 102, Stats., shall, within one day after the death of an employee due to a compensable injury, report the death to the department and the employer's insurance carrier by telegraph, telephone, letter, facsimile transmission or other means authorized by the department on a case-by-case basis as communication technologies change. An insured employer shall also notify its insurance carrier of a compensable injury within 7 days after the accident or beginning of a disability from occupational disease related to the employee's compensable injury if any of the following occurs:

(a) Disability exists beyond the 3rd day after the employee leaves work as a result of the accident or disease. In counting the days on which disability exists, include Sunday only if the employee usually works on Sunday.

(b) An employer's insurance carrier has primary liability for unpaid medical treatment.

**(2) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES.** Except as provided in sub. (3m), for injuries under sub. (1) (a) self-insured employers and insurance companies shall submit all of the following reports to the department:

(a) A first report of injury with the information required by a completed form WKC-12 on or before the 14th day after an accident or the beginning of a disability from occupational disease. If an employer does not notify the insurance carrier of the injury until after the 14th day, the insurance carrier shall submit the

WKC-12 to the department within 7 days of receiving notice of the injury from any source.

(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.

(c) The wage information required by form WKC-13-A if the wage is less than the maximum wage as defined by s. 102.11 (1), Stats. The WKC-13 required in par. (b) and the WKC-13-A shall be submitted together, except that if the wage information required by form WKC-13-A is not available at the time the WKC-13 is submitted, the insurance carrier or self-insured employer shall estimate on the WKC-13 the date by which the WKC-13-A will be submitted.

(d) If applicable, a signed statement from the employee verifying that the employee restricts his or her availability on the labor market to part-time employment, and is not actively employed elsewhere. The employee's statement shall accompany the WKC-13-A, but no statement is required if the employee is under the age of 16.

(e) A report within 30 days after each of the following events occurs, with a copy to the employee, using form WKC-13 indicating all worker's compensation payments to date and the periods of time for which these payments were made:

1. Payment of compensation is changed from temporary disability to permanent disability.

2. Temporary disability benefits are reinstated.

3. Temporary partial disability is paid. The insurance carrier or self-insured employer shall also include the information required by form WKC-7359.

4. Final payment of compensation is made. If there are more than 3 weeks of temporary disability or any permanent disability, the insurance carrier or self-insured employer shall submit a final treating practitioner's report together with the final WKC-13 or shall explain why the report is not being submitted and shall estimate when the final practitioner's report will be submitted.

(f) When submitting a stipulation or compromise, and at the time of hearing, a current form WKC-13 indicating all worker's

compensation payments to date and the periods of time for which these payments were made.

(g) Written notice within 7 days, with a copy to the employee, after each of the following:

1. Payments are stopped for any reason. If any payments are stopped for a reason other than the employee's return to work, the self-insured employer or insurance carrier shall explain why it stopped payments and shall advise the employee what to do to reinstate payments.

2. A decision to deny liability for payment of compensation is made, giving the reason for the denial and advising the employee of the right to a hearing before the department.

3. Amputation will require an artificial member or appliance.

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

(i) If increased compensation is due, a final receipt within 30 days of the final payment to the employee, as proof of payment of that increased compensation.

(j) If the employee fails to return to a practitioner for a final examination, written notice within 30 days, with a copy to the employee, advising the employee that in order to determine permanent disability, if any, the final examination is necessary.

**Note:** All of the forms referred to in this rule can be obtained from the Department of Workforce Development, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707-7901.

**(3) EVALUATION.** In evaluating whether payments of compensation and reports made by insurance carriers and self-insured employers were prompt and proper under the provisions of ss. 102.28 (2) and 102.31 (3), Stats., and before undertaking to revoke the exemption from insurance under s. 102.28 (2) (c), Stats., or before recommending under s. 102.31 (3), Stats., to the commissioner of insurance that enforcement proceedings under s. 601.64, Stats., be invoked the department will consider all of the following performance standards together with all other factors bearing on the performance and activities of the insurance carrier or self-insured employer:

(a) *Payment of first indemnity.* Whether 80% or more of first indemnity payments are mailed to the injured employee in 14 days or less following the date of injury or the last day worked after the injury before the first day of compensable lost time.

(b) *First report of injury.* Whether 70% or more of reports required under sub. (2) (a) are received by the department within 14 days of the date of injury or the last day worked after injury before the first day of compensable lost time.

(c) *Correct and complete names.* Names of self-insured employers on reports filed with the department must be correct and complete. The name of an insurance group is not a substitute for the name of the individual company insuring the risk. The name of an insurance service company is not a substitute.

(d) *Penalty frequency and severity.* The number and amount of penalties assessed for violations of ss. 102.18 (1) (bp), 102.22 (1), 102.57, and 102.60, Stats.

**(3m) REPORTING BY ELECTRONIC, MAGNETIC OR OTHER MEDIA.**

(a) An employer, self-insured employer or insurer may make a written request to the department to submit the 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 authorize an employer, self-insured employer or insurer to use electronic, magnetic or other reporting media after considering the extent to which it will help the employer, self-insured employer

or insurer meet or exceed the applicable reporting requirements and performance standards in subs. (1) to (3).

(b) The authorization shall be in writing and shall state the terms and conditions for granting and revoking the privilege to use electronic, magnetic or other reporting media, including any terms and conditions relating to reporting requirements or performance standards in subs. (1) to (3). The written authorization shall specify what variations exist, if any, between the data required to be submitted on forms WKC-12, WKC-13, WKC-13-A, or other forms that are used by the department and the data required to be submitted via electronic, magnetic or other media.

**History:** 1-2-56; am. (1) and (2), Register, October, 1965, No. 118, eff. 11-1-66; am. Register, April, 1975, No. 232, eff. 5-1-75; am. (1), r. and recr. (2), Register, September, 1982, No. 321, eff. 10-1-82; am. (2) (intro.) and cr. (3), Register, September, 1986, No. 369, eff. 10-1-86; renum. (1) to be (1) (a) and am., cr. (1) (b) and (3m), am. (2) (intro.), Register, November, 1993, No. 455, eff. 12-1-93; r. and recr. (1) and (2), am. (3) (intro.), (a), (b), (3m) (b) and r. (3m) (c), Register, December, 1997, No. 504, eff. 1-1-98.

### DWD 80.025 Inspection and copying of records.

**(1)** The policy of the state on public access to records is set forth in ss. 19.31 to 19.37, Stats. The policy of the department is to provide, to the greatest extent possible, ready and open access to public records. In the worker's compensation division, access may be limited in particular cases only when consideration of the information in a file leads to the conclusion that the public interest served by nondisclosure is greater than the public interest served by disclosure. The inspection and copying of worker's compensation records shall be subject to the conditions specified in this section.

**(2)** The requester shall provide sufficient information on each individual file requested to permit identification and location of the specific file. Desirable information on claim files includes:

(a) The correct name of the individual who has claimed a work-related disability;

(b) The claimant's social security number;

(c) The date the claimed injury or illness occurred;

(d) The name of the employing firm or firms at the time of the claimed injury or illness;

(e) The name of the employing firm's insurance carrier.

**(3)** Requesters may inspect claim files only in the division's Madison office and under the supervision of division staff. Requesters shall direct requests to inspect files to the receptionist between the hours of 7:45 a.m. and 4:30 p.m. Requesters shall return all files by 4:30 p.m.

**(4)** Requesters may not remove files from the division offices without written authorization from the administrator of the division.

**(5)** Requesters wishing to make copies of all or a part of a file may do so under the supervision of division staff on the coin-operated copy machine provided for that purpose.

**(6)** The division shall provide transcripts of testimony taken or proceedings had before the division only in accordance with s. DWD 80.14.

**(7)** The division shall furnish copies of documents from worker's compensation claim files as requested, with the following limits:

(a) At least one week must be allowed before copies can be delivered or mailed.

(b) Advance payment shall not be required except as provided in par. (e). The division shall send an invoice to the requester for the necessary costs as set forth in par. (c).

(c) The following fees shall apply:

1. 20 cents per page for photocopying.

2. \$2.00 for certifying copies.

3. \$3.00 per request for postage and handling when copies are to be mailed.

(d) Upon a proper showing of inability to pay, the division shall furnish the requested copies upon such terms as may be agreed.

(e) If the requester has unpaid copying fees from prior requests outstanding in an amount that exceeds \$5.00, the division shall require the requester to pay the amount owed before providing more copies.

**History:** Cr. Register, March, 1986, No. 363, eff. 4-1-86.

**DWD 80.03 Compromise.** (1) Whenever an employer and an employee enter into a compromise agreement concerning the employer's liability under ch. 102, Stats., for a particular injury to that employee, the following conditions shall be fulfilled:

(a) The compromise agreement shall be in writing, or in the alternative, oral on the record at the time of scheduled hearing;

(b) The compromise agreement shall be mailed to the department unless made on the record;

(c) The compromise agreement must be approved by the department; and

(d) No compromise agreement may provide for a lump sum payment of more than the incurred medical expenses plus sums accrued as compensation or death benefits to the date of the agreement and \$5,000 in unaccrued benefits where the compromise settlement in a claim other than for death benefits involves a dispute as to the extent of permanent disability. Lump sum payments will be considered after approval of the compromise in accordance with s. DWD 80.39.

(e) Compromise agreements which provide for payment of a lump sum into an account in a bank, trust company or other financial institution, which account is subject to release as the department directs, will be authorized.

(f) Appropriate structured settlements will be approved.

(g) All written compromise agreements submitted to the department shall contain the following:

The employee has the right to petition the department of industry, labor and human relations to set aside or modify this compromise agreement within one year of its approval by the department. The department may set aside or modify the compromise agreement. The right to request the department to set aside or modify the compromise agreement does not guarantee that the compromise will in fact be reopened.

(2) If the department approves the compromise agreement, an order shall be issued by the department directing payment in accordance with the terms of the compromise agreement. No compromise agreement is valid without an order of the department approving the agreement.

(3) Section 102.16 (1), Stats., places upon the department the responsibility for reviewing, approving, modifying, setting aside and issuing awards on compromise agreements. The action that is taken on any individual claim is dependent upon the facts, circumstances and judgment of the merits of compromise in that specific case. In arriving at a judgment of the merits the department will take into account the following general considerations:

(a) Medical reports, statements or other information submitted by the parties to show that there is a genuine and significant basis for a dispute between the parties.

(b) Estimates of the disability by the physicians, chiropractors or podiatrists which do not vary significantly in estimates of the scheduled or nonscheduled disability will not be presumed to demonstrate a basis for dispute.

(c) The length of time since active treatment has been necessary. The presumption is that the longer the interval the less likely that treatment will be required in the future.

(d) Scientific knowledge or experience indicating that there may be further progression of the disability or that future treatment may be required. Examples of such conditions are: skull

fractures with laceration of the dura, sub-capitol fractures of the femur, silicosis and asbestosis.

(e) The length of time since the date of injury.

(f) Any and all other factors that bear on the equity of the proposed compromise.

**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; am. (1) (d), cr. (1) (f) and (g) and (3), Register, September, 1986, No. 369, eff. 10-1-86.

**DWD 80.05 Procedure on claim.** (1) In cases of disputes in matters coming under the jurisdiction of ch. 102, s. 101.47, 56.21 or 40.65, Stats., any party to the dispute may apply to the department for relief and the department shall make such order or award as shall be lawful and just under the circumstances.

(2) In all such cases under sub. (1), the party complaining shall file his or her application with the department, along with sufficient copies of the application for service on the adverse parties. The department shall thereupon serve the adverse parties with a copy of the application and the adverse parties shall file an answer to the application with the department within 20 days after the service and likewise serve a copy of the answer on the party making application. The department shall thereupon notify the parties of the time and place of hearing, at least 10 days prior to the hearing. If no answer is mailed by the respondent within 20 days of mailing by the department, the department may issue an order by default, without hearing, in accordance with the application, as provided by s. 102.18 (1) (a), Stats. (s. 102.17, Stats.)

**History:** 1-2-56; am., Register, April, 1975, No. 232, eff. 5-1-75; am. Register, September, 1982, No. 321, eff. 10-1-82; am. (1), Register, September, 1986, No. 369, eff. 10-1-86.

**DWD 80.06 Parties.** The parties to the controversy shall be known as the applicant and the respondent. The party filing the application for relief shall be known as the applicant and an adverse party as the respondent. Any party may appear in person or by an attorney or agent.

**History:** 1-2-56; am. Register, September, 1982, No. 321, eff. 10-1-82.

**DWD 80.07 Service.** All service of papers, unless otherwise directed by the department or by law, may be made by mail and proof of such mailing shall be prima facie proof of such service. Time within which service shall be made shall be the same as in courts of record unless otherwise specified by rule or order of the department.

**History:** 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75.

**DWD 80.08 Amendments.** Amendment may be made to the application or answer by letter mailed to the department prior to the date the notice of hearing is mailed. Copies of the letter shall be sent directly to the other parties. The letter shall state reasons for the amendment.

**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.

**DWD 80.09 Witness attendance; extension of time and postponement.** (1) Upon receipt of the notice of hearing, it is the responsibility of each party to contact any witnesses necessary for that party's case and to make arrangements to have them attend the hearing.

(2) Requests for postponements and continuances shall be considered by the department only if such requests are received within a reasonable time before the date of the hearing.

(3) The department shall grant postponements and continuances only because of extraordinary circumstances. Neither the scheduling problems nor the convenience of the parties shall be considered extraordinary circumstances.

(4) A postponement, continuance or extension of time may not be granted upon the mutual agreement of the parties without the consent of the department.

**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.

**DWD 80.10 Stipulations.** Parties to a controversy may stipulate the facts in writing, and the department may thereupon make its order or award. Stipulations must set forth in detail the manner of computing the compensation due and must be accompanied by a report from a physician stating the extent of the disability.

**History:** 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75.

**DWD 80.11 Depositions.** Depositions may be taken and used in any hearing only in accordance with s. 102.17 (1) (f), Stats. These depositions shall be taken in the same manner as in courts of record. Depositions for the purpose of discovery before the hearing are specifically prohibited.

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

**DWD 80.12 Rules of practice; selection of hearing site. (1)** (a) The rules of practice before the department shall be such as to secure the facts in as direct and simple a manner as possible.

(b) The examiner may limit testimony to only those matters which are disputed.

(c) The examiner may not allow into the record, either on direct or cross-examination, redundant, irrelevant or repetitive testimony. Hearsay testimony may be admitted at the discretion of the examiner provided such testimony has probative value.

**(2)** The department may select places for a hearing after considering the geographical location and volume of claims in an area. A list of sites will be furnished upon request to interested parties by the department. From this list, a hearing site shall be selected at the discretion of the department. The department, in determining the site of the hearing, shall consider the following:

(a) The location choice of the applicant;

(b) The location of the office of the treating practitioner or practitioner appointed by the department under the provisions of s. 102.17 or 102.13 (3), Stats.; and

(c) The location where the injury occurred.

**History:** Cr. Register, August, 1976, No. 248, eff. 9-1-76; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82.

**DWD 80.14 Transcripts. (1)** Transcripts of testimony taken or proceedings had before the department will be furnished to the applicant or respondent or their attorneys in accordance with the following provisions:

(a) After the commencement of an action to review an order of the commission in circuit court, a copy of the hearing record will be furnished to the plaintiff or other parties upon payment to the department of the reporter's fees set forth in s. 757.57 (5), Stats., and not as set forth in s. 757.57 (2), Stats.

(b) Transcripts of the hearing may not be provided until after commencement of an action in circuit court.

(c) Upon proper showing of financial inability to pay for copies of such testimony or proceedings, the department in its discretion will furnish copies of the same on such terms as may be agreed upon.

**History:** 1-2-56; am. (1) (a) and (b), Register, October, 1965, No. 118, eff. 11-1-65; am. Register, November, 1970, No. 179, eff. 12-1-70; am. (1) (a), Register, April, 1971, No. 184, eff. 5-1-71; r. and recr. (1) (a) and (b), Register, September, 1982, No. 321, eff. 10-1-82.

**DWD 80.15 Payments after an order.** Except for a stipulation or compromise, unless a party has filed a petition for review under s. 102.18 (3), Stats., that party shall pay an administrative law judge's order awarding compensation within 21 days after the department mails a copy of the administrative law judge's finding and order to that party's last known address. For payments ordered by stipulation or compromise, a party shall pay within 10 days after the department mails a copy of the order to that party's last known address.

**History:** Cr. Register, July, 1996, No. 487, eff. 8-1-96.

**DWD 80.20 License to appear. (1)** The following rules shall govern the issuance, suspension, or revocation of licenses to appear before the department in compensation matters under the provisions of s. 102.17 (1) (c), Stats.

(a) Permission to appear at a single hearing may be issued by the department through any examiner upon application evidencing qualifications provided by statute and the department's rules. Such permission may be given to appear in 3 cases before the issuing of license. When appearance has been made in 3 cases, license shall be required, which shall be issued only upon execution and filing with the department of application upon form prescribed by the department.

(b) Before license shall be issued applicant shall have appeared in representation of a party before the department on at least 3 formal hearings.

(c) The following conditions shall operate as grounds for refusal, suspension, or revocation of license.

1. Charging of excessive or unconscionable fees, misrepresentation of clients, dishonesty, fraud, sharp practice, neglect of duty, or other improper conduct in the representation of a party before the department, unless satisfactorily explained or excused by the department on the grounds of subsequent good conduct.

2. Disbarment from the practice of law, or resignation by request of properly constituted authorities, unless there has been subsequent reinstatement and continuance in good standing.

3. Contumacious conduct in hearing, gross discourtesy toward department representatives, or failure to conform to rulings or instructions of the department or its representatives.

4. Intentional or repeated failure to observe provisions of the compensation act or rules of procedure adopted by the department.

5. Any other gross evidence of lack of good moral character, fitness or act of fraud, or serious misconduct.

**History:** 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75; am. (1) (intro.), Register, September, 1986, No. 369, eff. 10-1-86.

**DWD 80.21 Reports by practitioners and expert witnesses. (1)** Upon the request of the department, any party in interest to a claim under ch. 102, Stats., shall furnish to the department and to all parties in interest copies of all reports by practitioners and expert witnesses in their possession or procurable by them.

**(2)** In cases involving nonscheduled injuries under s. 102.44 (2) or (3), Stats., any party in interest to a claim under the act shall, upon the request of the department, also furnish to the department and to all parties in interest any reports in their possession or reasonably available to them relating to the loss of earning capacity as set forth in s. DWD 80.34.

**(3)** Any party who does not comply with the request of the department under sub. (1) or (2) shall be barred from presenting the reports or the testimony contained therein at the hearing.

**(4)** No testimony concerning wage earning impairment shall be received unless the party offering such testimony has notified the department and the other parties in interest of the intent to produce such testimony. The names of the witnesses who are going to testify as to wage earning impairment shall also be furnished to the department and the parties in interest. Such notification shall be given at least 30 days prior to a scheduled hearing.

**History:** 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75; am. (1), cr. (2), (3) and (4), Register, September, 1982, No. 321, eff. 10-1-82.

**DWD 80.22 Use of physicians' reports as evidence.**

**(1)** Matters stated in or material evidence if given as oral testimony shall not be competent or material evidence if given as oral testimony shall not be competent or material as prima facie evidence if objection is made, except as corroborated by competent and material oral testimony.

**Note:** See s. 102.17 (1) (d), Stats.

(2) Use of reports shall be permitted in any case in which claim for compensation is made, provided the reporting doctor is available for cross examination.

(3) An applicant shall be informed of the provisions of s. 102.17 (1) (d), Stats., and the department's rules and also that a form for reporting will be supplied to the applicant upon request.

(4) Report shall be submitted to the department upon a form prescribed by the department and shall be verified or certified. The department may require additional or supplementary reports. Upon failure of the applicant to submit such reports within the time specified prior to hearing, all reports previously filed may, in the discretion of the department, be excluded as evidence.

(5) Reports shall be filed with the application for adjustment of claim or as soon thereafter as possible. Reports not filed with the department 15 days prior to the date of hearing shall not be acceptable as evidence except upon good cause for failure so to file, established to the satisfaction of the department.

(6) Simultaneously with the filing of a WKC-16B form or a verified report of a vocational expert with the department, a party shall serve copies upon all other parties in interest. Service upon the designated representative of a party shall be deemed service upon the party. Service upon the insurance carrier for an employer shall be deemed service upon the employer. However, if a party does not have a representative, the department may elect to make service upon other parties.

**History:** 1-2-56; am. (intro. par.), (7) and (4), Register, October, 1965, No. 118, eff. 11-1-65; am. Register, April, 1975, No. 232, eff. 5-1-75; am. (3) and r. and recr. (6), Register, September, 1982, No. 321, eff. 10-1-82; am. (intro.), Register, September, 1986, No. 369, eff. 10-1-86.

**DWD 80.23 Common insurance of employer and third party.** In all cases where compensation becomes payable and the insurance carrier of an employer and of a third party shall be the same, or if there is common control of the insurer of each, the insurance carrier of the employer shall promptly notify the parties in interest and the department of that fact.

**History:** 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75.

**DWD 80.24 Statement of employee.** When an employee gives a statement signed by him, which in any way concerns his claim, a copy of such statement must be given to the employee. When such statement is taken by a recording device and is not immediately reduced to writing, a copy of the entire statement must be given to the employee or to his attorney within a reasonable time after application for hearing is filed, and the actual recording must be available as an exhibit if formal hearing is held. Failure on the part of the employer or insurance carrier to comply with the above will preclude the use of such statement in any manner in connection with that claim.

**History:** Cr. Register, March, 1956, No. 3, eff. 4-1-56; am. Register, October, 1965, No. 118, eff. 11-1-65.

**DWD 80.25 Loss of hearing.** The department adopts the following standards for the determination and evaluation of noise induced hearing loss, other occupational hearing loss and accidental hearing loss:

(1) **HARMFUL NOISE.** Hearing loss resulting from hazardous noise exposure depends upon several factors, namely, the overall intensity (sound pressure level), the daily exposure, the frequency characteristic of the noise spectrum and the total lifetime exposure. Noise exposure level of 90 decibels or more as measured on the A scale of a sound level meter for 8 hours a day is considered to be harmful.

(2) **MEASUREMENT OF NOISE.** Noise shall be measured with a sound level meter which meets ANSI standard 1983 and shall be measured on the "A" weighted network for "slow response." Noise levels reaching maxima at intervals of one second or less shall be classified as being continuous. The measurement of noise is primarily the function of acoustical engineers and properly trained personnel. Noise should be scientifically measured by properly trained individuals using approved calibrated instruments which at the present time include sound level meters, octave band analyzers and oscilloscopes, the latter particularly for impact-type noises.

(3) **MEASURE OF HEARING ACUITY.** The use of pure tone air and bone conduction audiometry performed under proper testing conditions is recommended for establishing the hearing acuity of workers. The audiometer should be one which meets the specifications of ANSI standard 53.6-1969 (4). The audiometer should be periodically calibrated. Preemployment records should include a satisfactory personal and occupational history as they may pertain to hearing status. Otological examination should be made where indicated.

(4) **FORMULA FOR MEASURING HEARING IMPAIRMENT.** For the purpose of determining the hearing impairment, pure tone air conduction audiometry is used, measuring all frequencies between 500 and 6,000 Hz. This formula uses the average of the 4 speech frequencies of 500, 1,000, 2,000, and 3,000 Hz. Audiometric measurement for these 4 frequencies averaging 30 decibels or less on the ANSI calibration does not constitute any practical hearing impairment. A table for evaluating hearing impairment based upon the average readings of these 4 frequencies follows below. No deduction is made for presbycusis.

(5) **DIAGNOSIS AND EVALUATION.** The diagnosis of occupational hearing loss is based upon the occupational and medical history, the results of the otological and audiometric examinations and their evaluation.

(6) **TREATMENT.** There is no known medical or surgical treatment for improving or restoring hearing loss due to hazardous noise exposure. Hearing loss will be improved in non-occupational settings with the use of a hearing aid. Since a hearing aid relieves from the effect of injury the cost is compensable where prescribed by a physician.

(7) **ALLOWANCE FOR TINNITUS.** In addition to the above impairment, if tinnitus has permanently resulted due to work exposure, an allowance of 5% loss of hearing impairment for the affected ear or ears shall be computed.

(8) **HEARING IMPAIRMENT TABLE.**

Average Decibel Loss ANSI	Percent of Compensable Hearing Impairment	Average Decibel Loss ANSI	Percent of Compensable Hearing Impairment
30	0.0	62	51.2
31	1.6	63	52.8
32	3.2	64	54.4
33	4.8	65	56.0
34	6.4	66	57.6
35	8.0	67	59.2
36	9.6	68	60.8
37	11.2	69	62.4
38	12.8	70	64.0
39	14.4	71	65.6
40	16.0	72	67.2
41	17.6	73	68.8
42	19.2	74	70.4
43	20.8	75	72.0
44	22.4	76	73.6
45	24.0	77	75.2
46	25.6	78	76.8
47	27.2	79	78.4
48	28.8	80	80.0
49	30.4	81	81.6
50	32.0	82	83.2
51	33.6	83	84.8
52	35.2	84	86.4
53	36.8	85	88.0
54	38.4	86	89.6
55	40.0	87	91.2
56	41.6	88	92.8
57	43.2	89	94.4
58	44.8	90	96.0
59	46.4	91	97.6
60	48.0	92	99.2
61	49.6	93	100.0

(9) METHOD FOR DETERMINING PERCENT OF HEARING IMPAIRMENT. (a) Obtain for each ear the average hearing level in decibels at the 4 frequencies, 500, 1,000, 2,000 and 3,000 Hz.

(b) See Table for converting to percentage of hearing impairment in each ear.

(c) To determine the percentage of impairment for both ears, multiply the lesser loss by 5, add the greater loss and divide by 6. Following are examples of the calculation of hearing loss:

**A. Mild to Marked Bilateral Hearing Loss**

	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right Ear	15	25	45	55
Left Ear	30	45	60	85

1. Calculation of average hearing threshold level:

$$\text{Right Ear : } \frac{15 + 25 + 45 + 55}{4} = \frac{140}{4} = 35 \text{ db} = 8\% \text{ loss}$$

2. Calculation of hearing handicap:

Smaller number (better ear)  
 $8\% \times 5 = 40$

Larger number (poorer ear)  
 $40\% \times 1 = 40$

Total  $80 \div 6 = 13.33\%$  loss

Therefore, a person with the hearing threshold levels shown in this audiogram would have a 13.33% hearing handicap.

**B. Slight Bilateral Hearing Loss**

	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right Ear	15	15	20	30
Left Ear	25	30	35	40

1. Average hearing threshold level:

$$\text{Right Ear : } \frac{15 + 15 + 20 + 30}{4} = \frac{80}{4} = 20 \text{ db} = 0\% \text{ loss}$$

$$\text{Left Ear : } \frac{25 + 30 + 35 + 40}{4} = \frac{130}{4} = 33.0 \text{ db} = 4.8\% \text{ loss}$$

Therefore, the hearing loss is 4.8% left ear

**C. Severe to Extreme Bilateral Hearing Loss**

	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right Ear	80	90	100	110
Left Ear	75	80	90	95

1. Average hearing threshold level (use 93 db maximal value):

$$\text{Right Ear : } \frac{80 + 90 + 100 + 110}{4} = \frac{380}{4} = 95 \text{ db} = 100\% \text{ loss}$$

$$\text{Left Ear : } \frac{75 + 80 + 90 + 95}{4} = \frac{340}{4} = 85 \text{ db} = 88\% \text{ loss}$$

2. Hearing handicap:

Smaller number (better ear)  
 $88\% \times 5 = 440$

Larger number (poorer ear)  
 $100\% \times 1 = 100\%$

Total  $540 \div 6 = 90\%$  loss

Therefore, the hearing handicap is 90%.

**History:** 1-2-56; am. Register, January, 1960, No. 49, eff. 2-1-60; am. Register, October, 1965, No. 118, eff. 11-1-65; r. and recr. Register, September, 1972, No. 201, eff. 10-1-72; am. (1) to (4), r. (5), renum. (6) and (7) to be (5) and (6), cr. (7) and am. (8), Register, September, 1975, No. 237, eff. 10-1-75; am. (intro.), (2) to (4), (6), (8) and (9), Register, September, 1986, No. 369, eff. 10-1-86.

**DWD 80.26 Loss of vision; determination.** The following rules for determining loss of visual efficiency shall be applicable to all cases settled after December 1, 1941, irrespective of the date of injury, except that, in the examples for computations of compensation payable and of the percentage of permanent total disability, the computation of the percentage of visual impairment must be applied to the provisions of the worker's compensation act as they existed at the date of the injury.

(1) MAXIMUM AND MINIMUM LIMITS OF THE PRIMARY COORDINATE FACTORS OF VISION. In order to determine the various degrees of visual efficiency, a) normal or maximum, and b) minimum, limits for each coordinate function must be established; i.e., the 100% point and the 0% point.

(a) *Maximum limits.* The maximum efficiency for each of these is established by existing and accepted standards.

1. Central visual acuity. The ability to recognize letters or characters which subtend an angle of 5 minutes, each unit part of which subtends a 1 minute angle at the distance viewed is accepted as standard. Therefore a 20/20 Snellen or A.M.A. and a 14/14 A.M.A. are employed as the maximum acuity of central vision, or 100% acuity for distance vision and near vision respectively.

2. Field vision. A visual field having an area which extends from the point of fixation outward 65, down and out 65, down 55, down and in 45, inward 45, in and up 45, upward 45, and up and out 55 is accepted as 100% industrial visual field efficiency.

3. Binocular vision. Maximum binocular vision is present if there is absence of diplopia in all parts of the field of binocular fixation, and if the 2 eyes give useful binocular vision.

(b) *Minimum limits.* The minimum limit, or the 0% of the coordinate functions of vision, is established at that degree of deficiency which reduces vision to a state of industrial uselessness.

1. Central visual acuity. The minimum limit of this function is established as the loss of light perception, light perception being qualitative vision. The practical minimum limit of quantitative visual acuity is established as the ability to distinguish form. Experience, experiment and authoritative opinion show that for distance vision 20/200 Snellen or A.M.A. Chart is 80% loss of visual efficiency, 20/380 is 96% loss, and 20/800 is 99.9% loss, and that for near vision 14/141 A.M.A. Reading Card is 80% loss of visual efficiency, 14/266 is 96% loss, and 14/560 is 99.9% loss. Table 1 shows the percentage loss of visual efficiency corresponding to the Snellen and other notations for distant and for near vision, for the measurable range of quantitative visual acuity.

2. Field vision. The minimum limit for this function is established as a concentric central contraction of the visual field to 5. This degree of contraction of the visual field of an eye reduces the visual efficiency to zero.

3. Binocular vision. The minimum limit is established by the presence of diplopia in all parts of the motor field, or by lack of useful binocular vision. This condition constitutes 50% motor field efficiency.

(c) Where distance vision is less than 20/200 and the A.M.A. Chart is used, readings will be at 10 feet. The percentage of efficiency and loss may be obtained from this table by comparison with corresponding readings on the basis of 20 feet, interpolating between readings if necessary. In view of the lack of uniform standards among the various near vision charts, readings for near vision, within the range of vision covered thereby, are to be

according to the American Medical Association Rating Reading Card of 1932.

**(2) MEASUREMENT OF COORDINATE FACTORS OF VISION AND THE COMPUTATION OF THEIR PARTIAL LOSS.** (a) *Central visual acuity.*

1. Central visual acuity shall be measured both for distance and for near, each eye being measured separately, both with and without correction. Where the purpose of the computation is to determine loss of vision resulting from injury, if correction is needed for a presbyopia due to age or for some other condition clearly not due to the injury (see section on miscellaneous regulations), the central visual acuity "without correction", as the term is used herein, shall be measured with a correction applied for such presbyopia or other preexisting condition but without correction for any condition which may have resulted from the injury. The central visual acuity "with correction" shall be measured with correction applied for all conditions present.

2. The percentage of central visual acuity efficiency of the eye for distance vision shall be based on the best percentage of central visual acuity between the percentage of central visual acuity with and without correction. However, in no case shall such subtraction for glasses be taken at more than 25%, or less than 5%, of total central visual acuity efficiency. If a subtraction of 5%, however, reduces the percentage of central visual acuity efficiency below that obtainable without correction, the percentage obtainable without correction shall be adopted unless correction is nevertheless necessary to prevent eye strain or for other reasons.

**TABLE 1**

**Percentage of Central Visual Efficiency Corresponding to Specified Readings for Distant and for Near Vision for Measurable Range of Quantitative Visual Acuity**

A.M.A. Test Chart or Snellen Reading for Distance	A.M.A. Card Reading for Near	Percentage of Visual Efficiency	Percentage Loss of Vision	A.M.A. Test Chart or Snellen Reading for Distance	A.M.A. Card Reading for Near	Percentage of Visual Efficiency	Percentage Loss of Vision
20/20	14/14	100.0	0.0	20/122.5	—	40.0	60.0
20/15	14/17.5	95.7	4.3	20/137.3	—	35.0	65.0
20/25.7	—	95.0	5.0	20/140	14/98	34.2	65.8
20/30	14/21	91.5	8.5	20/155	—	30.0	70.0
20/32.1	—	90.0	10.0	20/160	14/112	28.6	71.4
20/35	14/24.5	87.5	12.5	20/175	—	25.0	75.0
20/38.4	—	85.0	15.0	20/180	14/126	23.9	76.1
20/40	14/28	83.6	16.4	20/200	14/141	20.0	80.0
20/44.9	14/31.5	80.0	20.0	20/220	14/154	16.7	83.3
20/50	14/35	76.5	23.5	20/240	14/168	14.0	86.0
20/52.1	—	75.0	25.0	—	14/178	12.3	87.7
20/60	14/42	69.9	30.1	20/260	14/182	11.7	88.3
20/60.2	—	70.0	30.0	20/280	14/196	9.7	90.3
20/68.2	—	65.0	35.0	20/300	14/210	8.2	91.8
20/70	14/49	64.0	36.0	20/320	14/224	6.8	93.2
20/77.5	—	60.0	40.0	20/340	14/238	5.7	94.3
20/80	14/56	58.5	41.5	20/360	14/252	4.8	95.2
20/86.8	—	55.0	45.0	20/380	14/266	4.0	96.0
20/90	14/63	53.4	46.6	20/400	14/280	3.3	96.7
20/97.5	—	50.0	50.0	20/450	14/315	2.1	97.9
20/100	14/70	48.9	51.1	20/500	14/350	1.4	98.6
20/109.4	—	45.0	55.0	20/600	14/420	0.6	99.4
20/120	14/84	40.9	59.1	20/700	14/490	0.3	99.7
—	14/89	38.4	61.6	20/800	14/560	0.1	99.9

3. The percentage of central visual acuity efficiency of the eye for near vision shall be based on a similar computation from the near vision readings, with and without correction.

4. The percentage of central visual acuity efficiency of the eye in question shall be the result of the weighted values assigned to these 2 percentages for distance and for near. A onefold value is

assigned to distance vision and a twofold value to near vision. Thus, if the central visual efficiency for distance is 70% and that for near is 40%, the percentage of central visual efficiency for the eye in question would be:

Distance (taken once) . . .	70%	
Near (taken twice) . . . . .	40	
	40	
		$150 \div 3 = 50\%$ central visual acuity efficiency

5. The Snellen test letters or characters as published by the Committee on Compensation for Eye Injuries of the American Medical Association and designated "Industrial Vision Test Charts" subtend a 5 minute angle, and their component parts a 1 minute angle. These test letters or the equivalent are to be used at an examining distance of 20 feet for distant vision (except as otherwise noted on the Chart where vision is very poor), and of 14 inches for near vision, from the patient. The illumination is to be not less than three foot candles, nor more than ten foot candles on the surface of the chart.

6. Table 1 shows the percentage of central visual acuity efficiency and the percentage loss of such efficiency, both for distance and for near, for partial loss between 100% and zero vision for either eye.

(b) *Field vision.* 1. The extent of the field of vision shall be determined by the use of the usual perimetric test methods, a white target being employed which subtends a 1 degree angle under illumination of not less than 3 foot candles, and the result plotted on the industrial visual field chart. The readings should be taken, if possible, without restriction to the field covered by the correction worn.

2. The amount of radial contraction in the 8 principal meridians shall be determined. The sum of the degrees of field vision remaining on these meridians, divided by 420 (the sum of the 8 principal radii of the industrial visual field) will give the visual field efficiency of one eye in per cent, subject to the proviso stated in the section on "Minimum Limits" that a concentric central contraction of the field to a diameter of 5 degrees reduces the visual efficiency to zero.

3. Where the impairment of field is irregular and not fairly disclosed by the 8 radii, the impaired area should be sketched upon the diagram on the report blank, and the computation be based on a greater number of radii, or otherwise, as may be necessary to a fair determination.

(c) *Binocular vision.* 1. Binocular vision shall be measured in all parts of the motor field, recognized methods being used for testing. It shall be measured with any useful correction applied.

2. Diplopia may involve the field of binocular fixation entirely or partially. When diplopia is present, this shall be plotted on the industrial motor field chart. This chart is divided into 20 rectangles, 4 by 5 degrees in size. The partial loss due to diplopia is that proportional area which shows diplopia as indicated on the plotted chart compared with the entire motor field area.

3. When diplopia involves the entire motor field, causing an irremediable diplopia, or when there is absence of useful binocular vision due to lack of accommodation or other reason, the loss of coordinate visual efficiency is equal to 50% loss of the vision existing in one eye (ordinarily the injured, or the more seriously injured, eye); and when the diplopia is partial, the loss in visual efficiency shall be proportional and based on the efficiency factor value of one eye as stated in table 2. When useful correction is applied to relieve diplopia, 5% of total motor field efficiency of one eye shall be deducted from the percent of such efficiency obtainable with the correction. A correction which does not improve motor field efficiency by at least 5% of total will not ordinarily be considered useful.

(3) **INDUSTRIAL VISUAL EFFICIENCY OF ONE EYE.** The industrial visual efficiency of one eye is determined by obtaining the product of the computed coordinate efficiency values of central visual acuity, of field of vision, and of binocular vision. Thus, if central visual acuity efficiency is 50%, visual field efficiency is 80% and the binocular vision efficiency is 100%, the resultant visual efficiency of the eye will be  $50 \times 80 \times 100 = 40\%$ . Should useful binocular vision be absent in all of the motor field so that binocular efficiency is reduced to 50%, the visual efficiency would be  $50 \times 80 \times 50 = 20\%$ .

(4) **COMPUTATION OF COMPENSATION FOR IMPAIRMENT OF VISION.** When the percentage of industrial visual efficiency of each eye has been thus determined, it is subtracted from 100%. The difference represents the percentage impairment of each eye for industrial use. These percentages are applied directly to the specific schedules of the Worker's Compensation Act.

(5) **TYPES OF OCULAR INJURY NOT INCLUDED IN THE DISTURBANCE OF COORDINATE FACTORS.** Certain types of ocular disturbance are not included in the foregoing computations and these may result in disabilities, the value of which cannot be computed by any scale as yet scientifically possible of deduction. Such are disturbances of accommodation not previously provided for in these rules, of adaptation to light and dark, metamorphopsia, entropion, ectropion, lagophthalmos, epiphora, and muscle disturbances not included under diplopia. For such disabilities additional compensation shall be awarded, but in no case shall such additional award make the total compensation for loss in industrial visual efficiency greater than that provided by law for total permanent disability.

**TABLE 2**  
**Loss in Binocular Vision**

No loss	equals	100.0%	Motor	Field	Efficiency
1/20	"	99.0	"	"	"
2/20	"	97.7	"	"	"
3/20	"	96.3	"	"	"
4/20	"	95.0	"	"	"
5/20	"	93.7	"	"	"
6/20	"	92.3	"	"	"
7/20	"	90.7	"	"	"
8/20	"	89.0	"	"	"
9/20	"	87.3	"	"	"
10/20	"	85.7	"	"	"
11/20	"	83.7	"	"	"
12/20	"	81.7	"	"	"
13/20	"	79.7	"	"	"
14/20	"	77.3	"	"	"
15/20	"	75.0	"	"	"
16/20	"	72.7	"	"	"
17/20	"	69.7	"	"	"
18/20	"	66.0	"	"	"
19/20	"	61.0	"	"	"
20/20	"	50.0	"	"	"

(6) **MISCELLANEOUS RULES.** (a) Compensation shall not be computed until all adequate and reasonable operations and treatment known to medical science have been attempted to correct the defect. Further, before there shall be made the final examination on which compensation is to be computed, at least 3 months shall have elapsed after the last trace of visible inflammation has disappeared, except in cases of disturbance of extrinsic ocular muscles, optic nerve atrophy, injury of the retina, sympathetic ophthalmia, and traumatic cataract; in such cases, at least 12 months and preferably not more than 16 months shall intervene before the exami-



nation shall be made on which final compensation is to be computed. In case the injury is one which may cause cataract, optic atrophy, disturbance of the retina, or other conditions, which may further impair vision after the time of the final examination, note thereof should be made by the examining physician on his report.

(b) In cases of additional loss in visual efficiency, when it is known that there was present a preexisting subnormal vision, compensation shall be based on the loss incurred as a result of eye injury or occupational condition specifically responsible for the additional loss. In case there exists no record or no adequate and positive evidence of preexisting subnormal vision, it shall be assumed that the visual efficiency prior to any injury was 100%. In order to effect the above purpose, the examining physician should carefully distinguish, in regard to each of the coordinate factors, between impairments resulting from the injury and impairments not so resulting as established by the type of proof here stated. Such other impairments should, however, be also reported, separately. Computation must occasionally also be made of impairment of vision not resulting from the injury, as, for instance, for the purpose of computing additional indemnity due under the provisions of the Worker's Compensation Act on account of preexisting disability of one or both eyes.

**Note:** Example of computation covering partial disability to a single eye

**A. Central Visual Acuity:**

<b>Distance</b> —Reading of 20/32.1 with glasses equals visual efficiency of .....	90.0%
Reading of 20/200 without glasses equals visual efficiency of .....	20.0%
<b>Difference</b> .....	70.0%
Rated efficiency is 90.0% minus 25% (Because one-half of 70.0% exceeds 25) or 65.0%	
<b>Near</b> —Reading of 14/21 with glasses equals visual efficiency of .....	91.5%
Reading of 14/35 without glasses (except that correction is applied for presbyopia due to age) equals visual efficiency of .....	76.5%
<b>Difference</b> .....	15.0%
Rated efficiency is 91.5% minus 7.5% (which is one-half of 15%) or 84.0%	
<b>Final Central Visual Acuity Efficiency is:</b>	
65.0 + 84.0 + 84.0 = 233.0 ÷ 3 = 77.7%	

**B. Field Vision:**

**Sum of eight principal meridians of the field remaining divided by 420 is:**

40
50
50
50
40
40
40
<u>40</u>
350 ÷ 420 = 83.3%

**C. Binocular Vision:**

Diplopia in 3 rectangles (3/20) is 96.3% motor field efficiency.

**D. Industrial Visual Efficiency of the one eye is:**

77.7% × 83.3% × 96.3% or 62.3%

**E. Impairment of the one eye for industrial use is:**

100.0% — 62.3% = 37.7%

**F. Compensation payable is:**

Total impairment of one eye 250 weeks.  
250 weeks × 37.7% = 94.25 weeks

**Note:** Example of computation covering partial disability to both eyes

**1. Left Eye is 62.3% efficient, see Example I.**

**2. Right Eye:**

**A. Central Visual Acuity:**

<b>Distance</b> —Reading of 20/30 with correction equals visual efficiency of .....	91.5%
Reading of 20/35 without glasses equals visual efficiency of .....	87.5%
<b>Difference</b> .....	4.0%
Rated efficiency is the vision without correction (because correction gives improvement of less than the 5% minimum allowance for glasses, and is not necessary to prevent eye strain, etc.) 87.5%.	
<b>Near</b> —Reading of 14/14 with glasses equals visual efficiency of .....	100.0%
Reading of 14/21 without glasses equals visual efficiency of .....	91.5%
<b>Difference</b> .....	8.5%
Rated efficiency is 100.0% minus 5% (because 5% is the minimum allowance for glasses) or 95.0%	
<b>Final Central Visual Acuity Efficiency is:</b>	
87.5% + 95% + 95% = 277.5 ÷ 3 = 92.5%	

**B. Field vision is 100%**

**C. Binocular vision is 100%**

**D. Industrial visual efficiency of the right eye is:**

92.5% × 100% × 100% or 92.5%

**E. Impairment of right eye for industrial use is:**

100.0% — 92.5% = 7.5%

**3. Compensation payable is:**

Left eye (Example I):	94.25 weeks
Right eye:	
250 weeks × 7.5% = 18.75 + 200% multiple	<u>56.25 weeks</u>
Total	150.5 weeks

**Note:** Example of compensation covering enucleation of one eye and partial disability of the other eye

**1. Left eye** is 35.28% impaired (77.7% × 83.3% = 64.72%; 100% — 64.72% = 35.28%, as allowance for binocular vision is inapplicable when the other eye is enucleated or blind), in indemnity payable for 88.2 weeks

**2. Right eye** is enucleated, which, results in indemnity payable for 275 weeks

**3. Total payable:** 88.2 weeks × 3 (multiple injury) = 264.6 + 275 = 539.6 weeks  
The number of weeks indemnity indicated as payable for impairment of vision or for enucleation is in addition to indemnity for temporary disability. All results are subject to the limitation that the total amount of indemnity payable, including that for temporary disability, shall not exceed the indemnity which would be payable for permanent total disability. The statutory and legal rules applicable to the determination of additional compensation payable out of the special state fund on account of preexisting disabilities are not here stated.

**DWD 80.27 Forms.** A sample copy of all forms referred to in these rules may be obtained upon a request to the Worker's Compensation Division, Department of Workforce Development, Post Office Box 7901, Madison, WI 53707.

**History:** Cr. Register, October, 1957, No. 22, eff. 11-1-57; am. (1), Register, October, 1965, No. 118, eff. 12-1-65; am. Register, April, 1975, No. 232, eff. 5-1-75; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82; correction made under s. 13.93 (2m) (b) 6., Stats., Register, July, 1996, No. 487, eff. 8-1-96.

**DWD 80.29 Value of room or meals.** For the purpose of determining the value of lodging and meals for wage purposes under ch. 102, Stats., the allowance provided under ch. DWD 272 shall apply.

**History:** Cr. Register, October, 1960, No. 58, eff. 11-1-60; am. (1) (a) and (b), Register, October, 1963, No. 94, eff. 11-1-63; r. and recr. Register, January, 1967, No. 133, eff. 2-1-67; am. Register, November, 1970, No. 179, eff. 12-1-70; r. and recr. Register, April, 1975, No. 232, eff. 5-1-75; correction made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1996, No. 487, eff. 8-1-96; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1997, No. 504.

**DWD 80.30 Average weekly earnings for members of volunteer fire companies or fire departments.** The maximum average weekly earnings under the provisions of s. 102.11, Stats., which are in effect on the date of injury shall be used in computing the amount of compensation payable to an employee as defined by s. 102.07 (7), Stats., except as specific showing may be made in an individual case that such wage is not proper.

**History:** Cr. Register, June, 1961, No. 66, eff. 7-1-61.

**DWD 80.31 Procedure and claims under ch. 40, Stats.** The department shall observe the same rules and procedures and may use the same forms in processing and determining claims made under s. 40.65, Stats. as are used under ch. 102, Stats.

**History:** Cr. Register, October, 1965, No. 118, eff. 11-1-65; am. Register, April, 1975, No. 232, eff. 5-1-75; am. Register, September, 1986, No. 369, eff. 10-1-86.

**DWD 80.32 Permanent disabilities.** Minimum percentages of loss of use for amputation levels, losses of motion, sensory losses and surgical procedures.

(1) The disabilities set forth in this section are the minimums for the described conditions. However, findings of additional disabling elements shall result in an estimate higher than the minimum. The minimum also assumes that the member, the back, etc., was previously without disability. Appropriate reduction shall be made for any preexisting disability.

**Note:** An example would be where in addition to a described loss of motion, pain and circulatory disturbance further limits the use of an arm or a leg. A meniscectomy in a knee with less than a good result would call for an estimate higher than 5% loss of use of the leg at the knee. The same principle would apply to surgical procedures on the back. The schedule of minimum disabilities contained in this section was adopted upon the advice of a worker's compensation advisory council subcommittee after a survey of doctors experienced in treating industrial injuries.

**(2) Amputations, upper or lower extremities**

At functional level	Equivalent to amputation at midpoint
Stump unsuitable to accommodate prosthesis	Equivalent to amputation at next most proximal joint
Stump not functional	Grade upward

All ranges of joint motion or degrees of ankylosis not listed below are to be interpolated from existing percent of disability listed.

**(3) Hip**

Ankylosis, optimum position, generally 15° to 30° flexion	50%
Mal position	Grade upward
To compute disabilities for loss of motion relate % of motion lost to average range	
Shortening of leg (no posterior or lateral angulation)	
No disability for shortening less than 3/4 inch	
3/4 inch	5%
1 inch	7%
1-1/2inches	14%
2 inches	22%

Greater than 2 inches of shortening results in greater proportionate rating than above

Prosthesis Total	Minimum of 40%
Partial	35%

**(4) Knee**

Ankylosis, optimum position, 170°	40%
Remaining range, 180° – 135°	25%
Remaining range, 180° – 90°	10%
Prosthesis Total	50%
Partial	45%
Removal of patella	To be based on functional impairment
Total or partial meniscectomy (open or closed procedure)	
Excellent to good result	5%
Anterior cruciate ligament repair	Minimum of 10%

**(5) Ankle**

Total ankylosis, optimum position, total loss of motion	40%
Ankylosis ankle joint	
Loss of dorsi and plantar flexion	30%
Subtalar ankylosis	
Loss of inversion and eversion	15%

**(6) Toes**

Ankylosis great toe at proximal joint	50%
All other toes at proximal	40%
Ankylosis great toe at distal joint	15%
All other toes at any interphalangeal joint	If no deformity, no disability
Mal position	On merits
Loss of motion	No disability

**(7) Shoulder**

Ankylosis, optimum position, scapula free	55%
In mal position	Grade upward
Limitation of active elevation in flexion and abduction to 45 but otherwise normal	30%

Limitation of active elevation in flexion and abduction to 90 but otherwise normal	20%
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Limitation of active elevation in flexion and abduction to 135° but otherwise normal	5%
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Prosthesis	50%
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**(8) Elbow**

Ankylosis, optimum position, 45° angle	
With radio-ulnar motion destroyed	60%
With radio-ulnar motion in tact	45%
Rotational ankylosis in neutral position	20%

Any mal position	Grade upward
Limitation of motion elbow joint, radio-ulnar motion unaffected	

Remaining range—180° – 135°	35%
Remaining range—135° – 90°	20%

Remaining range—180° – 90°	10%
Rotation at elbow joint	
Neutral to full pronation	10%
Neutral to full supination	15%
<b>(9) Wrist</b>	
Ankylosis, optimum position 30° dorsiflexion	30%
Mal position	Grade upward
Total loss dorsiflexion	12–1/2%
Total loss palmarflexion	7–1/2%
Total loss inversion	5%
Total loss eversion	5%

**(10) Complete Sensory Loss**

Any digit	50% Lesser involvement to be graded appropriately— 35% for palmar, 15% for dorsal surface
Total median sensory loss to hand	65–75%
Total ulnar sensory loss to hand	25%
Ulnar nerve paralysis	
Above elbow, sensory involvement	50% at wrist
Below elbow, motor and sensory involvement	45–50% at wrist
Below elbow, motor involvement only	35–45% at wrist
Below elbow, sensory involvement only	5–10% at wrist
Median nerve paralysis	
Above elbow, motor and sensory involvement	55–65% at wrist
Thenar paralysis with sensory loss	40–50% at wrist
Radial nerve paralysis	
Complete loss of extension, wrist and fingers	45–55% at wrist
Paroneal nerve paralysis	
At level below knee	25–30% at knee

**(11) Back**

Removal of disc material, no undue symptomatic complaints or any objective findings	5%
Chymopapain injection	To be rated by doctor
Spinal fusion, good results	5% minimum per level
Removal of disc material and fusion	10% per level
Cervical fusion, successful	5%
Compression fractures of vertebrae of such degree to cause permanent disability may be rated 5% and graded upward	

**Note:** It is the subcommittee's intention that a separate minimum 5% allowance be given for every surgical procedure (open or closed, radical or partial) that is done to relieve from the effects of a disc lesion or spinal cord pressure. Each disc treated or surgical procedure performed will qualify for a 5% rating. Due to the fact a fusion involves 2 procedures a 1) laminectomy (discectomy) and a 2) fusion procedure, 10% permanent total disability will apply when the 2 surgical procedures are done at the same time or separately.

Examples:

Patient A	12/01/1990	Laminectomy	5% PTD
	05/01/1992	Fusion	increases to 10% PTD
Patient B	12/01/1990	Laminectomy & Fusion	10% PTD
	05/01/1992	Re-fusion	increases to 15% PTD
	12/01/1992	Laminectomy at New Level	increases to 20% PTD
	05/01/1993	Fusion at 12/1/92 Level	increases to 25% PTD
	12/01/1993	Re-fusion at 5/1/93 Level	increases to 30% PTD

**(12) Fingers**

(a) Complete ankylosis

Thumb	Mid-position	Complete Extension
Distal joint only . . . . .	25%	35%
Proximal joint only . . . . .	15%	20%
Distal and proximal joints . . . . .	35%	65%
Carpometacarpal joint only . . . . .	20%	20%
Distal, proximal and carpometacarpal joints . . . . .	85%	100%
<b>Fingers</b>		
Distal joint only . . . . .	25%	35%
Middle joint only . . . . .	75%	85%
Proximal joint only . . . . .	40%	50%
Distal and middle joints . . . . .	85%	100%
Distal, middle and proximal joints . . . . .	100%	100%

(b) Loss of Motion

Fingers	Loss of Flexion	Loss of Use	Loss of Extension	Loss of Use
Distal joint only . . . . .	10% –	1%	10% –	2%
	20% –	2%	20% –	4%
	40% –	3%	30% –	6%
	40% –	5%	40% –	8%
	50% –	10%	50% –	15%
	60% –	15%	60% –	20%
	70% –	20%	70% –	30%
	80% –	25%	80% –	40%
			100% –	60%
Middle joint only . . . . .	10% –	5%	10% –	2½%
	20% –	10%	20% –	5%
	30% –	15%	30% –	10%
	40% –	25%	40% –	15%
	50% –	40%	50% –	30%
	60% –	50%	60% –	50%
	70% –	60%	70% –	70%
	80% –	70%	80% –	90%
			100% –	100%
Proximal joint only . . . . .	10% –	5%	10% –	2½%
	20% –	10%	20% –	5%
	30% –	15%	30% –	15%
	40% –	20%	40% –	20%
	50% –	25%	50% –	25%
	60% –	30%	60% –	40%
	70% –	35%	70% –	75%



mate of the amount that may be recovered from that employer, its receiver or trustee in bankruptcy. Such estimates shall be communicated to all exempt employers.

(4) At least annually following the original order the department shall estimate the amount due and payable during the following year and the charges expected from any insurance carrier or claims service for such year and assess and order payment by each exempt employer its pro rata share determined as provided by s. 102.28 (7) (b), Stats.

(5) At the time orders are issued under sub. (4) the department shall prepare an estimate of the remaining liability of the insolvent exempt employer and the amount that may reasonably be expected to be recovered from such employer, its receiver or trustee in bankruptcy. Such estimates will be communicated to all exempt employers.

(6) All money due and payable to injured employees which remain unpaid shall be considered money payable during the following year in making estimates.

(7) All money recovered by the attorney general and paid into the fund shall be used in the payment of unpaid claims and shall be taken into account in making estimates and assessments.

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

**DWD 80.41 Computation of monthly salary and reimbursement to retirement fund under s. 66.191, Stats.** (1) Fringe benefits shall not be included in the computation of salary, earnings or wages under s. 66.191, Stats., unless such benefits are income for Wisconsin income tax purposes.

(2) An eligible employee under s. 66.191, Stats., shall file with the department before an award is entered, as provided in s. 66.191, Stats., a waiver of disability annuity payments which may be due under s. 40.63, Stats., and further shall consent to reimbursement to the Wisconsin retirement fund of all disability benefits recovered under the provisions of s. 40.63, Stats.

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

**DWD 80.42 Vocational rehabilitation; reporting requirement.** In order to determine whether or not an employee should be referred to the division of vocational rehabilitation for services, the self-insured employer or insurance carrier shall notify the department whenever temporary total disability will exceed 13 weeks. This report shall be made within 13 weeks from the date of the initial disability or when such disability can be determined, whichever is earlier, and shall include a current practitioner's report.

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

**DWD 80.43 Fees and costs.** Section 102.26, Stats., provides for a maximum attorney's fee of 20% of the amount in dispute. Section 102.26 (3), Stats., places upon the department the responsibilities for fixing the fee and providing for the direct payment of the fee. In the exercise of this responsibility, the department shall take into account the following considerations:

(1) The department shall balance the need to preserve the maximum amount of benefits for the injured employee and the need for fees which are sufficient to insure adequate representation for claimants under ch. 102, Stats.

(2) Fees shall not be allowed on medical expenses to the extent that other sources, such as group insurance, are available to pay such expenses.

(3) Fees for permanent total disability shall not be allowed on compensation awards due beyond 500 weeks.

(4) The existence of a dispute under s. 102.26 (2), Stats., is dependent upon a disagreement after the employer or insurer has had adequate time and information to take a position on liability. Neither the holding of a hearing nor the filing of an application for a hearing alone may determine the existence of a dispute. However, a finding that a dispute exists shall not be precluded by an

employer's or insurer's purposeful inactivity on the issue of liability.

(5) Where representation is the result of the representative's employment by an insurance carrier, an employer, a union, a social service agency or a public agency, the representative may not charge a fee on a contingency basis.

(6) Where there has been successive representation by various representatives, the division of fees by the department shall take into account the relative value of the services performed by each representative, any concessions of disability, offers of settlement and other matters.

(7) Where a claimant appears by an attorney of record any fee shall be payable to such attorney regardless of the cooperation or involvement of agents or other non-attorneys. The division of such fee with agents or other non-attorneys shall be at the discretion of the attorney of record. If there is disagreement among successive attorneys the department will make appropriate apportionment of any or all fees for services.

**History:** Cr. Register, September, 1982, No. 321, eff. 10-1-82; cr. (7), Register, September, 1986, No. 369, eff. 10-1-86.

**DWD 80.44 Witness fees and travel reimbursement.** The fees and travel reimbursement of witnesses and interpreters for attending a hearing before an examiner of the department, shall be the statewide rate currently paid under s. 885.05 (1) (bn), Stats., notwithstanding any local county variations.

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

**DWD 80.46 Contribution to support of unestranged surviving parent.** In assessing support under s. 102.48, Stats., the payment of room and board by a child to his or her parent shall not be considered as contribution to support of the parent.

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

**DWD 80.47 Medical release of employee for restricted work in the healing period.** Even though an employee could return to a restricted type of work during the healing period, unless suitable employment within the physical and mental limitations of the employee is furnished by the employer or some other employer, compensation for temporary disability shall continue during the healing period.

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

**DWD 80.48 Reassignment of death benefits.** When a spouse who is entitled to death benefits remarries, the department shall reassign the death benefits to the children designated in ss. 102.51 (1) and 102.49, Stats., unless a showing is made that undue hardship would result for the spouse because of the reassignment.

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

**DWD 80.49 Vocational rehabilitation benefits.** (1) **PURPOSE.** The primary purpose of vocational rehabilitation benefits is to provide a method to restore an injured worker as nearly as possible to the worker's preinjury earning capacity and potential.

(2) **ELIGIBILITY.** The determination of eligibility for vocational rehabilitation training and whether a person is a suitable subject for training is the responsibility of the department of health and family services. If the department of health and family services determines that an employee is eligible to receive services under 29 USC 701 to 797b, but that the department of health and family services cannot provide those services for the employee, the employee may select a private rehabilitation specialist certified by the department to determine whether the employee can return to suitable employment without rehabilitative training and whether rehabilitative training is necessary to develop a retraining program to restore as nearly as possible the employee to his or her preinjury earning capacity and potential.

(3) **80-WEEK RULE.** Extension of vocational rehabilitation benefits beyond 80 weeks may not be authorized pursuant to s. 102.61

(1) or (1m), Stats., if the primary purpose of further training is to improve upon preinjury earning capacity rather than restoring it.

**(4) DEFINITIONS.** In subs. (4) to (11):

(a) "IWRP" or "individualized written rehabilitation program" means a plan developed by a specialist which identifies the vocational goal of a retraining program, the intermediate objectives to reach that goal and the methods by which progress will be measured.

(b) "Retraining program" means a course of instruction on a regular basis which provides an employee with marketable job skills or enhances existing job skills to make them marketable.

(c) "Specialist" means a person certified by the department to provide vocational rehabilitation services to injured employees under s. 102.61 (1m), Stats.

(d) Except as provided in sub. (5), "suitable employment" means a job within the employee's permanent work restrictions for which the employee has the necessary physical capacity, knowledge, transferable skills and ability and which pays at least 85 percent of the employee's preinjury average weekly wage.

**(5) SUITABLE EMPLOYMENT EXCEPTIONS.** (a) A job offer at or above 85% of the average weekly wage shall not constitute suitable employment if:

1. An employee's education, training or employment experience demonstrates a career or vocational path; the average weekly wage on the date of injury does not reflect the earnings which the employee could reasonably have expected in the demonstrated career or vocational path; and the permanent work restrictions caused by the injury impede the employee's ability to pursue the demonstrated career or vocational path; or,

2. The employee's average weekly wage is calculated pursuant to the part-time wage rules in s. 102.11 (1) (f), Stats., or s. DWD 80.51 (4) and the employee's average weekly wage for compensation purposes exceeds the gross average weekly wages of the part-time employment.

(b) The average weekly wage for purposes of determining suitable employment under par. (a) 1. shall be determined by expert vocational evidence regarding the average weekly wage that the employee may have reasonably expected in the demonstrated career or vocational path.

(c) The average weekly wage for purposes of determining suitable employment under par. (a) 2. shall be determined by expert vocational evidence regarding the employee's age, educational potential, past job experience, aptitude, proven abilities, and ambitions on the date of injury.

**(6) SPECIALIST CERTIFICATION.** (a) A person may apply to the department for certification as a specialist at any time. The department may require applicants to submit, and certified specialists to regularly report, information describing their services, including the geographic areas served by the specialist and the nature, cost and outcome of services provided to employees under this section.

(b) After evaluating the information submitted under par. (a), the department shall certify a person as a specialist if the person has a license or certificate which is current, valid and otherwise in good standing as one of the following, or may certify the person as provided in par. (c):

1. Certified professional counselor with specialty in vocational rehabilitation from the department of regulation and licensing;

2. Certified insurance rehabilitation specialist from the certification of insurance rehabilitation specialists commission;

3. Certified rehabilitation counselor from the commission on rehabilitation counselor certification;

4. Certified vocational evaluator from the commission on certification of work adjustment and vocational evaluation specialists.

**Note:** The Certification of Insurance Rehabilitation Specialists Commission (CIRSC) and Commission on Rehabilitation Counselor Certification (CRC) are

located at 1835 Rohlwing Road, Suite E, Rolling Meadows, Illinois 60008. The Commission on Certification of Work Adjustment and Vocational Evaluation Specialists is located at 7910 Woodmont Avenue, Suite 1430, Bethesda, Maryland 20814-3015.

(c) The department may certify a person as a specialist if the person has state or national certification, licensing or accreditation in vocational rehabilitation other than that required in par. (b) which is acceptable to the department. The department may require a specialist certified under this paragraph to serve a period of probation up to 3 years as a condition of certification. The department shall specify the conditions of the probationary certification. The department may revoke the probationary certification at any time without a hearing for conduct which violated the conditions of probation established by the department or conduct sufficient to decertify the specialist under par. (e).

(d) Unless certification is suspended or revoked under par. (e), certification by the department under par. (b) is valid for 3 years. If a specialist applies to the department to renew his or her certification before the expiration of the certification period, the certification shall remain in effect until the department renews or denies the application to renew. A renewal is valid for three years.

(e) Only the department may initiate a proceeding to suspend or revoke a specialist's certification under this section. The department may suspend or revoke a specialist's certification, after providing the specialist with a hearing, when the department determines that the specialist did not maintain a current, valid certificate or license specified in par. (b) or the specialist intentionally or repeatedly:

1. Fails to comply with the provisions of ch. 102, Stats., or ch. DWD 80;

2. Fails to comply with the orders, rulings, reporting requirements or other instructions of the department or its representatives;

3. Charges excessive fees compared to the value of the services performed or ordered to be performed; or,

4. Misrepresents the employee's work history, age, education, medical history or condition, diagnostic test results or other factors significantly related to an employee's retraining program.

(f) The department shall maintain a current listing of all specialists certified by the department, including the areas they serve, and shall provide the list at no charge to employees, employers, insurers, and others.

**(7) EMPLOYEE CHOICE.** (a) At the end of the medical healing period, the self-insured employer or insurance carrier shall notify the employee, on a form provided by the department, of the employee's potential eligibility to receive rehabilitation services.

**Note:** Forms can be obtained from the Department of Workforce Development, Worker's Compensation Division, 201 E. Washington Ave. P.O. Box 7901, Madison, Wisconsin 53707.

(b) The department shall arrange with the department of health and family services to receive timely notice whenever the department of health and family services determines under s. 102.61 (1m), Stats., that it cannot serve an eligible employee. When the department of health and family services notifies the department that it cannot serve an eligible employee, the department shall mail to the employee and the self-insured employer or insurance carrier a list of certified specialists serving the area where the employee resides.

(c) The employee may choose any certified specialist. The employee may choose a second certified specialist only by mutual agreement with the self-insured employer or insurance carrier or with the permission of the department. Partners are deemed to be one specialist.

(d) A specialist selected by an employee under par. (c) shall notify the department and the self-insured employer or insurance carrier within 7 days of that selection. The department may develop a form for this purpose.

**Note:** Forms can be obtained from the Department of Workforce Development, Worker's Compensation Division, 201 E. Washington Ave., P.O. Box 7901, Madison, Wisconsin 53707.

(e) The self-insured employer or insurance carrier is liable for the reasonable and necessary cost of the specialist's services and the reasonable cost of the training program recommended by the specialist provided that the employee and the specialist substantially comply with the requirements in subs. (8) to (11). Except with the prior consent of the self-insured employer or insurance carrier, the reasonable cost of any specialist's services to the employee shall not exceed \$1,000 for each date of injury as defined in s. 102.01 (2) (g), Stats. Effective on the first day of January each year after 1995, the department shall adjust the \$1,000 limit by the same percentage change as the average annual percentage change in the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, for the 12 months ending on September 30 of the prior year. The department shall notify insurance carriers, self-insured employers and specialists likely to be affected by the annual change in the limit.

**(8) EMPLOYER'S DUTIES UPON RECEIPT OF PERMANENT RESTRICTIONS.** Upon receiving notice that the department of health and family services cannot serve the employee under s. 102.61 (1m), Stats. the employee or a person authorized to act on the employee's behalf shall provide the employer with a written report from a physician, podiatrist, psychologist or chiropractor stating the employee's permanent work restrictions. Within 60 days of receiving the practitioner's work restrictions, the employer shall provide to the employee or the employee's authorized representative, in writing:

(a) An offer of suitable employment for the employee;

(b) A statement that the employer has no suitable employment available for the employee; or,

(c) A medical report from a physician, podiatrist, psychologist or chiropractor showing that the permanent work restrictions provided by the employee's practitioner are in dispute, and medical or vocational documentation that the difference in work restrictions would materially affect either the employer's ability to provide suitable employment or a specialist's ability to recommend a retraining program. If after 30 days the employee and employer cannot resolve the dispute, either party may request a hearing before the department to determine the employee's work restrictions. Within 30 days after the department determines the restrictions, the employer shall provide the written notice required in par. (a) or (b).

**(9) 90-DAY PLACEMENT EFFORT.** (a) If the employer fails to respond as required in sub. (8), it shall be conclusively presumed for the purposes of s. 102.61 (1m), Stats., that the employer has no suitable employment available and the employee is entitled to receive vocational rehabilitation services from a specialist.

(b) If the employer does not make a written offer of suitable employment under sub. (8), the specialist shall determine whether there is suitable employment available for the employee in the general labor market without retraining. If suitable employment is reasonably likely to be available, the specialist shall attempt to place the employee in alternative suitable employment for at least 90 days prior to developing a retraining program. The employee shall cooperate fully in the specialist's placement efforts and may not refuse an offer of suitable employment made within the 90-day period. In determining whether the offer is suitable the department shall consider age, education, training, previous work experience, previous earnings, present occupation and earnings, travel distance, goals of the employee, and the extent to which it would restore the employee's preinjury earning capacity and potential.

(c) If the employee is placed in or refuses to accept suitable employment, the self-insured employer or insurance carrier is not liable for any further costs of the specialist's services unless that suitable employment ends within the statute of limitations in s. 102.17 (4), Stats.

**(10) RETRAINING.** (a) If, after reasonably diligent effort by the employee and the specialist, the employee does not obtain suitable employment, then there is a rebuttable presumption that the employee needs retraining. The presumption is rebuttable by evidence that:

1. No retraining program can help restore as nearly as possible the employee's wage earning capacity;

2. The employee or the specialist did not make a reasonably diligent effort under sub. (9) (b) to obtain suitable employment for the employee; or

3. The employee or specialist withheld or misrepresented highly material facts.

(b) A retraining program of 80 weeks or less is presumed to be reasonable and the employer shall pay the cost of the program, mileage and maintenance benefits, and temporary total disability benefits.

(c) A retraining program more than 80 weeks may be reasonable, but there is no presumption that training over 80 weeks is required. Extension of vocational rehabilitation benefits beyond 80 weeks may not be authorized if the primary purpose of further training is to improve upon preinjury earning capacity rather than restoring it.

(d) If the retraining program developed by the specialist is for more than 80 weeks, the self-insured employer or the insurance carrier may offer an alternative retraining program which will restore the employee's preinjury earning capacity in less time than the retraining program developed by the specialist. An employee may not refuse a self-insured employer's or insurance carrier's timely, good-faith, written offer of an alternative retraining program without reasonable cause.

**(11) SPECIALIST'S SERVICES.** (a) A specialist shall develop an individualized written rehabilitation program for a retraining program for the employee, and may amend it to achieve suitable employment.

(b) A specialist shall make periodic written reports at reasonable intervals to the employee, employer and insurance carrier describing vocational rehabilitation activities which have occurred during that interval.

(c) Within a reasonable period of time after receiving a written request from an employee, employer, worker's compensation insurance carrier or department or their representatives, a specialist shall provide that person with any information or written material reasonably related to the specialist's services to the employee undertaken as a result of any injury for which the employee claims compensation.

**History:** Cr. Register, September, 1982, No. 321, eff. 10-1-82; emerg. am. (2), r. (3), renum. (4) to be (3), cr. (4) to (11), eff. 11-7-94, am. (2), r. (3), renum. (3) to be (4) and am., cr. (4) to (11), Register, April, 1995, No. 472, eff. 5-1-95; corrections in (2) and (5) a 2. made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1996, No. 487; eff. 8-1-96; corrections made under s. 13.93 (2m) (b) 6., Stats., Register, December, 1997, No. 504.

#### **DWD 80.50 Computation of permanent disabilities.**

**(1)** In computing permanent partial disabilities, the number of weeks attributable to more distal disabilities shall be deducted from the number of weeks in the schedule for more proximal disabilities before applying the percentage of disability for the more proximal injury, except that:

(a) Such a deduction shall not include multiple injury factors under s. 102.53, Stats.; and

(b) Such a deduction shall include preexisting disabilities.

**(2)** The number of weeks attributable to scheduled disabilities shall be deducted from 1,000 weeks before computing the number of weeks due for a non-scheduled disability resulting from the same injury. This deduction shall not include multiple injury factors under s. 102.53, Stats.

(3) Multiple injury factors under 102.53, Stats., do not apply to compensation for disfigurement under s. 102.56, Stats.

**History:** Cr. Register, August, 1981, No. 308, eff. 9-1-81; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82.

**DWD 80.51 Computation of weekly wage.** Pursuant to s. 102.11, Stats.

(1) In determining daily earnings, if the number of hours a full-time employee worked had been either decreased or increased for a period of at least 90 total days prior to the injury, then this revised schedule worked during those 90 days shall be considered to be normal full-time employment.

(2) When an employee furnishes his or her truck to the employer and is paid by the employer in gross to include operating expenses, one-third of that gross sum is considered as wages except as a showing is made to the contrary.

(3) Prisoners injured in prison industries are considered to be earning the maximum average weekly earnings under the provisions of s. 102.11, Stats., except as a showing is made to the contrary.

(4) The 30 hour minimum workweek under s. 102.11 (1) (f), Stats., does not apply to a part-time employee unless the employee is a member of a regularly scheduled class of part-time employees. In all other cases part-time employment is on the basis of normal full-time employment in such job. However, this subsection does not apply to part-time employees defined in s. 102.11 (1) (f), Stats., who restrict availability on the labor market. As to the employees so defined, those wages will be expanded to the normal part-time or full-time wages unless the employer or insurance company complies with s. DWD 80.02 (2) (a).

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

**DWD 80.60 Exemption from duty to insure (self-insurance).** (1) **DEFINITIONS.** In this section:

(a) "Applicant" means a business entity applying for self-insurance.

(b) "Divided-insurance" means consent to the issuance of 2 or more policies, as provided in s. 102.31 (1), Stats.

(c) "Employer" means a business entity or its parent guaranteeing payments.

(d) "Excess insurance" means catastrophic insurance for employers granted self-insurance, and is not full-insurance, self-insurance, partial-insurance or divided-insurance.

(e) "Full-insurance" means the insurance of all liability by one policy, as required in s. 102.31 (1) (a), Stats.

(f) "Partial-insurance" means self-insurance of a part of the liability and consent to the issuance of one or more policies on the remainder of the liability, as provided in ss. 102.28 (2) (b) and 102.31 (1), Stats.

(g) "Self-insurance" means exemption from the duty to insure, as provided in s. 102.28 (2) (b), Stats.

(2) **EXCESS INSURANCE.** Excess insurance may be carried without further order of the department or may be required by order of the department as set forth in sub. (4)(d)3. and 7.

(3) **REQUIREMENTS FOR THE STATE AND ITS POLITICAL SUBDIVISIONS.** (a) The state and its political subdivisions may self-insure without further order of the department, if they are not partially-insured or fully-insured, or to the extent they are not partially-insured by written order under s. 102.31 (1), Stats., under one or more policies, and if they agree to report faithfully all compensable injuries and agree to comply with ch. 102, Stats., and the rules of the department. However, any such employer desiring partial-insurance or divided-insurance must submit an application to the department and be given special consent as described in s. DWD 80.61.

(b) 1. Any political subdivision or taxing authority of the state electing to self-insure shall notify the department in writing of the election before undertaking self-insurance, every 3 years after the

initial notice, and 30 days before withdrawing from the self-insurance program.

2. The notice of election to self-insure shall be accompanied by a resolution, adopted by the governing body and signed by the elected or appointed chief executive of the applying political subdivision or taxing authority, stating its intent and agreement by the governing body to self-insure its worker's compensation liability and an agreement to faithfully report all compensable injuries and to comply with ch. 102 Stats., and the rules of the department in accordance with s. 102.28 (2) (b) and (c), Stats.

(c) Self-insurance granted under par. (a) is subject to revocation under s. 102.28 (2) (c), Stats. Once the privilege of self-insurance is revoked, further self-insurance may be authorized only under the procedures set forth in sub. (4).

(4) **REQUIREMENTS FOR OTHER EMPLOYERS.** (a) Employers other than those specified in sub. (3), but including those specified in sub. (3) (c), desiring self-insurance shall submit an application on a form available from the department. A non-refundable fee, determined by the department as described in par. (ag), per employer, shall accompany the initial application. If the application is approved, the department shall permit self-insurance by written order. Every 3 years, a self-insured employer shall submit an application to renew self-insurance at least 60 days before the expiration date specified in the department's order. Each quarter, or more often if requested by the department, a self-insured employer shall submit the most current financial statements to the department. Each year, a self-insured employer shall report work-injury claims payments to the department and other information related to worker's compensation liability requested by the department. A self-insured employer shall immediately report to the department in writing any change in organizational structure that differs from the information provided in the annual report submitted to the department, including mergers, acquisitions, company name changes, consolidation, sale, or divestiture of divisions or subsidiaries. After a change in organizational structure, the department may revoke or modify the exemption from the duty to insure by providing reasonable written notice to the self-insured employer. If these changes result in the creation of a new parent or subsidiary, the department may waive or modify the requirement in par. (b) 1. to submit 5 years of audited financial statements. A fee of \$200, per employer, and the assessment surcharge described in par. (am) may be billed by the department at the same time as the annual assessment under s. 102.75 (1), Stats. Self-insurance shall expire on the day specified by the department in its order. Unless the context indicates otherwise, all information submitted to the department to comply with this section shall be submitted on the latest version of a department approved form.

**Note:** For information regarding forms contact the worker's compensation division, bureau of insurance programs, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707.

(ag) In addition to any fee-for-service costs under par. (ax), the department shall charge each initial applicant for self-insurance a flat fee which the department estimates is the average cost for department employees to review the application for self-insurance, including employee salary and fringe benefits, supplies services and administrative costs, and information technology charges. The department shall review and, if necessary, modify the fee at least every 2 years.

(am) In addition to any fee-for-service costs under par. (ax), each year the department shall assess each self-insured employer except those specified in sub. (3), but including those specified in sub. (3) (c), a \$200 fee and a proportionate share of the department's remaining costs to administer the self-insurance program after deducting the total amount estimated to be collected from the \$200 fees and the fees charged under par. (ag) for initial applications. The department shall determine the assessment amount under this paragraph in the same manner as costs and expenses are apportioned in s. 102.75 (1), Stats.



(ax) To assist the department in evaluating an initial application or a renewal application for self-insurance, the department may contract for financial, loss control or other fee-for-service expertise or it may direct the applicant to provide the necessary information. The department shall charge the applicant for self-insurance the full cost of any fee-for-service expenses which the department incurs in evaluating the application for self-insurance. If these charges are related to an application for renewal of self-insurance, the department may bill the employer at the same time as the annual assessment under s. 102.75 (1), Stats.

(b) The minimum requirements necessary for initial consideration for self-insurance are set forth in this paragraph. References in this paragraph to "board of directors" and "stockholders of the corporation" apply only to corporations but an equivalent requirement as determined by the department shall be applied to sole proprietorships, partnerships and other forms of business ownership.

1. The applicant, when submitting an initial request for self-insurance, shall submit audited financial statements (which includes the opinion of a certified public accountant) for a minimum of the latest five. Except as authorized by the department, employers self-insured under this subsection shall submit to the department audited or unaudited financial statements each quarter and audited financial statements each year.

2. If the employer is a corporation or a partnership which is a majority or wholly owned subsidiary, it shall submit to the department a guaranty of payments by the ultimate or top parent company on a department form and a certified copy of the resolution adopted by the board of directors of the parent corporation.

3. If the employer is a corporation, it shall submit a certified copy of the resolution adopted by the board of directors authorizing the execution of the initial application:

a. Applications by organizations other than corporations shall be signed by one or more persons possessing authority to execute such application.

b. Partnerships must submit a consent by all the partners that all individuals executing the application have the authority to act for the applicant partnership.

4. Corporations, limited partnerships and limited liability companies shall be registered in the office of the department of financial institutions.

5. The employer shall submit a copy of its current safety and loss control plan.

(c) The following criteria may be considered by the department in evaluating the qualifications of an applicant for the initial application or renewal of self-insurance status:

1. The financial strength and liquidity of the employer to include: profit and loss history; financial and performance ratios; characteristics and trends for the employer or the consolidated group of employers to which the employer belongs; characteristics and trends for other employers of the same or the most similar industry in which the employer or the employer's consolidated group is involved;

2. The employer's organizational structure, management background, kind of business, length of time in business, and any intended or newly implemented reorganization including but not limited to merger, consolidation, acquisition of new business, divesting or spinning off of assets or other changes;

3. The nature and extent of the employer's business operations and assets in the state of Wisconsin;

4. The employer's bond or other business ratings;

5. The number of employer's employees, payroll and hours worked in Wisconsin;

6. The employer's performance indicators under ch. 102, Stats., including, but not limited to, promptness or time taken in making first indemnity payments, promptness or time taken in submitting first reports, and injury and illness incidence and severity rates;

7. The existing or proposed claims administration, occupational health, safety, and loss control programs to be maintained by the employer. The department may require certification of the occupational safety and health program by state or independently qualified specialists;

8. The worker's compensation loss history, experience modification factor, reported losses, loss reserves and worker's compensation premium of the employer; and

9. Excess insurance, surety bond, cash deposit or pledges of the employer, guaranty by the parent company, or other guarantees or pledges acceptable to the department.

(d) The required minimum bond, minimum amount of cash, letter of credit or securities deposits, minimum acceptable excess insurance upper limit, maximum excess insurance retention, or other security satisfactory to the department, shall be determined after the application has been reviewed and analyzed by the department. The employer and the employer's surety or other agent providing security shall use the latest version of any forms required by the department. All surety bonds and excess policies shall be written on standard forms approved by the Wisconsin compensation rating bureau or the commissioner of insurance, or both. Any change in the language used in the approved standard form is not accepted unless the department approves it in writing. The following conditions shall also apply to self-insured employers:

1. Surety bonds shall be written by companies authorized to transact surety business in Wisconsin and acceptable to the department.

2. Cash or equivalent securities shall be deposited with banks or trust companies authorized to exercise trust powers in Wisconsin and acceptable to the department. These securities shall be negotiable and converted into cash at anytime by the depository at the request of the department.

3. If excess insurance is required by the department, it shall be procured from a licensed excess insurance carrier and written on the basis of rates and policy form filed with and approved by the state of Wisconsin commissioner of insurance. The policy for the required excess insurance shall be filed with and approved by the Wisconsin compensation rating bureau.

4. Each self-insured employer shall provide security of at least \$500,000. The department may increase the minimum required security amount after considering the criteria in par. (c).

5. If the self-insured employer provides a surety bond, the surety company shall pay worker's compensation liabilities of the employer up to the aggregate amount of the bond without deducting any of its costs for investigating, paying, defending against, or providing other services related to the worker's compensation claims. If a self-insured employer has more than one surety bond, the surety company whose bond is in effect on the date of injury is liable for claims related to that injury.

6. If the self-insured employer provides security in any form other than a surety bond, the department shall add 30 percent to the minimum amount in subd. 4.

7. Each employer self-insured under this subsection shall obtain a specific per occurrence excess insurance policy with retention and maximum limits approved by the department and in a form approved by the Wisconsin compensation rating bureau under ch. 626, Stats. In determining the limits the department shall consider, among other things, the criteria in par. (c).

(dm) The department may call and use any security provided by an employer under par. (d) to pay that employer's worker's compensation liabilities and to administer that employer's worker's compensation claims if the department has a reasonable basis to believe that the employer is not able or will not be able to timely pay the worker's compensation liabilities incurred during the period for which that employer was authorized to be self-insured. The department may contract with a third-party administrator or other agent to administer payments. The employer is responsible

for any unpaid liabilities. Within 2 working days of receiving written notice from the department, the employer whose security was called shall provide the department with the names and addresses of all present and former employees of the employer during the most recent 3 years in which the employer was self-insured. Within 30 days of receiving written notice from the department, the employer whose security was called shall provide the department with copies of any worker's compensation, medical or employment files requested by the department or summary information related to those files in a format requested by the department.

**Note:** In addition to a demonstrated failure to make timely worker's compensation payments, "a reasonable basis to believe that an employer...will not be able to timely pay worker's compensation liabilities" is intended to include such things as proceedings before bankruptcy court which may have an adverse financial impact on the employer or credible reports that an employer is preparing to seek some form of shelter in bankruptcy or receivership.

(dx) A surety or bonding company shall provide the department with a written plan acceptable to the department for the review and payment of any worker's compensation liability of the self-insured employer within 15 days after the department notifies the surety or bonding company that it is calling the bond. When the department approves the plan the surety or bonding company may contract with a third-party administrator or other agent to pay worker's compensation benefits and other liabilities.

(e) Whenever the department has reason to believe that an employer currently or previously granted self-insurance for its parent or subsidiary company is liquidating and distributing its assets to its owners, or is selling or is about to sell the tangible property it owns and maintains in Wisconsin and the employer or its parent or subsidiary company is moving or is about to move its operations out of Wisconsin, without providing for the payment under the terms of the agreement in the self-insurance application or guaranty form it has executed and submitted to the department, the department may, through the attorney general, cause a petition to be filed to enjoin and restrain the employer from engaging in such action until such time as all obligations of self-insurance meet the satisfaction of the department. Whenever an employer exits self-insurance status the department may require such employer to provide all available information regarding past or outstanding worker's compensation claims or liability and may require securities sufficient to provide payment for those claims or liabilities.

(f) The department may require a self-insured employer to update the information provided in pars. (b) to (e) at any time.

**History:** Cr Register, September, 1982, No. 321, eff. 10-1-82; am. (3), (4) (a), (b) (intro.) and (c) (intro.), cr. (4) (b) 11., Register, September, 1986, No. 369, eff. 10-1-86; emerg. r. (4) (b) 1., renum. (4) (b) 2. to 11. to be 1. to 10., eff. 3-22-88; am. (4) (b) (intro.), r. (4) (b) 1., renum. (4) (b) 2. to 11. to be 1. to 10., Register, August, 1988, No. 392, eff. 9-1-88; am. (1), (2), (3) (b) and (4), Register, April, 1990, No. 412, eff. 5-1-90; am. (4) (a), cr. (4) (ag) to (ax), (f), Register, July, 1996, No. 487, eff. 8-1-96; am. (2), (3) (b), (4) (a), (am), (4) (b) 1. and 4., (4) (d) (intro.), cr. (4) (d) 4. to 7., (dm) and (dx), Register, November, 1998, No. 515, eff. 12-1-98.

**DWD 80.61 Divided-insurance and partial-insurance requirements under s. 102.31 (1) and (6), for all employers, including contractors working on a wrap-up project. (1) DEFINITIONS.** In this section:

(a) "Divided-insurance" means consent to the issuance of 2 or more policies, as provided in s. 102.31 (1), Stats.

(b) "Partial-insurance" means self-insurance of a part of the liability and consent to the issuance of one or more policies on the remainder of the liability, as provided in ss. 102.28 (2) (b) and 102.31 (1), Stats.

**(2) REQUIREMENTS.** (a) The requirements for partial-insurance and divided-insurance by 2 or more insurance companies are as follows:

1. Submission of an application on department forms available from the department. If the application is approved, the department shall permit partial-insurance or divided-insurance by written order. In the application, the employer shall agree to

assume full responsibility to immediately make all payments of compensation and medical expense as the department may require, pending a final determination as to liability between the insurance carriers under divided-insurance or between the employer and the insurance carrier under partial-insurance, if a dispute should arise as to which insurance company or whether the employer or insurance company is responsible for a particular injury or illness sustained during the time the written order is in effect.

2. If the applicant is a political subdivision of the state, it shall submit a certified statement by an officer or the attorney for the political subdivision which cites the legal authority for executing the application and agreement when the initial application is submitted.

3. If the employer is a corporation, it shall submit a certified copy of the resolution adopted by the board of directors authorizing the execution of the initial application. Applications by organizations other than corporations shall be signed by person(s) possessing authority to execute such application. Partnerships must submit a consent by all the partners that the individual(s) executing the application has the authority to act for the applicant partnership.

4. Partial-insurance or divided insurance shall not be permitted when the portion of the entity to be insured is unable to obtain coverage under voluntary markets. Otherwise,

a. The department shall permit divided-insurance to municipalities which have ownership of nursing homes in order that the nursing homes may be separately insured and develop a separate experience rate.

b. Subdivision 4. a. does not apply after December 31, 1992.

(b) Renewal applications shall be submitted to the department on a department form no later than 3 months prior to the expiration date of the department's order. Partial-insurance and divided-insurance shall expire on the date specified in the order unless continued in force by further order, as the department deems necessary.

**(3) DIVIDED-INSURANCE FOR DESIGNATED CARRIER WRAP-UP CONSTRUCTION PROJECTS.** (a) *Definitions.* In this subsection:

1. "Bureau" means the Wisconsin compensation rating bureau.

2. "Designated wrap-up carrier" means the designated carrier or insurance company which insures the wrap-up project under ch. 102, Stats.

3. "Job site" means the premises and vicinity upon which the operations covered under the contract with the contractor or subcontractor are to be performed.

4. "Material supplier" means vendors, suppliers, material dealers, and others whose function is solely to supply or transport material, equipment, or parts to or from the construction site.

5. "Owner" means the person, firm, corporation or municipality having lawful possession of the construction project.

6. "Regular carrier" means the insurance company which insures all operations of a contractor or subcontractor under ch. 102, Stats., except for work done on the wrap-up project.

7. "Subcontractor" means a person who contracts with a contractor and also includes any subcontractor of a subcontractor.

8. "Wrap-up project" means a construction project wherein the owner selects a carrier, and this carrier issues a separate worker's compensation policy to each contractor and subcontractor scheduled to work on the project for work which will be done on the project, and where the owner pays for each such policy.

(b) *Minimum wrap-up project requirements.* Wrap-up projects shall comply with the following:

1. The estimated project cost of completion shall be equal to at least \$25 million. The estimated project cost of completion shall

be the estimate of the costs of the total construction contracts to be awarded by the owner on the wrap-up project.

2. The estimated standard worker's compensation manual premium shall be equal to \$250,000 or more.

3. The project shall be confined to a single location except that in connection with the building of a road, bridge, pipeline, tunnel, waterway, or 2 or more concurrent wrap-up projects involving the same owner and the same insurance carrier the entire job or the concurrent projects are considered as a single project location.

4. The project shall have a definite completion date involving work to be performed continuously until completion and may not be extended to include maintenance work following completion.

5. All contractors and subcontractors shall be included under the wrap-up program.

6. All material suppliers shall be included in the safety program on the job site while unloading and handling material and performing other work, but material suppliers shall be excluded from the rest of the wrap-up program.

7. The submission of all bids and the letting of all contracts shall be on an ex-insurance basis.

(c) *Minimum requirements for owner.* The owner shall comply with the following requirements on a wrap-up project:

1. The wrap-up plan and application shall be submitted on department form WKCA-19.5 W-U to the department. If the application is approved, the department shall permit divided-insurance on the wrap-up project.

2. The owner shall comply with all conditions and agreements in the application, including, but not limited to:

a. The reimbursement of the department's costs incurred because of the wrap-up project;

b. The selection of a licensed and qualified designated wrap-up carrier having a record of compliance with the requirements of ch. 102, Stats., which is acceptable to the department;

c. Informing each contractor and subcontractor and each contractor's and subcontractor's insurance company either directly or through the bureau, at the bureau's discretion, of each one's responsibilities and the need for attaching a proper endorsement to the regular carrier's policy to exclude coverage for the wrap-up job site;

d. The submission of each contractor's and subcontractor's application form WKC A-19.4 W-U to the bureau prior to the time the contractor or subcontractor first starts work on the wrap-up project;

e. The notification of department and bureau of any entity status change resulting from ensuing reorganization;

f. The assumption of responsibility for immediately making direct compensation payments if a dispute arises over coverage; and

g. The payment of an employee's attorney's fees and lost wages resulting from a dispute.

3. If the owner is a corporation, it shall submit a certified copy of the resolution by the board of directors authorizing and directing the execution of the application and agreement.

4. If the owner is a subsidiary of a corporation, it shall submit a guaranty and agreement by the owner's ultimate or top parent company agreeing to promptly satisfy all of the requirements and obligations assumed by the owner on the wrap-up project in case of default by the owner.

(d) *Minimum requirements for designated wrap-up carrier.*

1. The designated wrap-up carrier shall submit an application on forms available from the department. If the application is approved, the department shall permit divided-insurance for each contractor and subcontractor scheduled to work on the wrap-up project.

2. The designated wrap-up carrier shall comply with all conditions and agreements in the application, including, but not limited to:

a. Informing each contractor's and subcontractor's insurance company either directly or through the bureau, at the bureau's discretion, of each one's responsibilities and the need for attaching a proper endorsement to the regular carrier's policy to exclude coverage for the wrap-up job site;

b. The issuance of each individual contractor's and subcontractor's wrap-up policy prior to the time the contractor and subcontractor begin work on the job site;

c. The notification of department and bureau of any entity status change resulting from ensuing reorganization;

d. Becoming the full risk insurer for any contractor or subcontractor not having purchased a worker's compensation policy during the time the contractor or subcontractor is under contract on the wrap-up project, except as to an employer granted self-insurance; and

e. Becoming the full risk insurer for any contractor or subcontractor not insured or self-insured while working on the wrap-up project.

3. The designated wrap-up carrier shall submit a certified copy of a statement from an officer authorizing and directing the execution of the application and agreement.

(e) *Application for contractors and subcontractors.* The owner shall submit an application for divided insurance on forms available from the department for each contractor and subcontractor scheduled to work on the project.

(em) *Waiver of requirements.* The department may waive one or more requirements in pars. (b) to (e) if it determines that a waiver will not impair the construction owner's ability to ensure minimum confusion about insurance coverage and maximum safety on the construction project site.

(f) *Reimbursement for expenses incurred by department.* The department shall be reimbursed for those expenses incurred because of the designated carrier wrap-up program. Where the department specifically consents to divided-insurance or partial-insurance on a wrap-up project, the owner shall reimburse the department, within 30 days after the date of a written request by the department, a sum determined by the department not to exceed 2% of the total audited worker's compensation premium charged, with payment not to exceed 1% of the estimated worker's compensation premium upon initial request. If an additional levy is determined to be necessary, a request shall be made for a sum that results in a total charge not to exceed 2% of the total audited worker's compensation premium charged.

(g) *Inapplicability to other employers.* Subsection (3) does not apply to any group of employers other than those specified in this section on any other type of operations nor to any single contract or policy of insurance for any group or association of employers.

**History:** Cr. Register, September, 1982, No. 321, eff. 10-1-82; am. (2) (a) 1., (3) (b) 3. and (3) (d) 3., r. and recr. (3) (e), Register, September, 1986, No. 369, eff. 10-1-86; am. (2) (a) 2. to (c), Register, April, 1990, No. 412, eff. 5-1-90; cr. (3) (em), Register, April, 1994, No. 460, eff. 5-1-94.

#### **DWD 80.62 Uninsured employers fund. (1) PURPOSE.**

The purpose of this section is to clarify the department's procedures for handling claims for compensation to injured workers under s. 102.81 (1), Stats. This section also defines the financial standards and actuarial principles which the department will use to monitor the adequacy of the cash balance in the fund to pay both known claims and claims incurred but not reported under s. 102.81 (1), Stats.

#### **(2) DEFINITIONS.** In this section:

(a) "Agent" means a third-party administrator or other person selected by the department to assist in the administration of the uninsured employers fund program.

(b) "Case reserve" means the best estimate documented in the claim-loss file of all liability to pay compensation on a claim under s. 102.81 (1), Stats.

(c) "Claim" means an injury suffered by an employee of an uninsured employer for which the uninsured employer is liable under s. 102.03, Stats., and which is reported to the department on a form approved by the department for reporting work-related injuries.

(d) "Fund" means the uninsured employers fund in s. 102.80, Stats.

(e) "Incurred but not reported reserve" or "IBNR reserve" means the best actuarial estimate of liability to pay compensation under s. 102.81 (1), Stats., for injuries which occurred on or prior to the current accounting date, for which there is no claim yet reported to the department.

(f) "Insolvent" means inadequate to fund all claims under s. 102.81 (1), Stats.

(g) "Solvent" means adequate to pay all claims under s. 102.81 (1), Stats.

(h) "Ultimate reserve" means the best actuarial estimate of aggregate case reserves from all claims, the expected future development of claims that have been reported, and IBNR reserve.

(i) "Uninsured employer" means an employer who is subject to ch. 102 under s. 102.04 (1), Stats., and who has not complied with the duty to insure or to obtain an exemption from the duty to insure under s. 102.28 (2) or (3), Stats.

**(3) REPORTING A CLAIM.** (a) In addition to the notice to an employer required under s. 102.12, Stats., an employee shall report a claim for compensation under s. 102.81, Stats., to the department on a form provided by the department within a reasonable time after the employee has reason to believe that an uninsured employer may be liable for the injury.

**Note:** For information regarding forms contact the worker's compensation division, P.O. Box 7901, Madison, Wisconsin 53707.

(b) After receiving a claim under par. (a), the department shall determine whether the employer is an uninsured employer by reviewing its own records and the records maintained by the Wisconsin compensation rating bureau. Within 14 days after receiving a claim under par. (a), the department shall send the employer written notice that a claim has been reported and that the department has made an initial determination that the employer is, or is not, an uninsured employer with respect to the claimed injury. The department shall send a copy of the notice to the employee who filed the claim. If the department later modifies its initial determination regarding the employer's insurance status with respect to a claim reported under this section, it shall promptly notify the employer and the employee of the reason for the modification and the likely impact of this change on the claim, if any. The employer shall notify its insurance carrier of any modification if the department determines that the employer is an insured employer.

(c) If the department determines that the employer is an uninsured employer it shall promptly seek reimbursement as provided in s. 102.82 (1), Stats., and additional payments to the fund as provided in s. 102.82 (2), Stats. The department may also initiate penalty proceedings under s. 102.85, Stats. If the department determines that the employer is not an uninsured employer it shall notify the parties and close the claim. Nothing in this section shall prevent the department from taking other appropriate action on a claim including penalties and interest due under ss. 102.16 (3), 102.18 (1) (b) and (bp), 102.22 (1), 102.35 (3), 102.57 and 102.60, Stats.

**(4) PAYING A CLAIM.** Within 14 days after a claim is reported to the department, the department or its agent shall mail the first indemnity payment to the injured employee, deny the claim or explain to the employee who filed a claim the reason that the claim is still under review. The department or its agent shall report to the employee regarding the status of the claim at least once every 30 days from the date of the first notification that the claim is under

review until the first indemnity payment is made or the claim is denied.

**(5) EMPLOYEE COOPERATION.** (a) An employee who makes a claim shall cooperate with the department or its agent in the investigation or payment of a claim.

(b) The department or its agent may deny compensation on a claim if an employee fails to provide reasonable assistance to the department or its agent, including recorded interviews, questionnaire responses, medical and other releases, copies of relevant payroll checks, check stubs, bank records, wage statements, tax returns or other similar documentation to identify the employer who may be liable for the injury under s. 102.03, Stats. The department or its agent may also require the employee to document any medical treatment, vocational rehabilitation services or other bills or expenses related to a claim. To verify information submitted in support of a claim for compensation the department or its agent may share information related to a claim with other governmental agencies, including those responsible for tax collection, unemployment insurance, medical assistance, vocational rehabilitation, family support or general relief. Any information obtained from a patient health care record or that may constitute a patient health care record will be shared only to the extent authorized by ss. 146.81 to 146.84, Stats.

(c) If an employee fails to cooperate as required by par. (b), the department may suspend action upon an application filed under s. 102.17 (1), Stats., or may issue an order to dismiss the application with or without prejudice.

**(6) EMPLOYER COOPERATION.** An employer who is alleged to be uninsured shall cooperate with the department or its agent in the investigation of a claim by providing any records related to payroll, personnel, taxes, ownership of the business or its assets or other documents which the department or its agent request from the employer to determine the employer's liability under s. 102.03, Stats. If an employer fails to provide information requested under this subsection, the department may presume the employer is an uninsured employer.

**(7) DEPARTMENT AGENTS.** (a) The department may select one or more agents to assist the department in its administration of the uninsured employers program, including agents selected for any of the following:

1. To receive, review, record, investigate, pay or deny a claim.
2. To represent the legal interests of the uninsured employers fund and to make appearances on behalf of the uninsured employers fund in proceedings under ss. 102.16 to 102.29, Stats.
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.
4. To seek additional payments to the fund under s. 102.82 (2), Stats.
5. To prepare reports, audits or other summary information related to the program.
6. To collect overpayments from employees or their dependents or from those to whom overpayments were made on behalf of employees or their dependents where benefits were improperly paid.

(b) Except as provided in this section, the department or its agent shall have the same rights and responsibilities in administering claims under ch. 102, Stats., as an insurer authorized to do business in this state. The department or its agent is not liable for penalties and interest due under ss. 102.16 (3), 102.18 (1) (b) and (bp), 102.22 (1), 102.35 (3), 102.57 and 102.60, Stats.

**(8) REPORTS.** Within 45 days following the end of each calendar quarter, the department shall submit a report to the governor and the presiding officer of each house of the legislature summarizing all of the following:

- (a) The claims activity related to the fund.
- (b) The payments made from the fund.

(c) The net balance in the fund.

(d) The department's enforcement activities against uninsured employers.

**(9) DETERMINING THE SOLVENCY OF THE FUND.** (a) The department shall monitor the fund's net balance of assets and liabilities to determine if the fund is solvent using the following accounting principles:

1. In determining the fund's assets, the department shall not include recoveries under s. 102.29 (1), Stats., unless they are in process of payment and due within 30 days, or vouchers in the process of payment which are not fully credited to the fund's account.

2. In determining the fund's liabilities, the department shall estimate the ultimate reserves without discounting, and shall not include reinsurance recoveries that are less than 60 days overdue.

(b) If the secretary determines that ultimate liabilities to the fund on known and IBNR claims exceed 85% of the cash balance in the fund, the secretary shall consult with the council on worker's compensation. If the secretary determines that the fund's ultimate liabilities exceed the fund's ultimate assets, or that there is a reasonable likelihood that the fund's liabilities will exceed the fund's assets within 3 months, the secretary shall file the certificate of insolvency in s. 102.80 (3) (ag), Stats.

**(10) TEMPORARY REDUCTION OR DELAY OF PAYMENTS FROM THE FUND.** (a) If the secretary files a certificate under s. 102.80 (3) (ag), Stats., the department shall continue to pay compensation under s. 102.81 (1), Stats., on claims reported to the department prior to the date specified in that certificate after which no new claims under s. 102.81 (1), Stats., will be accepted or paid.

(b) If the cash balance in the fund is not sufficient to pay all compensation or other liabilities due in a timely manner, the department may temporarily reduce or delay payments on claims to employees, dependents of employees, health care providers, vocational rehabilitation specialists and others to whom the fund is liable. To manage the fund's cash flow, the department may adopt a uniform, pro-rata reduction schedule or it may establish different payment schedules for different types of liabilities. The department may amend its payment schedule as necessary.

(c) The department shall provide written notice to each person who does not receive timely compensation from the fund which explains the reduced or delayed payment schedule adopted by the department to resolve the cash-flow problem.

**History:** Cr. Register, July, 1996, No. 487, eff. 8-1-96.

**DWD 80.65 Notice of cancellation or termination.**

Notice of cancellation or termination of a policy under s. 102.31 (1) (a), Stats., shall be given by certified mail or personal service to the Wisconsin compensation rating bureau, as defined in s. 626.02 (2), Stats., rather than to the department. Whenever the Wisconsin compensation rating bureau receives notice of cancellation or termination pursuant to this section, it shall immediately notify the department of cancellation or termination.

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

**DWD 80.67 Insurer name change.**

A worker's compensation insurer shall notify the department and the Wisconsin compensation rating bureau in writing 30 days before the effective date of a change in its name. The insurer shall comply with the name change requirements in its state of domicile and in the state of Wisconsin. On or before the effective date of an approved name change, the insurer shall notify each of its employers insured under ch. 102, Stats., that the insurer's name is changed. Insurers shall notify employers by an endorsement to the employer's existing policy that states the insurer's new name. The insurer shall file a copy of the endorsement with the Wisconsin compensation rating bureau by personal service, facsimile, or certified mail at the same time that it provides notice to its employers insured under ch. 102, Stats.

**Note:** The State of Wisconsin Office of the Commissioner of Insurance requires an advance notice of an insurer name change or reorganization. For further information, contact OCI at (608) 266-3585 or (800) 236-8517.

**History:** Cr. Register, September, 1986, No. 369, eff. 10-1-86; **CR 00-181: r. and recr., Register July 2001, No. 547 eff. 8-1-01.**

**DWD 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), Stats., 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 employee 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, Stats., 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 employee with the preexisting disability.

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

**DWD 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.

**DWD 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, GEF1, 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.

**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 superintendent of documents, U.S. government printing office, Washington, D.C., 20402, (stock number 917014000001).

(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-employee; the date of service; the health service procedure; and the amount charged for each procedure. The notice from the insurer or self-insurer to the provider shall specify:

1. The name of the patient-employee 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 employee 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 justifi-

fication 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 employee 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%, 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 post-marked 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.

**DWD 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 docu-

ments the treatment provided to the worker. The notice shall specify:

1. The name of the patient–employee;
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 employee 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 employee 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 applica-



tion 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.