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February 4, 2004

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Assembly Bill 669: Workforce Development--Worker's Compensation Law Changes

Assembly Bill 669, which would modify a number of provisions of the state's worker's compensation law, was developed by the Worker's Compensation Advisory Council, a thirteen-member council appointed by the Secretary of the Department of Workforce Development (DWD). AB 669 was introduced on November 13, 2003, by the Assembly Committee on Labor and referred to that Committee. Executive action was taken on the bill on January 7, 2004, and it was recommended for passage on January 14, by a vote of 9-0. Assembly Amendment 1 to AB 669 was introduced by Representative Nass on January 14, 2004.

SUMMARY OF BILL

AB 669 would modify current law worker's compensation provisions related to benefits, employer and insurer payments, and other miscellaneous items.

Benefit Provisions

Supplemental Benefits. Under current law, an injured employee who receives permanent total disability or continuous temporary disability payments more than 24 months after the date of injury for an injury that occurred prior to January 1, 1978, is entitled to receive supplemental benefits. The supplemental benefits are paid for weeks of disability occurring after January 1, 1980. If the employee is receiving the maximum benefits at the time of the injury, the supplemental benefit equals an amount, that when added to the employee's regular weekly benefit payment, totals $202. If the employee is receiving weekly benefits that are less than the maximum, the supplemental benefit is an amount that is sufficient to bring the total weekly benefits to the same proportion of $202 as the employee's weekly benefit is to the maximum weekly benefit.

Assembly Bill 669 would make an employee who is injured prior to May 13, 1980, eligible for supplemental benefits for weeks of disability occurring after January 1, 1982. In addition, the bill would increase supplemental benefits for a week of disability occurring after January 1, 2004, to an amount that, when added to the maximum weekly benefits, totals $233.

Payment of Permanent Partial Disability Benefits. Permanent partial disability benefits are paid when an employee is able to work, but for a lower wage or fewer hours than before the injury. Permanent partial disability benefits are paid to the employee or dependent on a monthly basis. Payment of compensation that results from an injury for which the employer or insurer concedes liability and that is based on a minimum permanent disability rating must begin within the later of 30 days after the end of the employee's healing period, or 30 days after the employer or insurer receives a medical report that provides a permanent disability rating. Payment of compensation that results from an injury for which the employer or insurer does not concede liability, or that is based on a permanent disability rating that is above the minimum, must begin within the later of 30 days after the end of the employee's healing period, or 30 days after the employer or insurer receives a medical report establishing a permanent disability rating. However, if, within the later of those 30-day periods, the employer or insurer notifies the employee that it is requesting an examination of the employee, payment of compensation must begin within the later of 30 days after the employer or insurer receives the report of examination, or 90 days after the date of request for the examination.

Assembly Bill 669 would modify these provisions to provide that, if the employer or insurer concedes liability for an injury that results in permanent disability and if the extent of the disability can be determined based on a minimum disability rating, payment of compensation would be required to begin within 30 days after the end of the employee's healing period. If the employer or insurer concedes liability for an injury that results in permanent disability, but the extent of the permanent disability could not be determined without a medical report that provided the basis for a minimum permanent disability rating, payment of compensation for disability would be required to begin within 30 days after the employer or insurer received a medical report that provided a basis for a permanent disability rating. The bill would also require DWD to promulgate rules for determining when payment of compensation for permanent disability would begin in cases in which the employer or insurer conceded liability, but disputed the extent of the permanent disability.

Advance Payment of Permanent Partial Disability Payments. Current law provides that DWD may direct advanced payment of unaccrued compensation or death benefits if the Department determines that the advanced payment is in the best interest of the injured employee or the employee's dependents. The bill would specify that the Department could make advanced payments of compensation for permanent disability, as well as for death benefits.

Payment of Benefit Awards. Current law requires that, in cases where the Department orders a party to pay an award of worker's compensation, the party must pay the award no later than 21 days after the date on which the order is mailed to the last known address of the party, unless a party files a petition for review. The bill would specify that the party which must pay the award, rather than any party to the action, must file a petition for review.

Employer/Insurer Payments

Payments to the Work Injury Supplemental Benefit Fund. The Work Injury Supplemental Benefit Fund is used to pay: (a) supplemental benefits to employees; (b) additional death benefits to children; (c) claims with at least 200 weeks of preexisting disability; and (d) certain barred claims. Employers or insurers must make the following payments to the fund: (a) $5,000 if a work-related injury is the proximate cause of death; (b) $7,000 for the total impairment or loss of a hand, arm, foot, leg, or eye; or (c) the amount of death benefit when there are no dependents.

Assembly Bill 669 would increase required payments by insurers or employers to the Work Injury Supplemental Fund as follows: (a) $10,000 when the injury was the proximate cause of death; and (b) $10,000 for loss of hand, arm, foot, leg, or eye.

Reimbursement Payments by Uninsured Employers. The Uninsured Employers Fund (UEF) is used to make benefit payments for worker's compensation claims filed by employees who are injured while working for illegally uninsured employers. When an employee of an uninsured business files a compensable claim, the UEF pays the injured worker's compensation benefits. The UEF is funded through penalties assessed against employers for illegally operating a business without worker's compensation insurance. The penalties are mandatory and nonnegotiable. In addition, the uninsured employer is required to reimburse the fund for all compensation paid to the injured employee or the employee's dependents.

The bill would require uninsured employers to also reimburse DWD for any expenses paid by the Department in administering the claim of the injured employee or the employee's dependents. The bill would include a technical change to specify that UEF payments and reimbursements would be made for compensation to or on behalf of an injured employee.

Waiver or Reduction of Forfeitures. Under current law, every employer and insurance company that fails to keep required records and make required reports or that knowingly falsifies such records or makes false reports is subject to a forfeiture of between $10 and $100 for each offense.

Under the bill, DWD would be authorized to waive or reduce a forfeiture if the employer or insurance company that violated the law requested a waiver or reduction in the forfeiture within 45 days after notice of the forfeiture was mailed and, in the waiver request, showed that the violation was due to mistake or an absence of information.

Miscellaneous Provisions

Health Care Practitioners for Certain Worker's Compensation Activities. Under current law, an employee can choose any physician, chiropractor, psychologist, dentist, or podiatrist licensed to practice and practicing in the state to treat a work injury. The bill would permit employees to also select physician assistants and advanced practice nurse prescribers to treat work-related injuries.

Currently, when an employee makes a claim for worker's compensation, the employer or worker's compensation insurer can request that the employee be examined by a physician, chiropractor, psychologist, dentist, or podiatrist provided and paid for by the employer or insurer. The worker's compensation law authorizes the employee to have his or her own physician, chiropractor, psychologist, dentist, or podiatrist present at the examination and to receive a copy of all reports of the examination prepared by the examining health care practitioner. The employer's or insurer's written request for an employee's examination must provide the employee with notification of certain information including: (a) the proposed date, time, and place of the examination and area of specialization of the examining physician, chiropractor, psychologist, dentist, or podiatrist present at the examination; (b) the employee's right to have a health care professional at the examination and to receive reports from the examining physician, chiropractor, psychologist, dentist, or podiatrist. Any physician, chiropractor, psychologist, dentist, or podiatrist, who is present at an examination may be required to testify as to the results of the examination and, if attending for a condition or complaint reasonably related to the claim for compensation, may be directed to testify before DWD. Such health care practitioners may furnish information and reports relative to the compensation claim to the employee, employer, or insurer. Current law permits the testimony of any licensed or practicing physician, chiropractor, psychologist, dentist, or podiatrist to be received in evidence in worker's compensation proceedings. Assembly Bill 669 would include physician assistants and advance practice nurse prescribers in the health care practitioners to whom all of these provisions apply.

Current law provides that an employee who reports a work-related injury or files an application for a hearing related to a worker's compensation claim waives any physician-patient, or chiropractor-patient privilege for any condition or complaint reasonably related to the claim. Any physician, chiropractor, psychologist, dentist, podiatrist, hospital or health care provider are required, upon written request, to provide the employee, employer, insurer, or Department with any information or written material related to the injury for which compensation is claimed. Such health care providers are required to provide legible duplicates of requested written material if certain conditions are met. The bill would include physician assistants and advanced practice nurse prescribers as health care practitioners that would be subject to these provisions.

Under current law, in claims disputes before the Department, the contents of certified medical and surgical reports by licensed or practicing physicians, podiatrists, surgeons, dentists, psychologists, and chiropractors presented by a party for compensation, and certified reports of such health care practitioners, if the practitioner consents to cross examination, constitute prima facia evidence of the content of the reports. Any physician, podiatrist, surgeon, dentist, psychologist, or chiropractor who knowingly makes a false statement of fact or opinion in a certified report may be fined, imprisoned, or both. Assembly Bill 669 would include physician assistants and advanced nurse prescribers in the list of health care providers subject to these provisions.

In addition, current law provides that certified reports by dentists are admissible as evidence of the diagnosis and necessity for treatment, but not of disability. The bill would provide that certified reports by dentists, physician assistants, and advanced practice nurse prescribers would be

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

Under current law, the record of a hospital or sanatorium in Wisconsin operated by any department or agency of the federal, state, or local governments, or the record of any other hospital or sanatorium in Wisconsin that is satisfactory to DWD, that is established by certificate, affidavit, or testimony of the supervising officer or other person in charge of the records, or that is established by a physician, podiatrist, surgeon, dentist, psychologist, or chiropractor, to be the record of the patient in question may be used in a worker's compensation proceeding. Such a record made in the regular course of examination or treatment of such patient, constitutes prima facia evidence, in any worker's compensation proceeding, of the contents of the record.

The bill would modify this provision in three ways. First, the bill would require all hospitals and sanatoriums to be found satisfactory to DWD, not just non-governmental institutions. Second, the provision would apply to records of physician assistants and advance practice nurse prescribers, in addition to physicians, surgeons, chiropractors, podiatrists, psychologists, and dentists. Finally, under the bill, such records would constitute prima facie evidence as to the matter contained in the record. The current reference to worker's compensation proceedings would be deleted.

Under current law, employees who receive worker's compensation are authorized to maintain a civil action against a physician, chiropractor, psychologist, dentist, or podiatrist for malpractice. The bill would add physician assistants and advanced nurse prescribers to the list of health care practitioners who could be subject to civil action for malpractice.

Fee and Treatment Disputes. DWD has jurisdiction to resolve disputes between insurers or self-insured employers and health service providers over fees charged for and the necessity of treatment provided to an employee for an injury.

Fee Dispute Resolution. An insurer or self-insured employer is required to notify the health service provider in cases where the insurer intends to dispute the reasonableness of a fee charged by the health service provider for health services provided to an employee who claims worker's compensation benefits. After receiving notice, the health service provider may not collect the fee from the injured employee who receives the services. If the insurer or self-insured employer and health service provider fail to reach an agreement over the disputed fee, the dispute may be submitted by the health service provider to DWD for resolution.

After a fee dispute is submitted to DWD, the insurer or self-insured employer must provide the Department with information on the disputed fee and fees charged by other health service providers for comparable services from a certified health service information database. Except in cases where the information is inaccurate, if the insurer or self-insured employer does not provide this information, DWD is required to determine that the disputed fee is reasonable and order that the fee be paid. If the insurer or self-insured employer cannot provide fee information because the information in the database in not accurate, the Department may use other reliable information to determine the reasonableness of the disputed fee. Where the insurer or self-insured employer

provides accurate information from a certified database, DWD is required to use that information to determine the reasonableness of the disputed fee.

DWD must analyze the data submitted in a fee dispute according to specified criteria. The Department is required to determine that the disputed fee is reasonable and order it paid if the fee is at or below the mean fee for the health service procedure for which the disputed fee was charged, plus 1.5 standard deviations from that mean, as shown by data from the certified database. The Department must determine that the disputed fee is unreasonable and order that a reasonable fee be paid if the disputed fee is above the mean fee for the health service procedure for which the disputed fee was charged, plus 1.5 standard deviations from that mean as shown by data from the certified database. However, the Department can approve a higher fee, if the health service provider proves to the Department's satisfaction that a higher fee is justified because the service provided in the disputed case was more difficult or more complicated to provide than in the usual case.

DWD may set aside, reverse, or modify a disputed fee determination within 30 days after the date of determination. A health service provider, insurer, or self-insured employer that is aggrieved by the determination may seek judicial review of a departmental determination following the same process used for review of disputed worker's compensation claims.

Assembly Bill 669 would modify the current fee dispute resolution process to provide that a health service provider could not submit a fee dispute to DWD before all treatment by the health service provider of the employee's injury had ended if the total fee amount in dispute was less than $25. After all of the treatment by the health service provider ended, the provider could submit a fee dispute to DWD, regardless of the fee amount. The level of standard deviations from the mean used to determine the reasonableness of a fee would be would be changed from 1.5 to 1.4 standard deviations from the mean. The bill also provides that, within 30 days after a determination in a fee dispute, DWD could set aside, reverse or modify the determination for any reason the Department considered sufficient. However, the Department could set aside, reverse, or modify the determination within 60 days after the determination on grounds of a mistake.

Necessity of Treatment. An insurer or self-insured employer that refuses to pay for treatment provided to an injured worker because it disputes that the treatment is necessary, is required to notify the health services provider that the treatment is being disputed. After receiving reasonable notice that the necessity of the treatment is being disputed, a health care provider may not collect the fee from the injured employee. In cases where the health care provider and insurer or self-insured employer do not agree regarding the necessity of treatment provided to an injured worker, the health care provider may request DWD to resolve the dispute.

When a request to resolve the dispute is submitted by the health service provider to DWD, the Department must notify the insurer or self-insured employer that it must pay for the treatment or submit information for the Department to use in the review process. Before determining the necessity of treatment, DWD may, but is not required to, obtain a written opinion on the necessity of treatment in dispute from an expert selected by the Department. To qualify as an expert, a person must be licensed to practice the same health care profession as the individual health service

provider whose treatment is under review. In addition, the person must either be performing services for an impartial health care services review organization, or be a member of an independent panel of experts established by the Department. DWD is required to adopt the written opinion of the expert as DWD's determination on the issues covered in the written opinion, unless the health service provider, or the insurer or self-insured employer, present clear and convincing written evidence that the expert's opinion is in error. DWD may set aside, reverse, or modify a determination within 30 days of the date of determination. A health service provider, insurer, or self-insurer that is aggrieved by the determination may seek judicial review in the same manner as disputed worker's compensation claims are reviewed.

Assembly Bill 669 would modify the current necessity of treatment dispute resolution process to provide that a health service provider could not submit a dispute over necessity of treatment to DWD before all treatment by the health service provider of the employee's injury had ended if the total amount in dispute was less than $25. After all of the treatment by the health service provider ended, the provider could submit a dispute over the necessity of treatment to DWD, regardless of the amount in dispute. The bill also provides that, within 30 days after a determination in a dispute over necessity of treatment, DWD could set aside, reverse or modify the determination for any reason the Department considered sufficient. However, the Department could set aside, reverse, or modify the determination within 60 days after the determination on grounds of a mistake.

Notice of Cancellation or Termination. Under current law, when an insurance company cancels or terminates a contract with an employer it must provide a notice of the cancellation or termination to the Wisconsin Compensation Rating Bureau by certified mail or facsimile machine transmission. The bill provides that the notice of cancellation or termination could be given to the Wisconsin Compensation Rating Bureau by certified mail, facsimile machine transmission, electronic mail, or other medium approved by DWD after consultation with the Bureau.

Technical Correction of Autopsy or Opinion Provisions. The bill would update statutory language related to the use of autopsies or opinions to obtain information for a worker's compensation hearing.

Effective and Applicability Dates. In general, provisions related to fee and necessity of treatment disputes, payment of compensation awards, and payment of permanent disability payments would first apply on the effective date of the bill. However, provisions related to reversal of fee and necessity of treatment dispute determinations would first apply to determinations made by DWD 30 days before the effective date of the bill.

The bill would take effect on the day after publication of the bill.

ASSEMBLY AMENDMENT 1

AB 669 would increase the supplemental benefits for a week of disability occurring after January 1, 2004, to an amount that, when added to the maximum weekly benefits, totals $233. Assembly Amendment 1 to AB 669 would first apply the supplemental benefit increase to a week of disability occurring after the effective date of the bill.

FISCAL EFFECT

DWD indicates that Assembly Bill 669 would not significantly increase costs for worker's compensation insurance premiums or assessments from employers and insurance carriers. In addition, the bill would not increase administrative costs for the Department. However, the bill would increase benefits from, and employer payments to, the Work Injury Supplemental Benefit Fund, which is a segregated fund used to make certain benefit payments.

Work Injury Supplemental Benefit Fund. Assembly Bill 669 would affect the Work Injury Supplemental Benefit Fund in two ways: (a) the maximum supplemental benefit amount would be increased to $233; and (b) insurer or employer payments to the fund for work-related deaths and dismemberments would be increased to $10,000. As of July 1, 2003 the balance in the Work Injury Supplemental Benefit Fund was approximately $4.3 million. Annual revenue to the Fund is approximately $2.0 million. It is estimated that the revenue in the Fund would be sufficient to pay the increased supplemental benefit rate under AB 669.

Supplemental Benefit Rate Increase. The bill would make an employee who was injured prior to May 13, 1980, eligible for supplemental benefits for weeks of disability occurring after January 1, 1982. The supplemental benefit rate for a week of disability occurring after January 1, 2004 would increase to an amount that, when added to the employee's regular benefits, would be $233. It is estimated that this maximum benefit rate would increase annual benefit payments from the Work Injury Supplemental Benefit Fund by $275,000 SEG.

Payments to the Work Injury Supplemental Benefit Fund. The bill would increase required payments from insurers or employers as follows: (a) payments for work-related deaths would increase from $5,000 to $10,000; and (b) payments for injuries resulting in dismemberment would increase from $7,000 to $10,000. It is estimated that annual revenues would increase by $300,000 for death claims and $45,000 for dismemberment injuries, for an annual total of $345,000.

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