

## Workers' compensation laws enacted in 1995

*New or revised legislation focused on detecting or preventing fraudulent claims, penalties for nonpayment of benefits or uncontested medical expenses, and coverage issues*

Charles A. Berreth

Several States now recognize collective bargaining agreements under their workers' compensation statute. For example, the agreements may allow workers' compensation benefits to be determined by collective bargaining agreements if the benefits and coverage are not less than those required by law (in Hawaii); call for an alternative system (including mediation and arbitration) for resolving claim disputes (New York); or with certain limitations, ex-

tend the recognition of agreements to qualified and certified construction industries (Minnesota).

Many of the changes in workers' compensation laws focused on detecting or preventing fraudulent claims, penalties for not paying benefits or uncontested medical expenses, and issues involving coverage.

Following is a summary of legislation enacted by individual States.

### Alaska

Higher premium rates may not be imposed on the construction industry just because the industry has higher wage rates. Injured construction workers may not file civil suits against professional architects, engineers, or land surveyors on a construction project unless the design professional specifically (1) assumes responsibility for job site safety practices, (2) controls the premises where the injury occurred, or (3) prepares the designs and specifications negligently, recklessly, or with intentional misconduct. Unless intentional, a safety inspector is not liable for civil damages for an employee's injury resulting from an act or omission in performing or failing to perform a loss control service, a safety inspection, or a safety advisory service in connection with an employer's insurance coverage.

Insurance rate filings in general now will be approved if they contain a reasonable method for recognizing differences in rates of pay which uses a credit scale that begins at an amount equal to the State's average weekly wage.

An employee's medical and rehabilitation records may be released, without consent, to a medical provider, a party to a claim filed by the employee, or a government agency, and may be

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quoted and discussed in connection with appeal proceedings.

The reductions in payments to a widow or widower, which were made 5 and 8 years after death, were eliminated; however, benefits for surviving spouses continue to terminate after 10 years.

An amendment provides specifics for calculating gross weekly earnings for employees paid by the hour, day, week, month, year, or employee output, and requires that overtime and premium pay be excluded from the calculation. It also defines methods of calculating earnings for infrequent situations not specifically covered before: those employed for fewer than 13 weeks immediately preceding injury; those performing seasonal or temporary work; those on concurrent contracts with multiple employers; and volunteers in areas with no full-time paid ambulance attendants, police officers, or firefighters on which to base wages for injured volunteers. The amendment provides for subjective administrative decisions for cases in which an employee's earnings during a period of disability are not fairly reflected.

"Seasonal work" is defined as employment not intended to continue through a calendar year, but recurs on an annual basis; and "temporary work" means employment that ends within 6 months or upon completion of the particular job or contract. An amendment describes acts which constitute misrepresentation for the purpose of obtaining benefits; those convicted of doing so will be required to make full reimbursement, including costs and attorney fees.

### Arkansas

The effective date of allowing maximum weekly disability and death benefits to increase from 70 percent to 85 percent of the State's average weekly wage is January 1, 1996.

Two or more employers who are members of the same trade or professional association are now permitted to pool their liabilities to qualify as common self-insurance groups. A separate guaranty fund will be established for the newly authorized common self-insurance groups (described above) and individual self-insurers and self-insurance groups of employers engaged in the same type of business activity who were authorized to self-insure prior to the amendments.

"Employee" and "employment" were redefined to exempt licensed real estate agents from workers' compensation coverage if they so elect. The permanent partial disability rate for amputation or permanent loss of use of a body member is now the same as the employee's total disability rate.

Attorneys with at least 5 years of experience representing either employers or employees are now qualified to serve as representatives for their respective groups on the three-member Workers' Compensation Commission.

Funds now may be transferred from the Workers' Compensation Fund to the Department of Labor Fund account.

An employer or insurer who willfully refuses to pay uncontroverted medical expenses within 45 days of receiving the expense statement may be fined up to \$10,000.

**California**

Under existing law, the legal principal of *collateral estoppel* provides that a judgment or final order is conclusive between the parties to a proceeding. An amendment provides that a determination of facts by the Workers' Compensation Appeals Board, under certain provisions, would not have *collateral estoppel* effect on any subsequent criminal proceedings.

An insurer is required to report certain events to its rating organization as corrections or revisions of losses pursuant to the unit statistical plan and uniform rating experience plan approved by the Insurance Commissioner.

The requirements for "board certified" and "board qualified" medical evaluators were revised. The Industrial Medical Council is authorized to suspend or terminate a medical evaluator without a hearing if the evaluator's license to practice in the State is suspended, revoked, or terminated; or if the evaluator fails to pay a required fee. A suspended evaluator's report is not admissible in a proceeding of the Workers' Compensation Appeals Board if it is not completed prior to the adverse action, nor is there liability to pay for the report. Time for completing medical evaluations may now be extended for reasons other than the evaluator not receiving test results and physician evaluations in due time.

Money not used by the Bureau of Fraudulent Claims in any fiscal year is to be distributed to the State's district attorneys and not returned to the general fund. Insurers are required to post bond to assure the payment of claims; this requirement is extended to the reinsurance of disability and death portions of workers' compensation policies.

The Medical Board of California, the State Bar, and the Board of Chiropractic Examiners now are required to investigate possible workers' compensation fraud.

Standards were established for initial and subsequent annual assessments on employers to fund the Cal-OSHA Targeted Inspection and Consultation Fund. The Franchise Tax Board was authorized to collect delinquent assessments and penalties. The assessment and collection provisions expire January 1, 1997.

A public member of a licensed rating organization, appointed by the Insurance Commissioner to represent either organized labor or insured employers, may only be removed for cause.

In connection with employee leasing companies, an employer may obtain workers' compensation coverage by entering into a valid agreement with another employer who has coverage on the same employees. Persons functioning as sports officials for a public or private nonprofit agency are not considered employees for workers' compensation purposes. Tuberculosis is now a compensable "injury" for firefighters.

It is now unlawful to make a false statement to obtain cheaper workers' compensation insurance.

**Colorado**

To cancel an employer's insurance policy, the Colorado Compensation Insurance Authority (the

State's competitive fund) must send a notice of cancellation by certified mail at least 30 days before the policy expires. For situations involving fraud, material misrepresentation, failure to file a wage report, or nonpayment of deductibles or premiums, notice may be sent in less than 30 days.

The Workers' Compensation Medical Care Accreditation Commission, scheduled to cease July 1, 1995, was extended for another year.

The Colorado Compensation Insurance Authority was authorized to enter into cooperative arrangements with public and private entities for the purpose of carrying out its powers, duties, and functions. The Workers' Compensation Fund manager, as approved by the State treasurer, may now make payments from the Fund.

Workers' compensation insurers are required to offer black lung insurance for coverage under Federal law through a nonprofit joint underwriting association. The requirement is temporary until the voluntary market responds or the General Assembly considers remedial legislation to address the problem of availability and the high cost of black lung insurance in the State.

To clarify the status of independent contractors as employees under workers' compensation, an amendment states: "The fact that an individual performs services exclusively or primarily for another shall not be conclusive evidence that the individual is an employee."

**Connecticut**

Effective July 1, 1996, the Connecticut insurance rating organization shall establish a credit program on workers' compensation premiums of high wage construction contractors, and file with the insurance commissioner a method of computing workers' compensation premiums which does not penalize employers in the construction industry solely because of the higher wages paid to its employees, compared with employers in other industries for the same job classifications.

The definition of "arising out of and in the course of employment" was amended to exclude an injury sustained while an employee is at home or preparing for work, unless the activity was undertaken at the direction of the employer.

If an investigation indicates an employer is in violation of the State's insurance requirements, a citation will be issued to the employer with notification of a hearing within 30 days. If the violation is confirmed by the hearing, a civil penalty will be assessed by the Commissioner of Workers' Compensation of not less than \$500 per employee or \$5,000, whichever is less; and not more than \$50,000 (previously, \$10,000). An additional penalty of \$100 for each day an employer is found to be in noncompliance (not to exceed \$50,000) is now allowed. If an injured employee works for more than one employer, weekly compensation shall be calculated based upon wages earned from all employers, and the employer in whose employ the injury was sustained is liable for all medical and hospital costs and a portion of the compensation rate equal to 75 percent of the employee's average weekly wage after Federal and State taxes.

The employer or insurer, as a condition of liability for a second injury, is required to notify the State insurance fund of intent to transfer liability for claim to the fund no later than 3 calendar years after an injury or no later than 90 days after completion of payments for the first 104 weeks of disability, whichever is earlier. (Previously, notification was required no later than 90 days and no earlier than 1 year before expiration of the first 104 weeks of disability.) Further, the fund is required to notify the employer or insurer of rejection of the claim within 90 days after receiving the completed notification. A claim not rejected is deemed accepted, unless the fund notifies the employer or insurer within the 90-day period that up to an additional 90 days is needed to determine if the transfer is acceptable.

A claim for injury prior to July 1, 1995, transferred to the State insurance fund, is deemed withdrawn with prejudice unless the employer or insurer notifies the fund before October 1, 1995, of its intention to pursue transfer. Any claim for an injury occurring on or after July 1, 1995, is the responsibility of the employer or insurer, rather than the fund.

The State insurance fund and the insurer seeking to transfer a claim to the fund must submit all controverted issues regarding the existence of a previous disability to the Workers' Compensation Commission, which will appoint three physicians to review the disputed claim and, if necessary, examine the claimant. The panel must submit its report within 60 days of receiving the submission; its fees will be paid by the insurer seeking reimbursement.

An advisory board was created to advise the fund on matters of administration, operations, claim handling, and finances.

Proof of workers' compensation coverage is required before a building permit is issued for construction projects costing \$100,000 or more.

Any member of a volunteer fire company and any person summoned by the State Forest Fire Warden to perform fire duties is construed to be an employee of the State for the purpose of workers' compensation. Presumed volunteer salaries for calculating benefits are based on average Statewide production wages, as determined by the labor commissioner. Volunteers are eligible for compensation only if the injury makes them unable to perform regular employment duties. Municipalities are exempt from covering volunteer firefighters.

**Delaware**

Surgical, medical, and hospital services, medicines and supplies, and funeral benefits must now be paid from the first day of injury. Maximum allowances for funeral expenses were increased from \$700 to \$3,500.

Employers who refuse or neglect to report an injury will be fined between \$100 and \$250 (formerly, between \$25 and \$100). Insurers or employers who do not make the first payment of compensation within 15 days of the injury will be fined between \$500 and \$2,500 (formerly, between \$100 and \$1,000). The penalties were re-

vised for employers who fail to file forms indicating proof of compliance with insurance requirements.

The board and lodging expenses were increased from \$3 to \$15 per day for beneficiaries whose wages included board and lodging expenses.

## Georgia

The definition of "self-insurer" was amended to include a county or municipal hospital authority. Amendments increased the funding level at which assessments for the Self-Insurers Guaranty Trust Fund cease from \$3 million to \$10 million, and allowed the fund to levy a special assessment if its level is reduced to \$7 million (previously, \$2 million).

A corporation's right to exempt its officers from workers' compensation coverage was limited to no more than five officers, who must be identified by name and office held.

Retroactive to July 1, 1992, death benefits are included in the employer's or insurer's right to recovery in a third party subrogation lien.

An employer or insurer is allowed to assert the employee's cause of action in tort, if the action is not brought by the employee *within* 1 year after injury, and must notify the employee of assertion to allow him or her to intervene. If the employee asserts action in tort *after* 1 year from the date of injury, he or she must notify the employer or insurer of assertion, allowing the employer or insurer to intervene. If the employer or insurer recovers more than the extent of the lien, the excess amount will be paid to the employee.

The civil penalty for a person who knowingly and intentionally makes a false or misleading statement to obtain or deny benefits, was increased to between \$1,000 and \$10,000 per violation (formerly, \$500 to \$5,000). Any person or business assessed a civil penalty may also be required to pay collection costs.

A fraud and compliance unit was established within the State Board of Workers' Compensation to prevent fraud and abuse and to assist the district attorney in investigating and prosecuting fraud. The Board can require mediation for disputed claims, conducted under its supervision.

The Workers' Compensation Truth in Advertising Act of 1995 was enacted to assure truthful and adequate disclosure in advertising that solicits persons to consult an attorney or a medical care provider for the purpose of asserting a workers' compensation claim. Television advertisements must state that willfully making a false or misleading statement to obtain or deny benefits is a crime carrying a penalty of imprisonment or a fine of between \$1,000 and \$10,000. Any advertiser violating the above notification requirement may be fined between \$1,000 and \$10,000 for each violation.

An injury that prevents an employee from performing prior work or any work available in substantial numbers within the economy will be admissible evidence as to whether the injury is catastrophic.

A penalty may be assessed of up to 20 percent

of reasonable medical charges not paid within 60 days of billing, payable to the medical provider.

The provision was repealed which limited the amount of compensation to \$1,000 for an injured employee's dependents who are not citizens or residents of the United States or Canada at the time of accident.

Money paid by insurers and self-insurers in no-dependency death cases is now deposited into the State treasury's general fund, rather than the Subsequent Injury Trust Fund.

A person performing voluntary service without pay for the Atlanta Committee for the Olympic Games or for the Atlanta Paralympic Organizing Committee will be deemed an employee of that organization for purposes of workers' compensation coverage while performing such service. (This provision expires on December 31, 1997.)

A group of employers engaged in similar business activities may now establish a workers' compensation insurance fund. The fund must have at least 15 members and 1,500 employees in the aggregate, and must maintain a gross annual premium of \$1 million. Up to 180 days will be granted to regain compliance for any fund that falls below the minimum number of members or employees, or falls below the minimum required premium. Each fund must maintain a deposit of \$200,000, or post a surety bond of \$250,000, equal to the deposit requirements of a domestic insurance company.

The Workers' Compensation Assigned Risk Insurance Plan was established as a method of apportioning rejected workers' compensation insurance policies.

A new provision grants immunity from legal action for injury or death of an employee to businesses using the services of a temporary help firm or employee leasing company when workers' compensation benefits are provided by either.

## Hawaii

Employers are allowed to determine workers' compensation benefits under collective bargaining agreements, provided the benefits and coverage are not less than those required by law. The schedules of charges submitted by prepaid health care plan contractors are the basis for establishing a fee schedule of prevailing charges. Employer health and safety programs can be certified, and qualify for reductions in workers' compensation insurance premiums.

Insurers are required to itemize the amount of premium each employer is charged for various benefits—medical care, wage loss, indemnity, and death—and disclose the portion of each premium attributable to loss control and administration, attorney fees, employer-requested medical examinations and private investigation costs. Insurers violating these rules may be fined up to \$5,000 for each violation.

Unprovoked fighting, other than for self-defense, is now a prohibition against compensation entitlement for self-inflicted injuries.

Generally, medical charges were capped at 110 percent of medicare rates, except when a medicare fee is determined unreasonable. Medical

charges not covered by medicare are paid at prevailing rates, based on a statistically valid survey. The frequency and extent of treatment cannot exceed the nature of injury and the process required for recovery. Special authorization is required from the Department of Labor and Industrial Relations for more than five visits to the doctor for an injury.

The maximum disfigurement allowance was increased to \$30,000 (previously, \$15,000).

If permanent partial disability is caused by more than one compensable injury, the amount of the award for the subsequent injury is offset by the amount awarded for the prior injury. For part-time workers, workers' compensation is based on average hours worked in the previous year for temporary partial and temporary total disabilities; compensation for permanent partial and permanent total disabilities and death are calculated as if the employee had been a full-time employee. Employer-requested medical examinations are limited to one per case, unless valid reasons exist regarding the claimant's medical progress.

The penalty for not paying rightful benefits to an injured worker was increased to 20 percent (from 10 percent) of the unpaid compensation.

The law comprehensively details fraudulent acts by employers and employees. Threats or implication of criminal prosecution by attorneys, insurers, health care providers, or hearings officers are deemed "inappropriate"; criminal offenses are Class C felonies if they involve more than \$2,000, and misdemeanors if they involve less than \$2,000. These actions require restitution, including reimbursement of attorney fees and other expenses. The maximum fine for each fraud violation is now \$10,000 (previously \$2,500).

Policy deductibles for medical benefits must be offered in amounts of \$5,000 and \$10,000, in addition to categories under \$5,000 already in the law. Deductibles of more than \$10,000 may also be offered, if agreed to by employer and insurer. A premium discount of at least 5 percent is required for employers with a safety and health program certified by a safety and health professional.

## Indiana

A medical service provider or his or her agent cannot collect or attempt to collect payment of charges for medical services or products from an employee or the employee's estate or family members. Violators will be assessed a civil penalty of at least \$100, but less than \$1,000 for each violation.

"Billing review service" (which refers to a person or an entity that reviews a medical service provider's bills to determine monetary liability) now includes an employer's workers' compensation insurance carrier if the carrier performs such a review; "billing review standard" refers to the data used by a billing review service to determine liability; "community" is the geographic service area based on Postal Service zip codes, and "pecuniary liability" refers to the responsibility of an employer or the employer's insurance carrier for the payment of the charges for each specific ser-

vice or product for human medical treatment in a defined community, equal to or less than the charges made by medical service providers at the 80th percentile in the same community for like services or products.

#### Iowa

Workers' compensation benefits are extended to volunteer ambulance drivers and emergency medical technician trainees. The Industrial Commissioner is required to send the entire record of a contested case to the reviewing court within 30 days of receiving notice of the filing of a petition for judicial review.

#### Kansas

Certificates of authority for group funded insurance pools will remain in force until suspended or revoked (previously, they expired April 30 of each year, unless suspended sooner). If an existing pool's certificate is suspended or revoked, the pool will be granted the same hearing rights as applicants for new certificates. Group funded pools are allowed to offer premium deductibles.

#### Louisiana

Physical therapy or work hardening programs cannot be suspended while a case is on appeal. The exemption from workers' compensation coverage for crop dusting and spraying by farming operations now covers employers whose principal business is the aerial application of any kind of product.

Requests for independent medical examinations must be made prior to a pretrial conference, except for good cause. To receive limited protection from subpoenas, independent examiners must submit their reports within 30 days, and the reports must detail the basis of the examiner's opinion and recommendations for future treatment. Reports of physical examinations must also include a complete list of tests and diagnostic procedures conducted during the examination, as well as the examiner's findings. Independent medical examinations are not subject to mediation; but objections may be heard by a hearing officer and must be scheduled within 30 days of receipt.

Groups of employers allowed to pool their liabilities under the Louisiana workers' compensation law may also do so for liabilities under the Federal Longshore and Harbor Workers' Compensation Act, with authorization of the U. S. Department of Labor.

If, in providing information on suspected fraud, a person acts in good faith and without malice, he or she will not be subject to civil liability for libel, slander, or any other relevant tort. Unlawful practices by employers and employees are listed in new legislation, and include misleading or fraudulent statements, misrepresentation of payroll and safety records, and third-party actions. Violators are subject to imprisonment for 1 to 10 years, or fines up to \$10,000, or both.

Insurers and self-insured employers must have

prior written approval to be reimbursed for a second-injury lump-sum or compromise settlement; such approval is necessary even if the settlement has been approved by the Office of Workers' Compensation or the courts. If the settlement is denied, the employer or insurer has preferential docket appeal rights. An employer who is not approved to self-insure is not entitled to be reimbursed for second-injury settlement claims.

"Health care provider" is defined as a hospital, person, corporation, facility, or institution licensed by Louisiana to provide health care or professional services, including a dentist, nurse, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, psychologist, and board-certified social worker.

Medical payments must be made within 60 days. Attorney fees must now be paid in disputed claims. If a health care provider prevails in a fee dispute, attorney fees may be awarded. Penalties and attorney fees may not be included in any formula used to establish insurance premium rates. If an award payable under the terms of a final judgment is not paid within 30 days after it becomes due, an amount equal to 20 percent, or \$100 per day beyond the due date together with reasonable attorney fees (whichever is greater) is added to the award as a penalty. The daily penalty may not exceed \$3,000.

All compensable medical expenses incurred prior to a settlement are to be paid by the insurer unless the agreement provides otherwise.

A new law exempts employees of private unincorporated farms, in connection with cultivating the soil or raising or harvesting any agricultural commodity, including livestock, when the employee's annual net earnings amount to \$1,000 or less, and the total net earnings of all employees on the farm do not exceed \$2,500. To be exempt, the employees efforts must not be incidental to any trade, business, or occupation of the farm. Brokers of employee services to farms are covered as employers for workers' compensation purposes.

Regardless of employment status, employees exempted from workers' compensation protection may seek tort recovery under an insurance policy purchased by the employer or a private residential homeowner.

The Office of Workers' Compensation can impose fines up to \$500 for violations of its administrative rules and regulations. The safety records of the Office's occupational safety and health section now are confidential and are not subject to subpoena (employee medical, compensation payment, and rehabilitation records already are confidential). However, safety records may be made available to a hearing officer if findings indicate that the record is necessary to resolve a disputed claim. Rules were established for making evidence, introduced during an appeal, available during other levels of the appeals process. The fee for administering the workers' compensation law, collected from each party against whom an award becomes final, increased to \$50 (previously, \$30).

A properly notified party who fails to appear at a mediation conference may be fined up to \$500, plus costs and reasonable attorney fees incurred by any other party to the conference. If

the party is the plaintiff, the case may be dismissed without prejudice. An appeal which suspends an appealable judgment must be filed within 30 days; an appeal which does not suspend an appealable judgment must be filed within 60 days. Motions for a new trial cannot be filed under administrative hearing procedures. Contempt procedures are provided for administrative hearings, and subpoena power was granted to hearing officers.

State and local governments are excluded by definition as employers from participating in group self-insurance plans. The amendments specify that each fund arrangement must be governed by a board of trustees. Throughout the existence of each fund, two or more members must maintain a minimum combined net worth of \$1 million and at least a 1-to-1 ratio of current assets to current liabilities. Employer groups allowed to pool their liabilities under the Louisiana workers' compensation law may also do so under the Federal Longshore and Harbor Workers' Compensation Act, with the authorization of the U. S. Department of Labor. The "bona fide trade or professional association," to which group fund employers must belong, is now defined as nonprofit and exempt from Federal income tax, and provides member services as a primary function apart from the sponsorship and management of the group insurance fund. Certain documents are now required of each fund to establish financial strength, including audited financial statements and current financial information from all members. Each fund must maintain at least \$500,000 in direct premiums each year, verified by an independent audit. Group funds are forbidden to pay dividends in deficit years.

Surety bond requirements for contractors providing services to group self-insurance funds were changed. Although the amount of the cash deposit remained \$50,000, alternative funds are now allowed—the contractor may deposit \$50,000 worth of U. S. bonds, or bonds issued by the State or its political subdivisions. The Department of Insurance has authority to issue cease and desist orders and revoke the certification of any fund not in compliance with the law's requirements. The Department may conduct hearings on violations and may levy fines up to \$2,000 per violation.

Fees allowed for an employee's attorney may not exceed 20 percent of the first \$20,000 of any award (previously, the first \$10,000) and 10 percent of any part of the award over \$20,000.

The weekly compensation for injured employees increased 50 percent in cases where the employer has failed to provide insurance. If the employer has failed to secure compensation, and has been previously fined for noncompliance, he or she may be subject to further fines, up to \$10,000, and a cease and desist order against further business operations until in full compliance. There is a presumption that an employer previously fined for a second offense, or criminally penalized, has willfully failed to secure workers' compensation obligations. In addition to the \$10,000 fine, these employers may be imprisoned up to 1 year.

Employer injury reports to insurers must contain certification by both employer and employee of compliance with the Louisiana workers' compensation law. Employers who fail to submit an

injury report can be fined \$500, payable to the insurer. Employees receiving benefits for more than 30 days must report other earnings to the insurer each quarter or lose benefits until the earnings report is made.

Maximum reimbursement for funeral expenses was increased to \$5,000 (previously, \$3,000).

## Maine

Nonresident employees were exempted from workers' compensation coverage. An employer using a temporary help service is now entitled to the same immunity from civil actions granted for the employer's own employees. Benefit offsets may not be made for Social Security if the benefits had started prior to the date of injury or if the benefits are a spouse's entitlement. New rules prohibit compensation for total or partial incapacity to anyone while incarcerated for a criminal offense.

The Workers' Compensation Residual Market Deficit Resolution and Recovery Act authorizes the continuation of emergency legislation, known as the "Fresh Start" plan, to clean up deficits in the residual insurance market. The plan calls for initial funding by the insurance industry and an employer surcharge of 6.32 percent (currently, 9.5 percent) over the next 8 years.

## Maryland

Employers must report orally within 8 hours to the Commissioner of Labor and Industry of an accident resulting in death or the hospitalization of at least three employees. An owner-operator of a tractor vehicle who enters into an agreement that does not create an employment relationship is generally not entitled to compensation from the principal contractor. Administrative appeals from decisions of the Workers' Compensation Commission, including the Subsequent Injury Fund and the Uninsured Employers' Fund, must be filed within 30 days after the Commission's order.

## Michigan

The use of therapeutic sound or electricity by a chiropractic service for the reduction or correction of spinal subluxation is reimbursable.

## Minnesota

An insurer may offer a scheduled credit or debit of up to 25 percent to a manual premium if the premium otherwise complies with the law. In approving a rate filing, separate consideration is given to past and prospective loss experience to the extent necessary to develop credible rates; dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders; and a reasonable allowance for profit.

A fraud unit was established to investigate illegal practices of health care providers, employers, insurers, attorneys, and employees.

"Maximum medical improvement" is now de-

termined without regard to subjective complaints of pain by the patient. Once the date of maximum medical improvement has been determined (except cases in which an employee is medically unable to continue working), no further determinations of other dates of maximum medical improvement for that personal injury are permitted. A determination of maximum medical improvement is not rendered ineffective by the worsening of the employee's medical condition and recovery therefrom.

As of October 1, 1995, maximum weekly compensation payable for temporary total disability changed to \$615 per week (formerly, 105 percent of the State's average weekly wage). The minimum changed to the lesser of \$104 per week or the injured employee's actual weekly wage (formerly, 20 percent of the State's average weekly wage). Payment of temporary total benefits is limited to 104 weeks, and once stopped can be restarted only in limited circumstances. Compensation for temporary total disability stops if the employee withdraws from the labor market, fails to diligently search for appropriate work, has been released to work without any physical restrictions, or refuses an offer of work that is consistent with a plan of rehabilitation. The compensation stops 90 days after the employee has reached maximum medical improvement.

An employee may not receive compensation for more than a 100-percent disability of the whole body, even if disability is sustained to two or more body parts. Permanent partial disability is payable upon cessation of temporary total disability, in installments at the same intervals and amount as the employee's temporary total disability rate on the date of injury, rather than a lump-sum payment. Permanent total disability ceases at age 67, because the employee is presumed retired from the labor market. For permanent total disability, the minimum weekly compensation is equal to 65 percent of the State's average weekly wage.

Permanent total disability involves the total and permanent loss of the sight of both eyes, the loss of both arms at the shoulder, the loss of both legs so close to the hips that no effective artificial members can be used, complete and permanent paralysis, total and permanent loss of mental faculties, or any other injury which totally or permanently incapacitates the employee from working at an occupation which brings the employee an income. To qualify for benefits for permanent total disability, the employee must also meet one of the following criteria: at least a 17-percent permanent partial disability rating of the whole body; a permanent partial disability rating of the whole body of at least 15 percent and the employee is at least 50 years old at the time of injury; or a permanent partial disability rating of the whole body of at least 13 percent and the employee is at least 55 years old at the time of the injury, and has not completed grade 12 or obtained a general high school equivalency (GED) certificate.

The provision was eliminated which states that an employee who receives compensation for occupational disease will no longer be eligible for supplementary benefits after 4 years have elapsed since the date of last significant exposure to the

hazard of the occupational disease, if that employee's weekly compensation rate is less than the current supplementary benefit rate.

An employer with 15 or more employees who refuses to offer continued employment to an employee even though available duties are within the employee's physical limitations is liable in a civil action for 1 year's wages, up to a maximum of \$15,000.

All insurers must now provide occupational health loss control consultation services, in addition to safety consultation already required, to policyholders on request.

The maximum attorney fee for a disputed medical or rehabilitation benefit for which a dollar value is not reasonably ascertainable is the amount charged in hourly fees for the representation, or \$500, whichever is less, to be paid by the employer or insurer.

Subject to a \$13,000 maximum, up to 25 percent of the first \$4,000 awarded to the employee, and 20 percent of the next \$60,000, may be withheld from an employee's periodic payments for attorney fees. If an attorney fails to appear at a scheduled hearing or is unprepared to participate, the commissioner or compensation judge will require the attorney to pay any reasonable expenses incurred.

The penalty which the review panel may impose for each violation made by a rehabilitation consultant or vendor was increased to \$3,000 (previously, \$1,000).

Retraining will not be available after 104 weeks of any combination of temporary total or temporary partial compensation benefits have been paid, unless the request for the retraining has been filed with the commissioner prior to the time the 104 weeks of compensation have been paid.

The medical services review board may penalize a provider \$200 each time it provides unauthorized treatment. Formerly, the commissioner could not issue a warning or a restriction on providing treatment that required pre-authorization.

Employers may form light-duty work pools for the purpose of encouraging injured employees to return to work.

In addition to suspension, the commissioner may assess an administrative penalty of up to \$25,000 against a managed care plan for each incidence of noncompliance. Providers of the plan have 30 days from the date the penalty notice is issued to file a request for an administrative review of the commissioner's determination. The maximum penalty for not releasing medical data on a timely basis was increased to \$600 (from \$200). The maximum penalty was increased to \$10,000 (from \$5,000) for each offense in which a self-insurer knowingly violates self-insurance rules. The penalty increased to 25 percent (from 10 percent) of the payments due a claimant, which the employer must pay to the claimant if the employer has been found guilty of inexcusable delay in making such payments. Certain other penalties increased against employers, insurers, and self-insurers.

Provisions of collective bargaining agreements pertaining to workers' compensation are now recognized for employers and groups of employers in the construction industry who qualify and are

certified by the State. Qualified agreements must be limited to, but need not include all of the following: a dispute resolution system that is an alternative or modification to the State's workers' compensation appeals procedures; a list of agreed medical providers and vocational rehabilitation programs; a list of impartial physicians to conduct independent medical examinations; a light duty or return to work program; or safety procedures and the adoption of a 24-hour health care coverage plan if one is authorized by law.

The annual report by the Department of Labor and Industry will identify insurers who do not meet the 14-day payment standard for claims.

A joint labor-management safety committee must be formed by all employers with more than 25 employees, and by smaller employers having high accident rates.

The medical component of workers' compensation insurance merged with the Minnesota Care program into a 24-hour coverage pilot project, overseen by the departments of commerce, health, and labor and industry, which will provide the plan and make recommendations of any needed legislative changes by January 1, 1996.

### Mississippi

The rules for reporting injuries were modified. Administrative judges now have authority to add \$100 to any award made for an injury which was not timely reported. Interim medical reports of injury and treatment by a physician must be submitted every 30 days until a final report is made. Injured employees cannot be billed for covered medical treatment, including any amount not paid by the insurer. Findings of a second opinion medical examination requested by the employer must be furnished to the employee within 14 days of the examination.

The penalty for fraud is now \$5,000 a year, or double the value of the fraud (whichever is greater), or imprisonment not to exceed 3 years (previously, \$1,000 a year, or imprisonment not to exceed 1 year).

### Montana

Direct sellers, as defined by Federal law (26 U.S.C. 3508), are excluded from workers' compensation requirements. Petroleum land professionals (those who engage in negotiating for mineral rights) now have limited exemption from workers' compensation, unless the employer elects to cover them.

Certain volunteer firefighters and ambulance service workers are now covered. Volunteers are exempt from coverage unless the employer, with the approval of the insurer, elects coverage. Jockeys, licensed by the Montana Board of Horse-racing are granted limited exemption from workers' compensation coverage, unless the employer elects coverage.

The basis for computing the security deposit for self-insured employers was revised to include their liabilities for the first 3 of the last 4 years, instead of the past 3 years. The minimum security

deposit remained \$250,000; however, the Department of Labor and Industry, with the concurrence of the Montana Self-Insurers Guaranty Fund, is authorized to reduce the amount of the security deposit if evidence indicates that the full amount is unnecessary. Conversely, the Department and Fund also have discretionary authority to require additional security when it is determined that the employer may lack the ability to pay benefits.

Changes were made to the method for determining insurance premiums and weekly benefits for volunteer firefighters for whom workers' compensation coverage is elected. Premiums and benefits are now based on the following formula: the number of volunteer hours (training and response time and time spent at the fire station premises) is multiplied by the State's average weekly wage for all covered employment, and divided by 40 hours. As before, the computation is subject to a maximum of 1-1/2 times the State's average weekly wage.

The term "aid or sustenance" is defined as any public or private subsidy that provides a means of support, maintenance, or subsistence for the recipient. "Household or domestic employment" is the employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or the employer's family, including but not limited to housecleaning and yard work, but does not include employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care. "Sole proprietor" is the person who has the exclusive legal right or title to, or ownership of, a business enterprise. The term "employer" now includes limited liability companies.

Corporate officers and members or managers of limited liability companies are excluded from workers' compensation coverage unless the employer elects to cover them. The rules of elected coverage and weekly compensation benefits for partnerships and proprietorships now apply to members of limited liability companies for which coverage is elected.

When informing the insurer that coverage is elected, the employer must state in writing the level of compensation coverage desired and the amount of wages to be reported, which may not be less than \$900 a month or more than 1-1/2 times Montana's average weekly wage; the employer must also report any change in the amount of elected wages. Weekly compensation benefits are based on elected wages, subject to minimum and maximum limitations for compensation. The elected coverage rules now also apply to coverage of quasi-public corporations, private corporations, and manager-managed limited liability companies. However, the amount of wages reported may not be less than \$200 a week and not more than 1-1/2 times the Montana average weekly wage.

The prohibition against a medical provider referring a worker for treatment to a facility owned wholly or in part by the provider does not apply if the referral is to a managed care organization certified by the Department of Labor and Industry.

Applications for exemptions from workers' compensation coverage must be renewed annually. A fine of \$1,000 can be imposed for each

false statement or misrepresentation in the application.

An amendment required that any investment income of the Uninsured Employers Fund be deposited in the Fund, and removed the \$50,000 limit on an insured employer's liability for claims.

The Department of Labor and Industry is authorized to file cease and desist orders against those making contracts with uninsured employers. Penalties for violators include a fine of up to \$1,000 per day for each violation.

A district court can request a workers' compensation judge to determine the amount of recoverable damages due an uninsured injured worker.

The time allowed for a party to respond to a workers' compensation mediator's recommendation was reduced to 25 days (previously, 45 days).

Unless workers' compensation coverage is elected, the employment of an employer's spouse, for whom an exemption based on marital status may be claimed under Federal tax law (26 U.S.C. 7703) is exempted.

The application of the "old fund" liability tax—the tax on employers to underwrite the unfunded liability of injuries occurring before July 1, 1990—was changed to exclude an employer whose employees are covered by Federal workers' compensation legislation. Three Federal laws are included by specific reference: the Federal Employees' Compensation Act, the Federal Employers' Liability Act, and the Defense Base Act.

"Ongoing activities" and "publicly traded limited partnership" were defined as used in connection with the tax on employers to underwrite the unfunded liability of injuries occurring before July 1, 1990. The amendment also made other clarifying changes to the liability tax, including a provision that interstate employers and employees, who are now subject to tax withholding, are assessed only on income earned in Montana.

The definitions of "temporary service contractor" and "temporary worker" now stipulate that temporary work assignments must have a finite ending date.

Drug or alcohol testing was authorized as a condition of continued employment when the employer has reason to believe that an employee may have contributed to a work-related accident that causes death or personal injury or property damage in excess of \$1,500. Test results can be removed from the employee's record if the accident is subsequently found not to be the employee's fault.

Attorneys are required to return fees and costs paid by an insurer for a workers' compensation claimant convicted of obtaining benefits through fraud or deception.

A claimant's benefits may be modified when obtained by fraud or deception, and an insurer is required to file any allegation of fraud or deception within 2 years of discovery.

The Montana Professional Employer Organizations and Groups Licensing Act require licensing of and standards for professional employer organizations and groups. Covered employee definitions were amended to require the professional employer organizations and groups to provide workers' compensation coverage to their employees.

The Board of Directors of the State Fund was authorized to assess a policy charge, minimum premium, or both, in lieu of a minimum yearly premium, to keep the Fund solvent.

Compensation benefits may be reduced by 30 percent, not to exceed 30 percent of the recovery, in cases involving third-party awards. If an insurer is entitled to pursue subrogation, the amount subrogated must be offset by any reduction in a claimant's benefits.

An insurer can pay a medical claim based upon a report of nonwage loss injury or occupational disease without the payments being construed as an acceptance of liability.

New time requirements are established for processing of claims—the first payment is due within 14 days of acceptance, and settlements are due within 30 days of the approving order.

"Primary cause," used in reference to heart, cardiovascular, and respiratory conditions means that the condition is responsible for more than 50 percent of the disability.

Average earnings for compensation purposes are normally computed using the four pay periods immediately preceding injury. An amendment permits going back for up to a year for cases in which the preceding four pay periods do not accurately reflect the claimant's employment history.

Eligibility for benefits must be established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

Eligibility for temporary total disability benefits continues until the worker is released to return to the pre-injury job or similar employment, and may be terminated on the day of such release without prior 14-day notice, as required in other situations.

Compensation for permanent partial disability is payable only when the injury causes actual wage loss, and medical findings establish an impairment rating. If there is no wage loss, the worker is eligible for an impairment award only. The percentages assigned to certain factors (age, education, wage loss, and ability) used to determine total impairment ratings were each lowered. Permanent partial disability benefits for claimants eligible for a rehabilitation plan must be calculated based on the wages that the worker earns or would be qualified to earn after completing the rehabilitation plan.

An insurer's liability for payment of disability and rehabilitation benefits ends with the receipt of retirement benefits from a system that is an alternative to Social Security, the same as for Social Security payments.

Benefits can be suspended while a claimant is incarcerated for a misdemeanor.

To receive rehabilitation benefits, a worker must have actual wage loss and a reasonable opportunity to reduce the wage loss through rehabilitation. The plan must take into consideration the worker's age, education, training, work history, residual physical capacities, and vocational interests. The plan must specify a beginning date and be completed within 26 weeks of the specified completion date. Rehabilitation benefits are not subject to lump-sum agreements. To be eli-

gible for rehabilitation benefits, a worker must begin rehabilitation within 78 weeks of reaching maximum medical healing.

The time for reporting an occupational disease claim was reduced to 1 year (previously, 2 years), from the date the claimant knew or should have known that the condition was the result of an occupational disease.

An amendment generally revises the workers' compensation insurance rating laws. The Commissioner of Insurance will designate an advisory organization as an agent for authorized workers' compensation insurers in Montana, replacing the National Council on Compensation Insurance, which formerly was identified in the law as the authorized agent. Although the National Council on Compensation Insurance exclusive role was changed, insurers may still use its services or instead file their own insurance rates and supplementary rate information.

## Nevada

The definition of "police officer" now includes forensic specialists in State prisons and forensic specialists and correctional officers employed in State facilities for mentally disordered offenders.

The penalty for fraudulently obtaining benefits was revised to create a distinction for fraud involving less than \$250, a misdemeanor. A misdemeanor conviction will result in the permanent closing of the claim and forfeiture of any future payments. For fraud involving more than \$250, the penalty remains a felony, calling for imprisonment from 1 to 10 years or a maximum fine of \$10,000.

The establishment of group self-insurance associations was restricted to businesses in the same business or trade associations that have been in operation for at least 5 years. Proof of solid financial conditions of each participant is required before the association can be certified and allowed to operate. Members are "jointly and severally liable" for unfunded costs for the life of any claim. If one of the group self-associations goes bankrupt, the other associations must contribute to a solvency fund to cover the bankrupt association's unfunded claims.

A person who forms or finances an association of self-insured employers must obtain a solicitor's permit; failure to do so could result in 1- to 6-year imprisonment or a \$5,000 fine; and a surety for an association must hold a certificate issued by the Commissioner of Insurance. The legislation limits the ability of an employer to rejoin an association or the Nevada industrial insurance system under certain circumstances. Associations were required to employ an administrator responsible for the daily operation of the association. An association member that changes its name or form of organization remains liable for any obligations it incurred or any responsibilities imposed by law.

Effective July 1, 1999, private insurance companies can sell workers' compensation insurance in Nevada, subject to certification by the Nevada Insurance Commission. Until then, aside from certified group self-insurance, the State fund is the exclusive underwriter of

workers' compensation insurance.

Managed care is now required for all active claims, regardless of date of injury. Previously, only workers injured after 1993 who resided in Clark and Washoe counties were required to use managed care. If a medical provider is now under contract with a managed care organization and is treating an injured worker, the provider must charge the lower contract rate for services and follow utilization guidelines. If a medical provider is not under contract with a managed care organization, the provider must follow utilization guidelines. Injured workers are required to change providers if their provider refuses to follow the guidelines.

Workers must now notify their employer of an injury within 7 days (formerly, 30 days). Failure to do so could result in denial of a claim for benefits.

If responsibility for an employee's undisputed claim is contested, the insurer to which the claim is first submitted must pay compensation, until the issue is finally resolved.

No cause of action may be brought against an insurer or third-party administrator who violates the law concerning industrial insurance or occupational diseases; redress is limited to the administrative fines imposed by the law.

Separate payroll records and workers' compensation insurance policies must be maintained for an employee leasing company and temporary employment service operated by the same person.

A subsequent injury fund for associations of self-insured public or private employers was established with a five-member governing board. A similar board was created for the self-insured employers' fund.

The American Medical Association's Guides to the Evaluation of Permanent Impairment must be incorporated by reference in the State's administrative regulations.

Real estate salespersons and brokers are added to the list of employee exclusions.

Health maintenance organizations (HMO's) are now identified as a type of managed care organization with which the State may contract to provide services to injured employees. Further, managed care organizations must not exclude health care providers because of race, creed, sex, national origin, age, or disability.

An employee with a preexisting condition is not entitled to compensation for a subsequent injury, unless information from a physician or chiropractor establishes to the satisfaction of the insurer that the subsequent injury is the primary cause of the resulting condition.

If an initial program of vocational rehabilitation is unsuccessful, an employee can request a second and third program which relates to the same injury. An insurer must authorize the second program for good cause and, with the approval of the employer, may authorize a third program. However, denial of a third program may not be appealed.

The presence of any amount of a controlled substance in an employee's system at the time of injury, for which the employee did not have a lawful prescription, is presumed to be the proximate cause of injury, unless rebutted by evidence, and

thus the basis for denying compensation.

Permanent total disability compensation does not accrue while an employee is incarcerated. If an employee is paid a lump sum for permanent partial disability and is subsequently determined to be permanently and totally disabled, monthly compensation will reflect deductions for the lump-sum payment. Now, different conditions for paying permanent partial disability compensation in a lump sum apply to injuries occurring before and after July 1, 1995.

Failure to provide or unreasonably delay medical or compensation payments to an injured employee, or reimbursements to an insurer, now calls for an administrative fine of \$250 to \$1,000 for each violation.

Notification of an occupational disease now must be made within 7 days, instead of 30 days, of an employee's or dependent's knowledge of the disability.

### New Hampshire

The effective date for adopting a medical and rehabilitation fee schedule is extended to July 1, 1997 (previously, July 1, 1993). A representative of self-funded employers is now on the workers' compensation advisory council.

The term "employee" now exempts inmates of State correctional facilities, and participants performing community service work under court order.

The commissioner has authority to regulate third party administrators to assure that they have sufficient capability and financial qualifications to manage self-insurers. The commissioner also has the authority to make rules for licensing and bonding third party administrators; and the establishment of fees not to exceed \$200 for issuance and renewal of licenses; and, assessment of civil penalties not to exceed \$2,500 for each violation of such rules.

An employer or insurance carrier can test for blood borne diseases when critical employee exposure occurs.

The definition of private "employee" now means any person, other than a direct seller or qualified real estate broker, agent, or appraiser, who performs services for pay for an employer and is presumed to be an employee; the presumption may be rebutted.

### New Jersey

A lump-sum payment to a spouse of a deceased employee who remarries increases from \$2,500 to 100 times the amount of weekly compensation paid immediately preceding the remarriage, or the remaining amount which would have been due had the spouse not remarried, whichever is less. The deduction for income earned by a surviving spouse is eliminated, and the maximum age at which other dependents receive compensation after 450 weeks is now age 23 (previously, age 18), if the dependent is enrolled as a full-time student.

Employees eligible under the Federal Longshore and Harbor Workers' Compensation

Act were exempted from New Jersey's compensation law.

### New Mexico

Legislation provided contractor licensing for employee leasing contractors domiciled in New Mexico as of September 30, 1995. Leased workers must be covered by the employee leasing contractor and the client as co-insurers, who must provide workers' compensation benefits as authorized by the State's insurance code.

### New York

A collective bargaining agreement may establish an alternative system for resolving workers' compensation claims, including mediation or arbitration. It cannot diminish any benefits to which an employee, dependents or survivors may be entitled. The agreement may provide for a managed care organization, list authorized providers for medical treatment, and provide supplemental workers compensation. A collective bargaining agreement may also provide for light duty, modified job, or return to work program; a vocational rehabilitation or retraining program; and a worker injury and illness prevention program.

The determination of an arbitrator or mediator under the collective bargaining agreement is not reviewable by the Workers' Compensation Board, and the venue for an appeal is the court. Determinations rendered as a result of an alternative dispute resolution procedure remain in force while the employer and a certified representative renegotiate a collective bargaining agreement. Upon expiration of a collective bargaining agreement, the resolution of injury and disease claims may, if provided for in the collective bargaining agreement, be subject to the expired agreement until a new one is negotiated. Once an agreement is terminated, both the employer and the employees are subject to the New York workers' compensation law to the same extent they were prior to the collective bargaining agreement. However, if a claim has been adjudicated under the agreement's alternative dispute resolution procedure, the claimant or employer may not raise identical issues about the claim before the Board.

### North Carolina

Employers self-insuring their workers' compensation liabilities under an authorized pooling arrangement are now required to be members of the same trade professional association. The association must be incorporated in North Carolina, be in existence for at least 5 years, and be exempt from Federal taxation.

### North Dakota

A fraud unit was established to investigate payroll misrepresentation by employers and false

claims by employees. Those who assist the fraud unit in its investigations are granted confidentiality and immunity from civil liability. There is a 60-day amnesty from criminal prosecution, after the fraud unit is established, to allow employers to repay any claim and penalty related to payroll misrepresentation, and to allow employees to repay false claims. Investigative information gathered by the fraud unit will be classified as criminal information and subject to disclosure restrictions. Existing laws were amended to treat fraud involving more than \$500 as a class C felony, rather than a misdemeanor.

Injury reports from employees and employers now are mandatory. Employees must take immediate steps to notify the employer of an accident, either orally or in writing; employers must file a first report within 7 days from receiving the employee's notice. Failure of either party to file the required reports affect compensation entitlement. Previously, the first employer report was required within 1 year of the accident, 2 years in death cases.

Except for an initial determination of compensability, an attorney fee cannot exceed 20 percent of the amount awarded, subject to a maximum fee. Disputes regarding the fees will be resolved by a hearing officer or arbitrator, rather than an arbitration panel, which was abolished. Arbitration is now used to resolve disputes involving less than \$3,000, including medical fees, between the Workers' Compensation Bureau and an injured employee. The arbitrator's decision continues to be final and cannot be altered by any court.

Upon recovery of its subrogation interest from a third-party lawsuit, the Workers' Compensation Bureau must reimburse the employer's account at an amount up to that actually expended on a claim.

New rules allow employers to require employees to use preferred providers during the first 60 days of a compensable injury. After 60 days, and 30 days prior to treatment, the employee may request, with reason, to change providers, subject to objection by the employer and subsequent approval by the Workers' Compensation Bureau. Employees may also elect, in writing prior to an injury, to be treated by someone other than the preferred provider; however, payment for the treatment is not reimbursable if the Bureau does not approve the election.

The provision was repealed which had allowed for reinstatement of benefits denied because of an employee's intoxication or illegal drug use, after the employee completed a treatment program. The term "heart attacks" now includes "other heart related diseases"; and a mental injury "arising from mental stimulus" is deemed not compensable.

Funding for reinsurance expenditures through appropriations are more definite (previously, reinsurance expenditures from the Workers' Compensation Fund required prior approval). A continuing appropriation in an amount necessary to establish a program of reinsurance is now required. The Bureau can negotiate a contract for reinsurance binding on the Bureau and reinsurer.

A doctor's report indicating the employee has reached maximum medical recovery is no longer a presumption that the claim is closed.



An injured employee is considered retired upon receiving Social Security or other retirement benefits, or when eligible for retirement benefits at age 65. The employee will no longer be paid injury compensation, but remains eligible for medical benefits. Employees younger than age 65 who are eligible to retire but who continue to work and are injured on the job, remain eligible for compensation. Evidence that an employee is truly in the labor market or has not announced a retirement date to the employer, may no longer be used to invalidate the presumption that an injured employee receiving compensation is retired.

Following a rehabilitation program, an employee is not considered gainfully employed until, among other things, earnings are restored to 90 percent (previously, 100 percent) of the employees average weekly wage at the time of injury; or 66-2/3 percent (previously, 75 percent) of the State's average weekly wage, whichever is less. Returning the employee to the same or an alternate occupation with any employer is now a appropriate job option after rehabilitation. Once released by the doctor to return to part-time employment, an employee with reasonable expectation of attaining a full-time job may be paid temporary partial disability benefits in the interim. A minimum income test for those employees who must accept less income was changed from 50 percent of the State's average wage to the State's hourly minimum wage.

Employees who would otherwise have to maintain two households to go to school are allowed to commute and still receive the rehabilitation allowance, if the distance is at least 30 miles.

The maximum penalty for failure to obtain workers' compensation insurance was increased to 2-1/2 times the premium that would have been paid on payroll expenditures (previously, 1-1/2 times). The maximum penalty for not furnishing payroll and other required information was increased to \$2,000 (previously, \$500). An employer who refuses to permit the Workers' Compensation Bureau to inspect company books, records and payrolls is now subject to a \$500 fine, up from \$100, for each offense. An amount of \$2,000 was added to the penalty for willful misrepresentation of payroll. The maximum penalty for default in the payment of workers' compensation premiums was increased from \$25 to \$250. Employers violating injunctions of the Workers' Compensation Bureau will be fined at least \$1,000 for each violation. Employers may be fined up to \$100 a day for not providing requested payroll records within 30 days; if the employer fails to pay the fine within 30 days, an additional penalty of 25 percent of the amount owed will be imposed.

For seasonal employees, the average weekly wage is the greater of one-fiftieth of the total wages the employee has earned from all occupations during the 12 calendar months preceding the injury; or one-fiftieth of the average annual income for the 3-year period preceding the injury.

An amendment changed the eligibility of full-time firefighters and law enforcement officers to have certain occupational illnesses covered by rebuttable presumptions after 5 years of continuous service (previously, 2 years). Employers must now require a physical examination upon employ-

ment, and annually thereafter, for the presumptions to be effective; these presumptions will be nullified if the firefighter or law enforcement officer uses tobacco.

New rules on permanent impairment and schedule awards are based on medical evaluations by treating physicians expressed as percentages of whole body impairment at the time of maximum medical improvement. A new schedule contains impairment ratings from 16 percent, payable for 5 weeks, to 100 percent, payable for 1,000 weeks. Schedule awards were eliminated for the loss of certain body parts and hearing loss, except for the loss of a finger, thumb, toe, or great toe.

Physicians are instructed to base their impairment evaluations on the American Medical Association's "Guides to the Evaluation of Permanent Impairment." New instructions for mental disorders require evaluations using the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders." Ratings for spinal injuries, other than those resulting in paraplegia, hemiplegia, or quadriplegia must not include factors for loss of range of motion, pain, and loss of strength and sensation. Other ratings for impairment based on loss of strength and sensation and loss of range of motion must be based on objective medical evidence of nerve damage or structural damage to a joint or loss of motor function. The amendment bars impairment awards due solely to pain.

Disputed impairment ratings are submitted to an independent doctor (chosen by the Worker's Compensation Bureau) and the injured employee from a list of medical specialists (compiled by the Bureau) who have not been involved in the injured employee's case. The independent doctor's decision becomes presumptive evidence of the degree of permanent impairment in any appeals process. If the employee disputes the decision, the employee is responsible for the expense of witness fees.

If a compensable injury causes permanent impairment resulting in a compensation award of at least \$2,000, the injured employee may defer payment of the award not to exceed the date the employee reaches age 65. The deferred award is payable as a lump sum and includes interest for the period of deferral. Lump-sum awards for injuries occurring after August 1, 1995 (the effective date of the amendment), are calculated by multiplying 33-1/3 percent of the State's average weekly wage by the number of weeks specified in the impairment schedule.

Legal services rendered to an employee associated with a bona fide dispute as to the percentage of permanent impairment or eligibility for compensation are payable according to reasonable hourly rates established by the Bureau, but may not exceed 20 percent of the award. A permanent impairment award is exempt from the claims of creditors, including an employee's attorney; but not court-ordered child support payments.

New provisions (which expire on July 31, 1999) establish a workers' adviser program to provide nonlegal assistance to injured workers, independent of the administrative claims process. Information contained in the files of the adviser program may not be used as evidence in subsequent

dispute proceedings. Attorney fees may not be paid for claimants unless they have first used the adviser services.

If an injured employee undertakes activities, on or off the job, which exceed recommendations of the treating physician and cause the condition to worsen, the employee may not receive benefits for the aggravation. However, the employee may receive compensation for the aggravated condition and the employer's insurance account may be charged for the extra expense, if the employer demanded the employee to do things in excess of the treatment recommendations.

## Ohio

A claimant's medical examination required by law must be promptly scheduled, and a compensation order issued within 28 days after an examination report is received by the Bureau of Workers' Compensation.

The term "statutory subrogee" is redefined to include the administrator of the Bureau of Workers' Compensation, a self-insured employer, or an employer who contracts for the direct payment of medical services. The payment of compensation or benefits creates a right of subrogation in favor of a statutory subrogee against a third party, including past payments and estimated future values of compensation and medical benefits.

A claimant must notify a statutory subrogee of the identity of all third parties against whom the claimant has or may have a right of recovery. No settlement, compromise, judgment, award, or other recovery in any action or claim by a claimant will be final unless the claimant provides the statutory subrogee with prior notice and a reasonable opportunity to assert its subrogation rights. If a statutory subrogee is not given notice, the third party and the claimant are jointly and severally liable to pay the statutory subrogee the full amount of the subrogation interest.

A statutory subrogee may pursue legal proceedings against a third party, alone or in conjunction with a claimant. If a claimant disputes the validity or amount of an asserted subrogation interest, the claimant shall join the statutory subrogee as a necessary party to the action against the third party.

The entire amount of any settlement or compromise of a claim is subject to the subrogation right of a statutory subrogee, regardless of the manner in which the settlement or compromise is characterized. A settlement or compromise that excludes compensation or medical benefits will not preclude a statutory subrogee from enforcing his or her rights under this section. The entire amount of any award or judgment is presumed to represent compensation and medical benefits and future estimated values that are subject to a statutory subrogee's rights, unless the claimant obtains a special verdict indicating that the award or judgment represents different types of damages.

Subrogation does not apply to the portion of any judgment, award, settlement, or compromise of a claimant to the extent of a claimant's attorney fees, costs, or other expenses, or of medical surgical, and hospital expenses paid by a claim-

ant from the claimant's own resources for which reimbursement is not sought. No additional attorney fees, costs, or other expenses in securing any recovery may be assessed against any subrogated claimants of a statutory subrogee.

In determining the premium rates for the construction industry, the Bureau of Workers' Compensation will calculate employers' premiums based on the actual pay construction industry employees receive, subject to a threshold amount of 150 percent of the State's average weekly wage. Formerly, the 150-percent threshold was not included in the calculation of construction industry premium rates.

The Workers' Compensation Board is required to submit a series of quarterly reports to the State legislature and several State agencies, until 1997, on finances, loss prevention, claims management, medical payments and cost containment, fraud management rehabilitation, and safety.

### Oklahoma

A temporary four-member Workers' Compensation Fraud Advisory Council is created to assess the extent of workers' compensation fraud in the State.

### Oregon

A requirement that attending physicians be instructed on the State's workers' compensation law and regulations was discontinued.

New provisions state that in accepted injury or occupational disease claims, disability caused solely by, or medical services directed solely to, a worker's preexisting condition are not compensable unless working conditions constitute the major contributing cause of a pathological worsening of the preexisting condition; working conditions constitute the major contributing cause of an actual worsening of the preexisting condition and not just its symptoms, and medical service is prescribed to treat a change in the preexisting condition, and not merely as an incident to the treatment of a compensable injury or disease.

The definition of "beneficiary" is revised to exclude one who intentionally causes the injury or death of a worker; "preexisting condition" is defined as any injury, disease, congenital abnormality, personality disorder, or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for a worsened condition resulting from the original injury; and a modification to the definition of "compensable injury" lowered the proof required to determine that drug and alcohol abuse was a major contributing factor to an injury from "clear and convincing" to "preponderance" of evidence.

The State's workers' compensation law is the exclusive remedy for all work-related injuries and diseases. Other exclusive remedy provisions in the law, in addition to applying to injuries, also include by additional reference, diseases, symptom complexes, or similar conditions arising out of and in the course of employment whether or not

the conditions are determined to be compensable.

The total labor cost, in any 30-day period, for employment to be considered casual, and thus not covered, was raised to \$500 (previously, \$200). Members of limited liability companies (including members managers), may elect workers' compensation coverage, except while working in construction and related activities, at which time they are subject to workers' compensation coverage.

Compensation claims from workers of employers who have not complied with insurance requirements are assigned to a claims agent appointed by the Department of Consumer and Business Services. All costs to the Department become a liability of the noncomplying employer.

The extraterritorial provisions of the law are amended to require either offsets to or payments of compensation involving another State or foreign country, so that the claimant receives the full amount required by Oregon's workers' compensation law.

Reimbursements for the cost of burial of a deceased worker cannot exceed 10 times the State's average weekly wage (previously, the reimbursement could not exceed \$3,000). For dependent children under age 18, monthly benefits will be 4.35 times 10 percent of the State's average weekly wage (formerly, \$150 per month) for each child of the deceased until that child becomes 18. If a surviving spouse receiving payments dies, leaving a child under 18 who is entitled to compensation, a monthly payment equal to 4.35 times 25 percent of the State's average weekly wage shall be paid to each child until age 18. Monthly dependent survivor's benefits cannot exceed 4.35 times 133-1/3 percent of the State's average weekly wage; if the sum of individual benefits exceeds this maximum, the benefit for each child will be reduced proportionally.

If a surviving spouse remarries or cohabits with another person for more than 1 year and a child results, an amount equal to 24 times the monthly benefit shall be paid in a lump sum as a final payment, but the monthly payments for each child entitled to compensation continue. If a worker has no spouse, but leaves a child under age 18, the child receives a monthly benefit equal to 4.35 times 25 percent of the State's average weekly wage (formerly, \$400 per month).

If an 18 year-old dependent is a full-time high school student, benefits continue. A dependent child attending college within 6 months of graduating from high school is entitled to benefits until age 23.

A gainful occupation, used in connection with permanent total disability benefits, is one that pays at least the State's minimum wage per hour.

The value of each degree on the schedule for compensating permanent partial disabilities is raised to \$347.15 (previously, \$305); on January 1, 1996, the value became \$420. Values for nonschedule injuries were established on a new three-tiered scale according to the number of degrees for the injury, with the highest value at \$620 for degrees in excess of 160. All permanent disability contemplates future "waxing and waning" of symptoms, the results of which may include loss of earning capacity, periods of temporary total or temporary partial disability, or

inpatient hospitalization.

Unpaid amounts of final awards for permanent partial compensation must be paid, upon the worker's application, by the insurer in a lump sum; if the insurer disagrees with payment, he or she has 14 days to appeal.

The parties to an agreement on a claim, except for medical services, can make a disposition on all matters regarding the claim.

The legislation enumerates in greater detail the medical services, including palliative services, that are compensable after a worker's condition has become stationary. Special rules apply to workers who must use a managed care organization for compensable treatment, regardless of the date of injury or medically stationary status. If the managed care organization determines that a change in provider would be medically detrimental to the worker, the worker will not be subject to the provider contract until found to be medically stationary or certain other conditions occur. A worker need not use the specified managed care organization that is more than 100 miles from home. If a claim for medical services is disapproved for any reason other than formal denial of compensability and the claim is disputed, an administrative review is required.

Medical fee schedules developed by the Workers' Compensation Division should represent reimbursement generally received for the services provided. The fees should consider current procedural codes and relative value units used by Medicare, fee schedules used by the State's health insurance industry, reasonable rates of markup for the sale of medical devices, other commonly used and accepted fee schedules and the actual cost of providing the medical services.

Accident and death notices must be given within 90 days (formerly, 30 days). Failure to give this notice bars a claim unless given within 1 year of the accident for situations in which the worker died within 180 days and the employer had knowledge of the injury or death.

Claims will not be closed if the worker's condition has not become medically stationary, unless the injury is no longer a major contributing cause of the condition and the worker is not engaged in training, or the worker fails to seek medical treatment for 30 days without the approval of the attending physician or fails to attend a closing examination. The amendments also revise the conditions for ending temporary total disability benefits, reconsidering a closed claim and overpayments.

Parties to a proceeding to determine who is responsible for compensation payments can agree to private mediation or arbitration; however, arrangements must be made for the payment of a claimant's attorney. A claimant not represented by an attorney has the right to refuse to participate in the proceedings.

A request for an administrative review of an order regarding vocational assistance may stay the payment of the assistance. Death benefits are not generally affected by provisions in the law which stay benefits during appeals. Reimbursement to medical service providers for claims that were originally denied must not exceed 40 percent (previously, 20 percent) of the total present

value of the settlement amount. Reimbursement shall not prevent medical service or health insurance providers from recovering the balance of amounts owed for these services directly from the worker.

If a worker is terminated for violation of work rules or for other disciplinary reasons, or if he or she is in violation of Federal immigration laws, temporary total disability payments cease and are replaced with temporary partial payments when the attending physician approves modified work.

If a worker recovers damages from a third person, new rules require that an offset against compensation be recoverable from compensation payable to the worker, or the worker's attorney or beneficiaries; no payments can be made until the offset is fully recovered.

Impairment is the only factor to be considered in evaluating a worker's disability if the worker returns to the pre-injury job, or the attending physician releases the worker to return but the worker refuses or is terminated for cause unrelated to the injury.

The membership of the Workers' Compensation Management-Labor Advisory Committee was reduced to 10 members (from 14) and is required to report on court decisions that significantly impact the workers' compensation system, the adequacy of benefits, medical and legal costs and administrative costs, and assessments.

A worker is required to prove with medical evidence supported by objective findings that employment conditions were the major cause of a disease or the worsening of a pre-existing condition. Among employment conditions not producing a compensable mental disorder is "employment decisions attendant upon ordinary business or financial cycles."

An injured worker's reemployment rights are terminated when the worker is medically unable to return to any position with the former employer, receives vocational assistance, or accepts another job or refuses light duty or modified employment after becoming medically stationary. Reemployment rights elapse 3 years from the date of injury.

Employers who do not assure the payment of compensation may be fined an amount twice the premium that would have been due during the period of noncompliance, or \$1,000, whichever is greater. The fine increases to \$250 (from \$25) for continued violations of the insurance provisions. If a noncomplying employer is a limited liability company, the company and its members and managers will be jointly and severally liable for civil penalties and claim costs.

An insurer is required to pay an employer's attorney fees if the employer is improperly declared noncompliant because the insurer failed to timely issue a guaranty contract or improperly canceled coverage.

### **Pennsylvania**

The percentage of permanent hearing impairment from long-term exposure to hazardous occupational noise will be calculated by using the binaural formula of the American Medical Association.

The impairment percentage is multiplied by 260 to determine the number of weeks of compensation entitlement at 66-2/3 percent of the worker's weekly wage. Compensation for permanent hearing loss due to work-related causes (such as acoustic trauma or head injury) other than occupational noise exposure is payable as follows: hearing loss in one ear—percentage of impairment multiplied by 60; loss in both ears—the impairment percentage multiplied by 260. No benefits are due for binaural hearing impairment of less than 10 percent. An employer is only liable for the hearing impairment caused by that employer, and may require audiometric testing from time to time, paid for by the employer. Hearing loss claims must be filed within 3 years of the last exposure.

### **Rhode Island**

If an employee returns to light duty while partially disabled, an earnings capacity determination will not be based upon actual wages earned until the employee has successfully worked at light duty for at least 13 weeks. "Medical services" was redefined to include palliative care services by a licensed physician for 12 visits after reaching maximum medical improvement, with additional palliative care as authorized by the insurer.

An employee's right to reinstatement to a former position terminates if the worker refuses the employer's offer of suitable alternative employment. Reinstatement disputes are decided only after a hearing, with appeal to the workers' compensation court within 30 days of the hearing decision.

The Division of Workers' Compensation has the authority to obtain information from insurers or self-insurers including, with cause, the power to subpoena.

Payments to totally incapacitated persons will be made from the Administrative Fund until the employee's total incapacity has ended or the employee's claim has been settled.

### **South Dakota**

Workers' compensation benefits were extended to all firefighters, not just volunteers; with compensation computed at the maximum rate by considering earnings for firefighters to be at the level that would entitle them to maximum compensation, whether or not they actually earned that much. Electric utilities can form workers' compensation self-insurance associations.

A claim against the Subsequent Injury Fund must include medical documentation and vocational rehabilitation evaluations, and be filed within 90 days of the date a decision is obtained from the Department of Labor finding that the injury is a compensable second injury.

All insurance carriers and employers are required to pay Subsequent Injury Fund assessments. Failure to pay may result in action to bar continued authorization to sell insurance or to self-insure in the State. New rules also require the second-injury

employer to be reimbursed from the Subsequent Injury Fund for two-thirds of all compensation, medical, and hospital expenses paid to or on behalf of the injured employee due to the subsequent injury. Previously, the reimbursement was for all expenses paid in excess of the compensation paid for the degree of disability which would have resulted from the last injury had there been no preexisting disability. In death cases, the provision was deleted which called for reimbursement of all compensation paid after 312 weeks.

Claims for additional compensation must be filed within 3 years from the date of the last payment of benefits. This time limitation does not apply to medical care, and claims for crutches, ambulatory devices, artificial limbs, eyeglasses and contact lenses, and hearing aids, or to mentally ill or retarded persons or minors not represented by a legal guardian.

Independent owner-operators of trucks were allowed to elect participation in the State workers' compensation system as sole proprietors. Coverage was also provided to owner-operated vehicles leased to motor carriers upon agreement between the parties concerning policy coverage and premium payment.

For an "injury" or "personal injury" to be compensable, medical evidence must establish one's employment as the major contributing cause of the disability, or a major contributor in second-injury cases. If an injury combines with a preexisting work-related injury, the subsequent injury is compensable if the subsequent employment contributed independently to the disability.

Payments are reduced for claimants receiving temporary total disability compensation if they refuse their employer's offer of suitable employment.

Medical providers are authorized to charge reasonable fees for reproducing information for employers, employees, insurers, and the Department of Labor.

Employees, employers, and insurers are permitted to use the results of post-offer base line testing or a functional capacity assessment, as utilized by the American Medical Association's "Guidelines to the Evaluation of Permanent Impairment," in determining the amount of compensation due for an impairment. Appeal officers may reject all the testimony of anyone who knowingly swears falsely to material fact in a workers' compensation proceeding.

In lieu of rehabilitation, the employer can require the employee to accept, in addition to earned income from alternative work, a supplemental wage benefit from the employer (which together equal the employee's benefit entitlement at the time of injury), plus an additional return to work incentive equal to 20 percent of otherwise payable temporary total compensation.

### **Texas**

The head of a business electing to provide workers' compensation insurance coverage is entitled to benefits under that coverage as an employee, unless specifically excluded by the policy. If an employee incurs an occupational disease, the eligibility for income benefits terminate after 401 weeks.

To be eligible to serve as a designated doctor, a doctor must meet specific qualifications, including training in the determination of impairment ratings, and must be in the same discipline and be licensed by the same board of examiners as the employee's doctor of choice. To avoid undue influence on a designated doctor, only the injured employee or the workers' compensation agency may communicate with the designated doctor about the employee's medical condition before the examination. The designated doctor can contact any doctor who has previously treated the employee for the injury.

A report of injury filed by the employer or insurer may not be used against them in a hearing or court proceeding. Information about benefits and the compensation process is to be available for claimants in English and Spanish. The ombudsman is directed to meet with unrepresented claimants privately for at least 15 minutes prior to a hearing.

Failure by an employer to submit injury and occupational disease reports is now a Class D violation, carrying a maximum fine of \$500. Knowingly, intentionally, or recklessly disclosing confidential information about an employee was made a Class A misdemeanor with a maximum fine of \$10,000. Employers identified as "extra-hazardous" may be excluded from such identification if satisfactory evidence is presented that the designation was only because of a fatality beyond the employer's control.

Fraudulently obtaining or denying benefits valued at less than \$1,500 is a class A misdemeanor, punishable with a fine of up to \$10,000; if the benefits are \$1,500 or more, the violation is criminal. Similar penalties are established for fraudulently obtaining workers' compensation insurance.

An emergency service organization, whether or not affiliated with a political subdivision, may elect to obtain workers' compensation coverage for its volunteers. "Professional athlete" now includes persons employed by the International Hockey League and the National Hockey League.

## Utah

An account was created in the State's general fund to promote workplace safety, funded partially by workers' compensation insurance premiums.

"Disability" was redefined as "an administrative determination that may result in an entitlement to compensation as a consequence of" becoming medically impaired as to function.

The employee now has the burden of proving that a disabling injury or disease was job-related. To be classified as permanently totally disabled, the employee must not be gainfully employed nor be able to work because of the impairment. However, an employee receiving permanent total disability benefits may be required to do reasonable and medically appropriate part-time work earning at least the minimum wage, unless the employment would disqualify the employee for Social Security benefits. An employee may also voluntarily obtain employment.

An employee's claim can be dismissed for failure to fully cooperate in the job placement pro-

cess. If the employee has gross earnings of more than \$500 in a 4-week period, compensation can be reduced by 50 percent.

Permanent total disability claims are subject to extensive periodic reexamination by the insurer or self-insured employer. The Industrial Commission can order the insurer to reimburse the employee for attorneys fees incurred in connection with a periodic reexamination. If the employee does not prevail, attorneys fees are limited to \$1,000.

The Industrial Commission was authorized to approve final settlement of medical, disability, and death claims, including lump-sum payments for future entitlement.

In employee leasing arrangements, the exclusive remedy provisions in the workers' compensation law apply to both the client company and the leasing company.

Workers' compensation and occupational disease laws were amended to clarify that any physician associated with, employed by, or billing through a hospital is subject to the medical fee schedule and reporting requirements. The amendment also provided that the medical fee schedule may reasonably differentiate based on the severity of the employee's condition, nature of necessary treatment, and facilities or equipment required for treatment.

Employers must not remove, disable, or bypass safety devices and safeguards. If an injury is caused by an employer's violation of its own written workplace safety program, the injured employee's compensation is increased 15 percent. Eligibility for compensation for injury or occupational disease is removed if the major cause of an employee's injury is the use of illegal substances, intentional abuse of drugs in excess of prescribed therapeutic amounts, or intoxication (that is, a blood or breath alcohol concentration of 0.08 grams or more). Nevertheless, compensation may not be withdrawn when an employer permitted, encouraged, or had actual knowledge of substance abuse or intoxication. Previously, intoxication reduced an employee's entitlement by 15 percent.

Mental stress is compensable only when there is sufficient legal and medical proof of a causal connection to employment. Good faith personnel actions (including discipline, work evaluation, job transfer, layoff, demotion, promotion, termination, or retirement) and alleged discrimination, harassment, or unfair labor practices, cannot be the basis of compensable stress. The burden of proof is on the employee to establish a claim by a preponderance of the evidence.

## Virginia

Volunteer medical technicians and search and rescue volunteers are deemed employees for purposes of workers' compensation coverage and will receive benefits at the minimum level.

Fees of attorneys and physicians and hospital charges for an initially contested claim which is subsequently held compensable will be based on the amount paid by the insurer to a third party

carrier or health care provider for medical services rendered to the employee through the date on which the contested claim is heard by the Workers' Compensation Commission. After review, attorneys, physicians, and hospitals may be required to refund charges found to be excessive.

Employers are required to report within 8 hours (previously, 48 hours) a work-related incident that results in a fatality or in the hospitalization of three or more persons. The term "employee" now includes managers of limited liability companies.

Benefits are restricted if an injured employee, without justification, refuses an offer of suitable employment. Once the employee recants and accepts the employment, the employer shall pay the employee during the period of partial incapacity weekly compensation equal to 66-2/3 percent of the difference between the employee's pre-injury wages and the wage that would have been earned by accepting the original offer of light duty employment. However, if the employee's refusal has lasted more than 6 months, the employer does not have to pay retroactive compensation for the period of refusal.

Employees injured during voluntary participation in employer-sponsored recreational activities are not covered if the activities are not part of the employee's duties.

## Washington

Payment must be made within 60 days if an injured employee or beneficiary in a State Fund claim prevails in an appeal (the 60-day period may be extended for good cause).

Claimants may seek injunctive relief if the Fund fails to pay on time; and a penalty of up to \$1,000 may be awarded to the claimant, if so ordered by the court.

Maximum burial reimbursements changed from \$2,000 to 200 percent of the State's average monthly wage. A fixed supplement to monthly death benefits changed from \$1,600 to an amount equal to 100 percent of the State's average monthly wage.

The Department of Labor and Industries has 180 days (instead of 60 days) to issue a tax assessment to a successor employer who has acquired a business. Payment of compensation is forbidden to a beneficiary if the worker deliberately produced injury or death to himself or herself or committed a felony that resulted in the injury or death.

## West Virginia

Upon a second or subsequent conviction for willfully failing to make payment or file a report, persons so convicted will be imprisoned for 1 to 3 years or fined between \$5,000 and \$25,000.

An employee of the Workers' Compensation Division will not be compelled to testify as to the basis, findings, or reasons for a decision or order rendered by the employee in a hearing conducted pursuant to Article 5 which deals with review.

Volunteer rescue squads or volunteer police

auxiliary units can elect to not subscribe to the Workers' Compensation Fund. If an employer does not subscribe to the Fund even though obligated to do so, the partner, proprietor, or corporate or executive officer of the employer will not be covered and will not receive benefits.

Employers who fail to timely file quarterly payroll reports or pay the premium tax due will pay a penalty of the greater of \$50, or 10 percent of the premium due, up to \$500.

Employers with sufficient capability and financial responsibility can apply for permission to self-insure their risks, but no employer can self-insure second injury risks. To be approved for self-insurance status, the employer must have an effective health and safety program and provide a determined amount of security or bond. An employer whose record shows a liability against the Workers' Compensation Fund will not have the right to self-insure. The Fund can assess and collect the present value of an employer's defaulted self-insurance premium taxes. A self-insured employer who elects not to self-insure its catastrophic risk must pay premium taxes for this coverage.

The Compensation Programs Performance Council can establish and administer a perpetual self-insurance security risk pool provided by private insurance carriers or other programs of the State, to secure the payment of obligations of self-insured employers.

An employer who elects to self-insure and who has complied with the legal requirements and rules will not be liable for damages at common law or by statute for the injury or death of any employee after the approval of the election and during the period that the employer is allowed to self-insure.

If an employer sells or otherwise transfers substantially all of its assets so as to give up the capacity and ability to continue in business, then the employer's owed premium taxes and deposits, interest, and other payments are due upon execution of the sale or transfer. If a new employer acquires all or substantially all of the assets of a predecessor employer, any liens for payments owed for premium taxes and deposits, interest, penalty premium rates, or other payments owed by the predecessor employer will be extended to the successor employer.

A claimant's degree of permanent disability must first be determined before the claimant's request for a permanent total disability award which deals with special funds is ruled upon. Thereafter, a decision will be made as to whether the award is a second injury or a permanent total disability award to be charged to the employer's account, or to be paid directly by the employer if he or she has elected to be self-insured.

Conditional approval of a claim for benefits may be given if obtaining additional medical evidence or other evidence related to the issue of compensability would aid in making a correct final decision. Benefits will be paid during the period of conditional approval; however, if the final decision rejects the claim, the amount will be considered an overpayment. Payment of permanent total disability benefits begins and continues for up to 12 months whenever the Division of Work-

ers' Compensation, Office of Judges or Appeals Board awards permanent total disability, even if an objection or appeal is filed. If all litigation is completed and the time for filing any further appeals has expired, and the award is upheld, then the claimant will receive the remainder of benefits due based on the determined onset date of total permanent disability. If the claimant is then owed retroactive benefits, interest at the rate of 6 percent per year from the date of the initial award to the date of the final order must be paid, in addition to benefits due.

A pharmacist must dispense a generic brand of medication, if one exists.

If a claimant elects to receive services from a health care provider outside the State, and if the provider refuses to accept the reimbursement made by workers' compensation as full payment, then, the claimant is personally liable for the difference between the scheduled fee and the amount demanded by the out-of-State provider, with these exceptions: an emergency situation where there is an urgent need for immediate medical attention to prevent the death of a claimant or to prevent serious and permanent harm; or if there is no health care provider in West Virginia reasonably near the claimant's home qualified to provide needed medical services or one who agrees to accept as payment in full the scheduled fees, then upon application by the claimant, the Division of Workers' Compensation may authorize another health care provider.

Should a claimant wish to change health care providers but the employer has established a preferred provider organization or a health maintenance organization, then the claimant will select a new health care provider through the managed care program.

Funeral expenses will be reimbursed in an amount that will be changed from time to time by the Division of Workers' Compensation (formerly, maximum funeral expenses were \$3,500).

Awards of permanent total disability, including pending claims, are payable until the claimant attains the age necessary to receive Social Security Old Age Retirement. The awarded benefits paid will not exceed 66-2/3 percent of the claimant's average weekly wage at the time of injury (not to exceed 100 percent of the State's average weekly wage).

A single or aggregate permanent disability of 85 percent or more entitles the employee to a rebuttable presumption of a permanent total disability, if he or she is at least 50 percent medically impaired on a whole body basis. The presumption may be rebutted if the evidence establishes that the claimant is not permanently and totally disabled.

If a claimant is released by the treating physician to return to work at the pre-injury job, but the employer does not offer the pre-injury job or a comparable job when one is available, the award for the percentage of partial disability will be computed on the basis of 6 weeks of compensation for each percent of disability.

With some exception, the degree of permanent disability other than permanent total is determined exclusively by the degree of whole body medical impairment that a claimant has suffered. The Occupational Pneumoconiosis Board will premise

its decisions on the degree of pulmonary function impairment solely upon whole body medical impairment.

A five-member interdisciplinary examining board will evaluate claimants, including an examination if the board so desires. The board will consist of three physicians qualified to evaluate medical impairment, and two vocational rehabilitation specialists.

If a claimant who has at least a 50-percent whole body medical impairment is denied an award of permanent total disability benefits, but continues to work at a lesser paying job than previously held, he or she will be eligible for temporary partial rehabilitation benefits for 4 years. The benefits will be paid at the level necessary to ensure the claimant's receipt of the following percentages of the average weekly earnings at the time of injury: 80 percent for the first year; 70 percent for the second year; 60 percent for the third; and 50 percent for the fourth. Benefits may not exceed 100 percent of the State's average weekly wage.

If a claimant is referred for an independent medical evaluation prior to a permanent disability award, he or she will receive benefits at the permanent partial disability rate, until the permanent disability is awarded or until the claimant returns to work (formerly, no references were made to the claimant having returned to work).

The lump-sum payment to dependents of a person receiving permanent total disability benefits who dies from a cause other than a disabling injury, was eliminated.

Now, a claimant eligible for permanent total disability may elect to receive reduced payments to provide an annuity at death for surviving dependents. The sum of \$20,000 will be the initial annuity and the Compensation Programs Performance Council will review the amount at least every 3 years.

An application for benefits (except for occupational diseases or pneumoconiosis) must be filed within 6 months from and after the injury or death as the case may be (formerly, the application was required within 2 years). In cases of occupational diseases which resulted in death, applications must be filed within 1 year of the employee's death (formerly, within 2 years).

Employers, claimants, and dependents now have 30 days (previously, 15 days) from notification of nonmedical findings for occupational pneumoconiosis claims to file objections; otherwise, the findings shall be forever final.

When an injured employee applies for a further award of permanent partial disability benefits or for an award of permanent total disability benefits, a decision is required within 30 days. If a permanent total disability award was made after April 8, 1993, and before February 2, 1995, the reopening eligibility requirements will be those applicable at the time the first award was made.

An award of permanent partial disability benefits for 20 weeks for occupational pneumoconiosis without measurable pulmonary impairment will not be counted towards the 85 percent needed to gain the rebuttable presumption of permanent total disability, or towards

the 50-percent threshold when the claimant has terminated active employment and is receiving Federal nondisability or retirement benefits (formerly, the 50 percent threshold was not included in this regard).

Once an objection to a decision has been filed with the Office of Judges, the parties to the objection will be offered an opportunity for mediation by an examiner not involved in the original decision. On medical treatment issues or diagnostic services, the parties must select from a list of appropriately specialized medical providers. If issues of medical necessity are intertwined with nonmedical or nondiagnostic issues, a medical provider and a designated examiner will co-mediate. The mediation shall be conducted in an informal manner and the mediator's decision shall be in writing. Once the parties agree to mediation, the agreement cannot be withdrawn.

Except for medical benefits, the claimant and employer may negotiate a final settlement of any issue in a claim, with the consent and approval of the Division of Workers' Compensation. Decisions of administrative law judges may be appealed to the Workers' Compensation Appeal Board.

Attorney fees are limited to 20 percent of any claimant's or dependent's award.

### Wyoming

Employers are authorized to offer temporary

light duty employment to recipients of temporary total disability benefits. The offer must be in writing, specific as to duration and functional capacity requirements, and pay at least two-thirds of the employee's preinjury wage. Whether or not the employee refuses the light duty, the disability award will be reduced by two-thirds and the balance of the award will not be charged to the employer's experience rating. An employee may refuse light duty based on medical evidence that such duty is likely to unreasonably hinder recovery, or if the employee is enrolled in a college or vocational retraining program approved by the workers' compensation agency.

In a contested case or appeal in which the issue is compensability of an injury, a prevailing employer's attorney fee will be paid from the workers' compensation account within the State's Trust and Agency Fund. The fees must not exceed the amount of contested benefits.

State workers' compensation coverage is eliminated for the Federal H2A program, which allows waivers for alien agricultural workers and requires workers' compensation coverage for participants. (This was accomplished by eliminating the program from the definition of Federal programs which are covered by Wyoming workers' compensation law.)

Employers subject to the workers' compensation law are forbidden to do business without a statement of coverage issued by the State. Purchasers of a business must assume the previous employer's workers' compensation account and experience rating until the

end of the current rating period.

"Employer" was redefined to include an owner-operator of a mine at which any mine rescue operation or training occurs.

The list of extrahazardous industries covered by the workers' compensation law was overhauled. Coverage of volunteers and service suppliers was modified, and elective workers' compensation coverage provisions were clarified.

The application of certain penalties against employers who fail to pay workers' compensation insurance premiums was delayed until 30 days after the premium is due. The due date for employer payroll reports and monthly premium payments was extended to the last day of the month (previously, the 15th).

The State must be notified of third-party settlements and given 15 days after the notice to object. The State may also provide legal representation to injured employees in third-party actions upon request. Upon recovery in State assisted actions, the State is entitled to an amount equal to all sums awarded as benefits and all anticipated future medical costs; the injured employee or estate receives any excess. The State or employer may initiate third-party actions on behalf of employees for 6 months beyond the expiration of the statute of limitations for employee actions. In such cases, the State is also entitled to recover litigation costs.

Employers and the Workers' Compensation Division are permitted to settle claims for up to \$2,500, without an admission of compensability or that the injury was work related.