

**Worker's Compensation
Insurance Letter**

INS #	415
Date	July 14, 2000
Program	Claims Management
Type	Procedural Change
	None



State of Wisconsin
Department of Workforce Development

201 East Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
e-mail: DWDDWC@dwd.state.wi.us

To: All Insurers' Claims Handling Offices
From: Judy Norman Nunnery, Division Administrator
Subject: Modified Procedures as a Result of Focus Group Meeting

Purpose: To communicate the procedural changes resulting from a focus group meeting with insurer representatives on May 17, 2000.

Background: Division managers met with representatives of insurance carriers and self-insured employers on May 17, 2000 to discuss the following:

- Wording of the Division's notification (standard paragraph #9) letter to the worker of the worker's appeal rights when insurers pay permanent disability based on a medical report other than the treating practitioner's report and fail to notify the worker or send a copy of the notice to the Division
- The date the final medical report is due to the Division
- The criteria for submitting final medical report to the Division
- The criteria used by the Division to send vocational rehabilitation questionnaires
- The wording used by the Division in the vocational rehabilitation questionnaires
- The necessity of the practice by the Division in sending "worksheets" for permanent disability ratings
- Recommendations for changing the WKC-13, Supplemental Report, to accommodate information about medical reports and vocational rehabilitation information

The results of the meeting, developed through consensus, were:

- The Division modified the wording of paragraph #9 (sample enclosed).
- The Insurers' representatives will develop and make recommendations to the Council on Worker's Compensation (CWC) to change the administrative code with respect to the criteria for submitting final medical reports and for the due dates of such reports.
- The Division modified its criteria for sending vocational rehabilitation questionnaires and changed the wording of the questionnaire (enclosed).
- The Division will continue its practice of mailing worksheets but will also consider posting the information to the web site as an optional means of receiving the disability ratings. Insurers will continue to do their own ratings and make prompt permanent disability payments based on their ratings in most cases.
- The Division drafted a revision of form WKC-13 (sample enclosed). This version is not the current valid form and may be modified further.

Action Requested: Inform appropriate claims-handling personnel of these changes. Contact focus group members for input or questions about recommendations to the CWC

Inquiries: If you have questions about the above proceedings, please contact Lee Shorey at phone (608) 267-9407 or e-mail to shorel@dwd.state.wi.us

Enclosures: Sample paragraph #9; Criteria for sending Vocational Rehabilitation Questionnaire; Sample Vocational Rehabilitation Questionnaire; Draft version of revised WKC-13; Letter from Don Grassl summarizing recommendations to be made to the CWC.

References: Worker's Compensation Division Internet Site (insert address)

Paragraph # 9

Background:

This statement, known as paragraph # 9, is included in letters from the Division to injured workers who sustained permanent disability. They are only sent when insurers notify the Division that it will not pay the amount of disability recommended by the Division in its "worksheet" which was mailed to the insurer based on medical reports received from the insurer's medical practitioner and from the worker's treating practitioner. Also, they are not sent to the injured worker if the insurer has included a copy of their notice to the injured worker if it contains basically the same information.

The language was changed in response to the focus group's request for the Division to present a more "neutral" position.

Revised Statement:

The insurer informed us that, based on their medical examiner's estimate of permanent partial disability (PPD), they are paying you \$XXX in benefits.

If PPD benefits were based on your own treating practitioner's disability estimate, you would receive \$XXX in benefits.

To resolve this type of minor dispute without the delay and expense of a formal hearing, the Department generally suggests that the insurer pay the average of the two estimates, or \$XXX.

You may also request a hearing where the Department assigns an administrative law judge to determine which estimate is correct. To receive the Application for Hearing form, please contact the Department.

Vocational Rehabilitation Selection Process

Background:

Prior to 7/1/2000, the division mailed the “**Voluntary Employment Status Questionnaire**” each month to all injured workers based on new claims showing that they sustained any permanent partial disability.

As of 7/1/2000, the Division will mail the monthly questionnaire only to those workers whose claims reflect healing periods of 13 weeks or greater and are receiving permanent disability benefits.

Return of the questionnaire is voluntary. Those that return the questionnaire which indicates a need for assistance receive an informational pamphlet, see reverse side.

Use of this selection process will reduce the number of questionnaires by about 75% on a monthly basis.

Explanation:

The following relevant rules provide the guidelines for selection of cases:

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

Effective 10/1/82, the “**13 week rule**” went into effect and is still in effect today. This rule states:

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

(see sample of pamphlet on reverse side)

Tommy G. Thompson
Governor

Linda Stewart, Ph.D.
Secretary

Judy Norman-Nunnery
Division Administrator



State of Wisconsin

Department of Workforce Development

WORKER'S COMPENSATION

201 East Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
<http://www.dwd.state.wi.us/wc/>
e-mail: DWDDWC@dwd.state.wi.us

Voluntary Employment Status Questionnaire

Personal information you provide may be used for secondary purposes, (Privacy law, s. 15.04(1)(m)).

Name: _____

Address: _____

Telephone number: (____) _____

Social Security #:

Dear Injured Employee:

The purpose of this questionnaire is to obtain information about your present employment status and to assess your need for vocational rehabilitation assistance. Completion of this questionnaire is voluntary. If your employment situation is suitable or you do not want or need assistance, you do not have to complete it or mail it back.

If the information provided reflects that you have a need for vocational assistance as a result of your work injury, we will send you additional information about available vocational rehabilitation services.

Additionally, your reply will help us evaluate the effectiveness of the Workers Compensation return to work program

1 Are you currently working? Yes No
If yes, please answer numbers 2 through 5.
If no, proceed to number 6.

2. Are you working full time or part-time? (Check one)

3. Are you working for the employer where you were injured, or
 new employer? (Check one)

(OVER)

a What is your present salary? \$_____ hourly \$_____ weekly

b What was your salary when you were injured?
\$_____ per hour \$_____ per week

6. Are you able to work? Yes No If no, please explain

7. Do you have work restrictions as a result of your work injury? Yes No
If yes, please explain:

8. Have you been contacted about vocational rehabilitation services available to assist you in returning to work? Yes No

If yes, please provide counselor name, city, and agency:

9. Do you need help in finding a suitable job? Yes No

10. Do you have any questions or comments on your Worker's Compensation claim or vocational rehabilitation?

Thank-you for your participation. Please return your completed questionnaire to
Worker's Compensation Division
Rehabilitation Unit
PO BOX 7901
Madison, WI 53707-7901

SUPPLEMENTARY REPORT ON ACCIDENTS AND INDUSTRIAL DISEASES

Department of Workforce Development
 Worker's Compensation Division
 P.O. Box 7901
 Madison, Wisconsin 53707-7901
 Telephone: (608) 266-1340
 http://www.dwd.state.wi.us/wc

SUBMIT THE WKC-12 WITH THIS REPORT IF IT WAS NOT PREVIOUSLY SUBMITTED.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. (Please read the instructions on reverse for completing this form)

1. Name of Injured Employee		2. Social Security Number					
3. Address		City		State		Zip Code	
4. Injury Date		5. Last Day Employee Worked		6. Nature of Injury or Illness			
7. Employer Name				8. Address (City, State and Zip)			
9. Insurance Carrier (Not TPA or Adjustor)		<input type="checkbox"/> Check if employer is self-insured		10. Insurer Claim Number		11. N.A.I.C. Number	
12. Insurer's Claim Handling Address		City		State		Zip Code	
13. Date & Type of First Compensation Payment		Type: <input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> Salary Cont'd <input type="checkbox"/> Other		14. Amount of 1st payment		15. Weekly Wage Used to Set TTD Rate	
Date: _____		\$		\$		16. TTD Rate <input type="checkbox"/> Attach WKC-13-A if Rate Below Max	
\$		\$		\$		\$	
17. If 1st Payment Was Late, (more than 14 days after injury date) State Reason							
18. Remarks: <input type="checkbox"/> Denied <input type="checkbox"/> Being Investigated (Attach Copy of Denial Letter)							
<input type="checkbox"/> Suspended -- Lack of Medical Information							
<input type="checkbox"/> Suspended -- Other Reason (Attach Copy of Suspension Letter)							
Date Final Medical Report required under DWD 80.02(2)(e) 4 is anticipated: _____ <input type="checkbox"/> Other Remarks (Specify)							
Payment Period							
19. Type of Payment	20. Last day of work	21. Date of return to work or end of healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer paid holidays	23. No. of Weeks and/or days paid	24. Rate	25. Amount of Comp. Paid	26. Accumulated Total amount paid
<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> Other _____							
<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> Other _____							
<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> Other _____							
<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> Other _____							
<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> Other _____							
27. Amount of Permanent Partial Disability due. (Attach supporting medical report if not previously submitted.)							
_____ Wks. @ \$ _____ = \$ _____				Indicate amount of PPD paid to date. \$ _____			
28. Final Indemnity Payment Date: Type of Payment: _____ Date of Payment: _____		29. Has the worker returned to work with wages at 85% or more of wages at the time of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Rule DWD 80.02(2). For injuries which require the first report of injury, self-insured employers and insurance companies shall:

- (a) Make a supplementary report on a form WKC-13 on or before 30 days following that on which the injury occurred.
- (b) Make a report within 7 days from the date that payments are stopped for any reason. If any payments are stopped for a reason other than the employee's return to work, provide an explanation to the department and the employee. The insurer shall advise the employee as to the reason for stopping payments, what the employee must do to reinstate payments, and the worker's rights to a hearing.
- (c) Make a report on form WKC-13 with a copy to the employee when payment of compensation is changed from temporary total disability or temporary partial disability to a permanent disability.
- (d) Make a final report on a form WKC-13 when final payment of any type of compensation has been made. A practitioner's report is necessary if temporary disability exceeds 6 weeks or if permanent disability has resulted. Medical report showing the extent of permanent disability and the end of healing is due within 180 days after the date that temporary compensation were suspended. If you are unable to obtain one, you must submit a notice explaining why you are unable to obtain one or a copy of your request for one along with the date you anticipate submitting one. If the original medical report was not that of the treating practitioner, a treating practitioner's report is also necessary if temporary disability exceeds 3 weeks or if permanent disability has resulted. Copies of the final WKC-13 form and the final practitioner's report must be sent to the employee.

INSTRUCTIONS ON HOW TO COMPLETE THIS FORM:

Items 1 thru 11. Fill in all blanks completely.

Item 12. Fill in the mailing address of the office or adjusting company that makes the payments.

All correspondence regarding this injury will be mailed to the insurer's designated claims handling address.

Items 13 thru 16. Fill in all blanks completely. If salary/wage is continued, check the box and include the weekly amount of salary in Item 15. If first payment covered temporary partial disability, check the box in Item 13. Include a WKC-13A for TPD if TTD rate is less than minimum.

Item 17. If the first payment was made more than 14 days after the date of injury or the day the employee left work prior to the first day for which WC is paid, give reason for the delay in payment.

Item 18. If payments are suspended for any reason other than return to work, state the reason. Explain unusual circumstances under "other remarks." If benefits are denied, be sure to include a copy of the denial letter to the worker. Enter the date the final medical report is anticipated if one is required under DWD 80.02(2)(e)4 and is not attached or previously sent. A final treating practitioner's report is due if there is any permanent disability or more than 3 weeks of temporary disability paid, including TPD or salary/wage continued.

Item 19. Check the appropriate box for the type of temporary total disability paid using sections 1-4 or attach another form if there are more payment periods of temporary total (TTD) or temporary partial disability (TPD) paid. If permanent partial disability (PPD), vocational rehabilitation or any other types of payments were made, indicate the payment type under "other".

Items 20 and 21. Enter the last day of work and the return to work or end of healing dates. Do not enter the return to work or end of healing date unless the type of compensation paid for that period has been suspended.

Item 22. Enter the number of holidays paid by the employer and not paid WC for each period of disability.

Item 23. Enter the number of whole weeks and days paid TTD or, if TPD, the number of days for which TPD was paid. Any part of one day paid is considered a whole day for TPD purposes.

Items 24 and 25. Enter the rates and compensation paid that apply to the weeks or days in items 20-23.

Item 26. Enter the cumulative total of compensation paid for that line, items 19-25.

Item 27. Enter the number of weeks due, the permanent partial disability rate, and total compensation due for the disability. (Follow Sec.102.52, 102.53, and 102.55 where applicable.) Attach supporting medical information if it was not previously submitted.

Item 28. Enter the date of the final payment of temporary compensation if the claimant has returned to work or has been released for work and all temporary compensation due has been paid. Enter the date of final payment of PPD or other type of payment.

Item 29. Check the appropriate box if all temporary compensation has been paid and a date in item 28 has been entered.

Sample of Items 19 – 26

19. Type of Payment	Payment Period		22. No. of paid holidays	23. No. of Weeks and/or days paid	24. Rate	25. Total Comp. Paid	26. Accumulated Total amount paid
	20. Last Day of Work	21. Return to Work Date (do not enter if the same type of comp. is continuing, e.g. TPD)					
<input checked="" type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> Other _____	2-1-99	6-6-99	3	17+2days	538.00	9,325.32	9,325.32
<input type="checkbox"/> TTD <input checked="" type="checkbox"/> TPD <input type="checkbox"/> Other _____	6/6/99	8/8/99	0	9	220.00	1980.00	11,305.32

<input type="checkbox"/> TTD							
<input type="checkbox"/> TPD							
<input checked="" type="checkbox"/> Other Voc Reh	8-8-99	12-20-99	0	19	538.00	10,222.00	21,527.32

D R A F T



June 28, 2000

Lee Shorey
Director, Bureau of Claims Management
Workers Compensation
201 E Washington Avenue
PO Box 7901
Madison, WI 53707-7901

Subject: Proposed Changes to DWD 80.02(2)(e)4

Lee, we have had additional discussion among the ad hoc committee members following our May 17, 2000 meeting.

The following is our suggested changes to 80.02(e)4. Essentially, we would eliminate paragraph (4) and create a new paragraph because the 30 day requirement would no longer apply.

(?) If more than 6 weeks of temporary disability (total or partial) or any permanent disability per 102.52 or 80.32 exists, the insurance carrier or self-insured employer shall submit a medical practitioner's final report to the Department, and a copy to the employee, upon receipt. If the insurance carrier or self-insured employer cannot submit the report within 180 days from the date temporary disability (total or partial) benefits were last paid as recorded on the WKC-13, it shall provide an explanation to the Department of why the report cannot be submitted and a date it anticipates sending the report.

If the medical practitioner's report used to suspend benefits is not the treating medical practitioner's report, the insurance carrier or self-insured employer must also request and submit when available the treating medical practitioner's report indicating the extent of permanent disability. The insurance carrier or self-insured employer must submit a copy of its request for a final medical report from the treating medical practitioner to the Department if the insurance carrier or self-insured employer is unable to obtain the report within 180 days.

Our suggestion to change the number of weeks of temporary disability is an attempt to reduce the amount of needless correspondence between the Department and the self-insured employers or insurance carriers. As was brought out by the Department analysis, approximately 10,390 claims are required to be reported to track approximately 1,458 claims with permanent disability.

Compare this with the number of claims with less than 3 weeks disability and it becomes clear that the changes could be made without any impact on the timely payment of permanent disability. Referencing the data you provided, there were 31,162 claims within the 3 week criteria of which approximately 2,648 resulted in the payment of permanent disability. The payment of permanent disability was made timely and the final medical report was filed on the 2,648 claims without the need

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to report on all of the 31,162 claims. We could achieve a similar result if the reporting criteria is changed from 3 weeks to 6 weeks.

The 180 day change recognizes the difficulty of securing a final medical report from a medical practitioner at the time of return to work or the end of the healing period if there is any permanent disability. In many cases, a medical practitioner delays the determination of permanent disability. On average, it takes approximately 156 days from return to work date to receive a final medical report according to Department records. More importantly, this change would have little impact on the timely payment of most cases involving permanent partial disability. Current practice is to begin the payment of permanent disability shortly after temporary disability benefits are finally suspended in accordance with 80.32 minimums.

The changes also clarify the point in time when the final report is required. As the rule currently reads, it could be interpreted that a final medical report is not required until all compensation has been paid. In effect, it could be years in some cases before the payment of permanent disability benefits are paid. The absence of a definition of "final payment of compensation" could adversely impact the Department's responsibility:

- to assure that permanent disability benefits due are paid correctly and timely.
- to assure that temporary disability benefit payments were not improperly suspended.

The changes also recognize the difficulty in some cases of securing a final medical report from a treating medical practitioner,... particularly one who is unfamiliar with the Workers Compensation reporting requirements. Although the insurance carrier or self-insured employer will be required to request a final report from the treating medical practitioner, it is not required to send the report to the Department if the report is unavailable.

Thanks for the opportunity to discuss this with the Department and offer our suggestions for modification of the rule.

Yours Truly,



Don Grassl