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Workers' Compensation Agency Profiles

International Association of Industrial Accident Boards and Commissions

2013 Edition

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Introduction

The International Association of Industrial Accident Boards and Commissions is pleased to release the 2013 edition of Workers' Compensation Agency Profiles. Since workers' compensation is regulated at the state-level in the U.S., workers' compensation agencies, policies, and procedures can vary widely across the country. This publication serves as a tool to compare how workers' compensation agencies are organized and operated. The document also provides links to additional jurisdictional resources that may be of interest to users. In the future, the IAIABC hopes to expand this publication to include workers' compensation agencies outside of the U.S.

This publication provides similar information to that contained in the U.S. Department of Labor's *State Workers' Compensation Administration Profiles* which ceased publication in 2005. Information presented here was compiled from a variety of public sources. All jurisdictions were given the opportunity to review and revise their profiles. At the time of publication, the IAIABC had not received updated profiles from Maine, Nevada, New Hampshire, North Carolina, Oregon, South Carolina, Utah, Vermont, and Wyoming.

The IAIABC would like to especially thank the agency staff that assisted the IAIABC in reviewing and updating their jurisdiction's profile. We look forward to working closely with jurisdictions to keep information updated and useful.

We welcome comments, feedback, and updates on this publication; please submit them to Keri Lore, IAIABC Education and Resource Coordinator, at klore@iaiabc.org.

Alabama

Alabama Workers' Compensation Division

649 Monroe Street

Montgomery, Alabama 36131

(334) 242-2868 or (800) 528-5166

http://dir.alabama.gov/wc/

Agency

General Information

Alabama's Workers' Compensation Division (WCD) is located within the Alabama Department of Labor with the authority for administration vested in a single administrator. The Workers' Compensation Division is responsible for the administration of the Alabama Workers' Compensation Law to ensure proper payment of benefits to employees injured on the job and encourage safety in the work place. The main function of the Division is to ensure proper payment of compensation benefits along with necessary medical attention to employees injured on the job or their dependents in case of death. Information and services are also provided to claimants, employers, insurance companies, attorneys, judges, legislators, labor and management groups, government agencies and other parties. The Division also administers the rules and regulations for individual self-insurers and group self-insurers.

Legislative and Regulatory Links

Alabama Workers' Compensation Act: http://alisondb.legislature.state.al.us/acas/CodeOfAlabama/1975/123309.htm

Alabama Laws and Legal Codes: http://dir.alabama.gov/docs/dept_type.aspx?id=3

Budget and Financing

General Information

WCD's operating budget is appropriated by the legislature and approved by the Governor of Alabama.

Agency Funding Source

All carriers and self-insured employers contribute to the Administration Fund which covers all expenses to administer the workers' compensation act. The assessment is based on the total amount of compensation and medical payments made in the preceding year, with a minimum amount of $1,000 (Statute 32-1541).

2012-2013 Budget/Staff Size

WCD's current staff size is 35. Operating budget information for FY 2013 was not available.

Funds

Second Injury Fund

Alabama does not have a Second Injury Fund.

Insurance Requirements and Resources

General Information

Alabama Workers' Compensation Law requires that employers with more than four employees (full-time or part-time, including officers of a corporation) carry workers' compensation coverage. Employers of domestic employees, farm laborers, or casual employees and municipalities that have a population of less than 2,000 are not required to provide coverage but can elect to be covered by the provisions of Alabama's Workers' Compensation Law.

Private Insurance

The Department of Insurance regulates insurance carriers in Alabama

Alabama Department of Insurance
P O Box 303351
Montgomery, Alabama 36130
(334) 269-3550
http://www.aldoi.gov/

Employers can purchase an approved insurance policy through a licensed insurance agent underwritten by an approved insurance carrier who will write an insurance policy for the company. An employer can also purchase insurance through the Assigned Risk Pool when insurance carriers decline to write an insurance policy for the company. CANDIDATES: Any employer who has a medium to high workers' compensation exposure or claim history.

Drug-Free Workplace Program

There is a 5 percent (5%) workers' compensation insurance premium discount for those employers who establish a certified drug-free workplace program.

The bill applies to all workers' compensation policies issued and renewed in Alabama on or after July 1, 1996.

To qualify for the discount, an employer's drug-free program must be certified by the Workers' Compensation Division of the Alabama Department of Labor as being in full compliance with the provisions of Code of Alabama, 1975, Sections 25-5-330 through 25-5-340. The Law requires that a program must contain all of the following elements:

1. A written drug-free workplace policy statement.
2. A substance abuse testing program.
3. Provisions for an Employee Assistance Program.
4. Employee education.
5. Supervisor training.

Group Self-Insurance

The Workers' Compensation Division regulates employers who decide to self-insure by issuing certificates, approving rates, and monitoring performance.

Alabama employers can obtain coverage by joining a group self-insurance fund. This is a common fund into which employers have, by agreement, pooled their liabilities for the purpose of providing Alabama workers' compensation benefits to their employees. Candidates include any employer who is willing to enter into an agreement to pool their workers' compensation liabilities and who meets the underwriting requirements set forth by the Fund.

Group self-insurance can be obtained through an independent insurance agent or by contacting the Group Fund Administrator.

Individual Self-Insurance

Individual Self Insurance is a long-term commitment by which a financially strong employer pays benefits to injured employees as mandated by the Alabama Workers' Compensation Law.

Candidates include any employer who meets the following four financial qualifications: (1) audited financial statements; (2) a $5 million minimum net worth; (3) current assets to current liabilities ratio of 1.0 or greater; and (4) a positive net income. You may conduct a feasibility analysis to determine if it is cost effective for you to self-insure.

Penalties for not Insuring

Alabama Code 25-5-8: Penalties for failure to secure payment of compensation; injunctions. An employer required to secure the payment of compensation under this section who fails to secure compensation shall be guilty of a misdemeanor, and upon conviction thereof, shall be subject to a fine of not less than $100.00 nor more than $1,000.00. In addition, an employer required to secure the payment of compensation under this section who fails to secure the compensation shall be liable for two times the amount of compensation which would have otherwise been payable for injury or death to an employee. The director may apply to a court of competent jurisdiction for an injunction to restrain threatened or continued violation of any provisions relating to the requirements of insurance or self-insurance. The court may impose civil penalties against an employer in noncompliance with this amendatory act, in an amount not to exceed $100.00 per day. Subsequent compliance with this amendatory act shall not be a defense.

Reporting Requirements

First Report of Injury

Employer first reports are required to be filed with the Alabama Workers' Compensation Division for all injuries that exceed three lost workdays and those which involve fatalities. Reports must be filed within 15 days from the date or knowledge of injury.

Other Reports/Claims Processing and Monitoring

A supplementary report must be filed within 10 days of first payment of compensation. If the first payment is not made within 30 days of injury, the supplementary report must explain the delay in filing. A summary report is necessary to order to terminate TTD benefits. A Circuit Court Judge determines a claimant's PPD rating using factors such as: impairment rating of attending physician and use of the AMA Guide to Physical Impairment.

Any person who makes or causes to be made knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation for himself or herself or any other person is guilty of a Class "C" felony which is punishable by a fine of up to $5,000 and a sentence of one to 10 years in a State penitentiary.

EDI Standards

Alabama currently used the International Association of Industrial Accident Boards and Commission's Claims Release 1 and Claims Release 3 for filing on a voluntary basis.

Contested Case Handling

General Information

Either party in a case can request mediation and the other party may agree or disagree to mediate. Circuit Courts hear the case if no mediation is agreed upon, or Courts may order mediation.

Medical Care and Evaluation

Medical Fee Schedule

The Alabama Medical Service Board sets physicians' fees through a fee schedule.
http://dir.alabama.gov/wc/FeeSchedules.aspx

Treatment Guidelines

Alabama does not have specific treatment guidelines for workers' compensation.

Managed Care

The employer has the option of conducting utilization review in order to determine whether the proposed treatment is necessary and appropriate for treatment of the accepted injury.

Choice of Treating Physician

If an employee is not satisfied with the initial physician, the employer must provide a panel of four additional physicians.

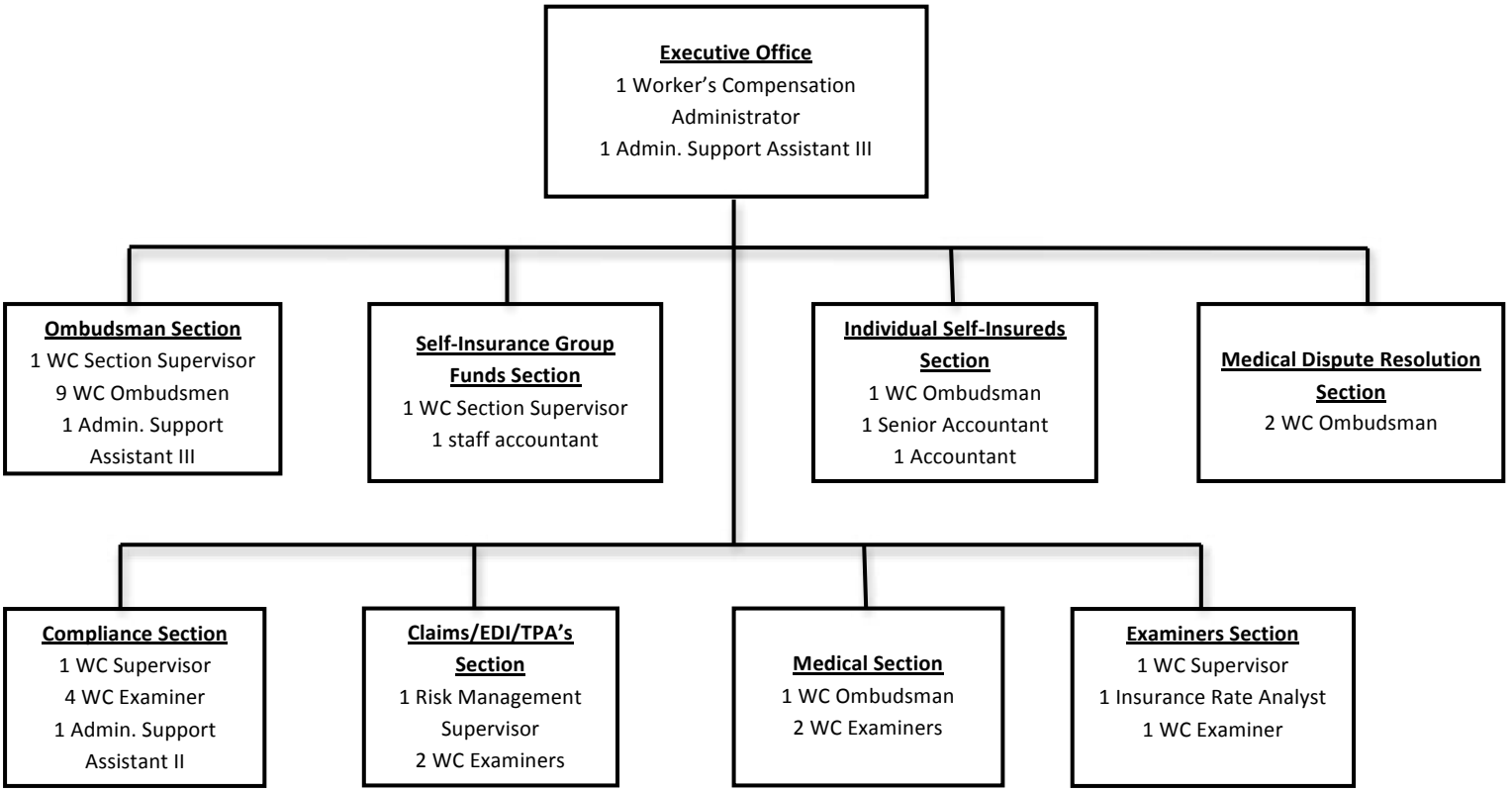
Rehabilitation

General Information

Under Alabama's workers' compensation statute, vocational and physical rehabilitation are provided and is paid for by the employers or insurers. Claimants who refuse rehabilitation will suffer loss of compensation during the period of refusal.

Workers' Compensation Division Organization Chart

WC Divisional Chart



Alaska

Alaska Division of Labor and Workforce Development

1111 West 8th St, Rm 305

P.O. Box 11551

Juneau, Alaska 99801

(907) 465-2790

http://www.labor.alaska.gov/wc/

Agency

General Information

The Alaska Division of Workers' Compensation operates inside of the Alaska Department of Labor and Workforce Development. The Division of Workers' Compensation is the agency charged with the administration of the Alaska Workers' Compensation Act (Act). The Act provides for the payment by employers or their insurance carriers of medical, disability and reemployment benefits to injured workers. The Division is required to administer the Act in a manner that is both fair and efficient to all parties.

The Division also houses the Alaska Workers' Compensation Board (AWCB) which hears disputes arising between employees and employers or their insurance carriers regarding the payment of benefits under the Act, and adopts regulations.

Legislative and Regulatory Links

Alaska Workers' Compensation Act (Alaska Statute 23.30)

Alaska Administrative Code (Title 8 Chapters 45-57)
http://www.legis.state.ak.us/basis/folio.asp

Alaska Workers' Compensation Decisions and Orders, Workers' Compensation Appeals Decisions, and Alaska Supreme Court Cases
http://labor.alaska.gov/wc/legaldir.htm

Budget and Financing

WCD's operating budget is appropriated by the Alaska Legislature and approved by the Governor of Alaska.

Agency Funding Source

The Workers' Safety & Compensation Administration Account (WSCAA) is used to fund the Division of Workers' Compensation. WSCAA revenue is derived from an annual 1.82% assessment against direct workers' compensation premium and a 2.9% assessment against benefits paid by self-insured and uninsured employers. (Alaska Statute 23.05.067)

Fiscal Year 2013 Operating Budget/Staff Size

The Alaska Division of Workers' Compensation has a staff of 50. In addition, there are 18 board members on the Workers' Compensation Board. The operating budget for FY 2013 is $5,600,800.

Funds

Second Injury Fund

The Second Injury Fund is financed by employer and carrier contributions up to 6% on all time loss and impairment compensation paid, and well as $10,000 in death cases where there are no dependents. The employer must have written knowledge of qualifying pre-existing conditions. The fund pays for time loss and impairment compensation only. The employer must pay medical, Attorneys' fee, and litigation costs. Payment is triggered by acceptance of the claim by the fund and a request for reimbursement by the employer or carrier.

Benefits Guaranty Fund

The Alaska Workers' Compensation Benefits Guaranty Fund (Fund) was established by the Alaska Legislature in 2005, and is applicable to injuries occurring on or after November 7, 2005. The Fund was created to assist injured workers who were injured while working for an uninsured employer, i.e., an employer who failed to have workers' compensation insurance on the date of injury. The Fund's revenue comes from civil penalties assessed against uninsured employers.

Fishermen's Fund

The Fishermen's Funds and is funded from revenue received from each resident and nonresident commercial fisherman's license and limited entry permit fee. This fund pays medical benefits to Alaska commercial fishers who become injured or ill in Alaska's waters or on shore and are not covered by workers' compensation or other sources.

Insurance Requirements and Resources

General Information

The Alaska Workers' Compensation Act requires each employer having one or more employees in Alaska to obtain workers' compensation insurance, unless the employer has been approved as a self-insurer. Determining employee status is accomplished utilizing the relative-nature-of-the-work-test as set out in Alaska Regulation 8 AAC 45.890.

Private Insurance

Insurance carriers are regulated by the Alaska Division of Insurance, Department of Commerce, Community, and Economic Development. The Alaska Division of Insurance issues licenses, sets rates, monitors performance, and carries out disciplinary measures.

Alaska Division of Insurance, Department of Commerce, Community, and Economic Development
9th Floor State Office Bldg.
333 Willoughby Avenue 99801
Juneau, Alaska 99811-0805
Main Phone (907) 465-2515
Fax (907) 465-3422
TDD (907) 465-5437

Self-Insurance

The Workers' Compensation Board monitors self-insured employers by issuing certificates with annual renewal, monitoring financial ability to pay claims and claims handling, and requires posting of bond if deemed necessary.

Alaska Statute 23.30.090 and Alaska Regulation 8 AAC 46.010 provides that a company may self-insure its workers' compensation liability in Alaska if it has the financial ability to meet the obligations; available claims facilities through its own staffed adjusting facilities located within the state or through independent, licensed, resident adjusters with power to effect settlement within the state; been in business within Alaska for at least five years; A safety/loss control program; In combination with its parent company or subsidiary companies of the employer, a minimum of 100 employees either in Alaska or in another state or states; and a net worth of at least $10,000,000.

Penalties for Failure to Insure

The Division has processes and procedures for investigating employers who are believed to be uninsured for workers' compensation. Investigations could be started dues to: injuries reported by workers in firms without insurance, telephone or mail tips, searches of unemployment insurance records detect possible violators, or investigation by the Division's Fraud Section.

Penalties for not insuring include: stop-work orders with a penalty of $1,000 a day for violation, civil penalty of $1,000 per day multiplied by the number of employees during the period that the employer was uninsured, may prohibit contract with the State for three years, or if a case is brought to court for prosecution, the court shall fine the employer $10,000 while a felony violation could result in $50,000 in fines and imprisonment up to 10 years.

Reporting Requirements

First Report of Injury

The filing of a first report of injury (FROI) is required for all injuries, illnesses, and fatalities, and must be reported to the employer within 30 days of knowledge of an injury or disease. Upon notification or knowledge, an employer has 10 days to submit a FROI to the Division. If a FROI is not filed, the statute of limitation is tolled for claims based on unreported injury or illness.

Other Reports/Claims Processing and Monitoring

Compensation Reports: A subsequent report of injury (SROI) is due within 28 days of first payment of compensation. If a SROI is not timely filed, a civil penalty will be issued in the amount of $100 for the first day and $10 for each day thereafter, to a maximum of $1,000.

Notice of Controversion (denial of benefits): with 21 days after employer's knowledge of injury or death. If compensation has been paid, this report is due within seven days after last payment.

Annual Report: An annual report is required by March 1st of each year.

Physician Reports: A provider who renders medical or dental services under the Act shall serve a report on the employer no later than 14 days after each service. The employer shall file the physician's report with the Board and serve a copy upon the employee after a workers' compensation claim has been filed under AS 23.30.110 and upon the reemployment benefits administrator if the employee is involved in the reemployment process under AS 23.30.041.

EDI Standards

The State of Alaska, Division of Workers' Compensation will be implementing electronic reporting of workers' compensation first reports of injury (FROI) and subsequent reports of injury (SROI) - commonly referred to as compensation reports. EDI reporting will be required for all trading partners (insurers, self-insured employers, and claims administrators). Mandatory implementation is planned for the 2nd quarter of 2013.

Electronic reporting will be via EDI transmission, using the Claims 3.0 reporting standards adopted by the International Association of Industrial Accident Boards and Commissions (IAIABC).

The State of Alaska has contracted with Insurance Services Office, Inc. (ISO) to manage its FROI/SROI reporting. ISO will be administering registration of trading partners, testing, and data collection and submission of EDI data to the State.

Additional information can be found online at http://www.adoledi.info/

Contested Case Handling

Disputes are adjudicated by the Alaska Workers' Compensation Board. Levels in the hearing process are as follows:

1. Pre-hearing conference
2. Board hearing
3. Workers' Compensation Appeals Commission
4. Supreme Court

Parties may voluntarily agree to mediation, which is not binding on the parties.

Attorneys' Fees

Attorneys' fees are regulated by statute, and are not valid unless approved by the Board. Fees may not be less than 25% of first $1,000 of compensation and 10% of the balance of benefits awarded.

Medical Care and Evaluation

Medical Fee Schedule

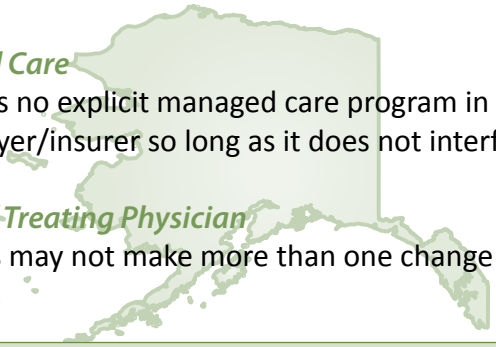
The current fee schedule, effective December 31, 2010, is available through OptumInsight, http://www.optuminsight.com/.

Medical fees and charges are subject to regulation by the Board.

There is a Medical Services Review Committee (MSRC), which assists and advises the Department of Labor and Workforce Development and the Board in matters involving the appropriateness, necessity, and cost of medical and related services provided under the Workers' Compensation Act.

Treatment Guidelines

Alaska does not have treatment guidelines for workers' compensation.



Managed Care

Alaska has no explicit managed care program in effect. A managed care arrangement may be implemented by an employer/insurer so long as it does not interfere with the employee's right to select a treating provider.

Choice of Treating Physician

Claimants may not make more than one change in choice of attending physician without written consent of the employer.

Vocational Rehabilitation

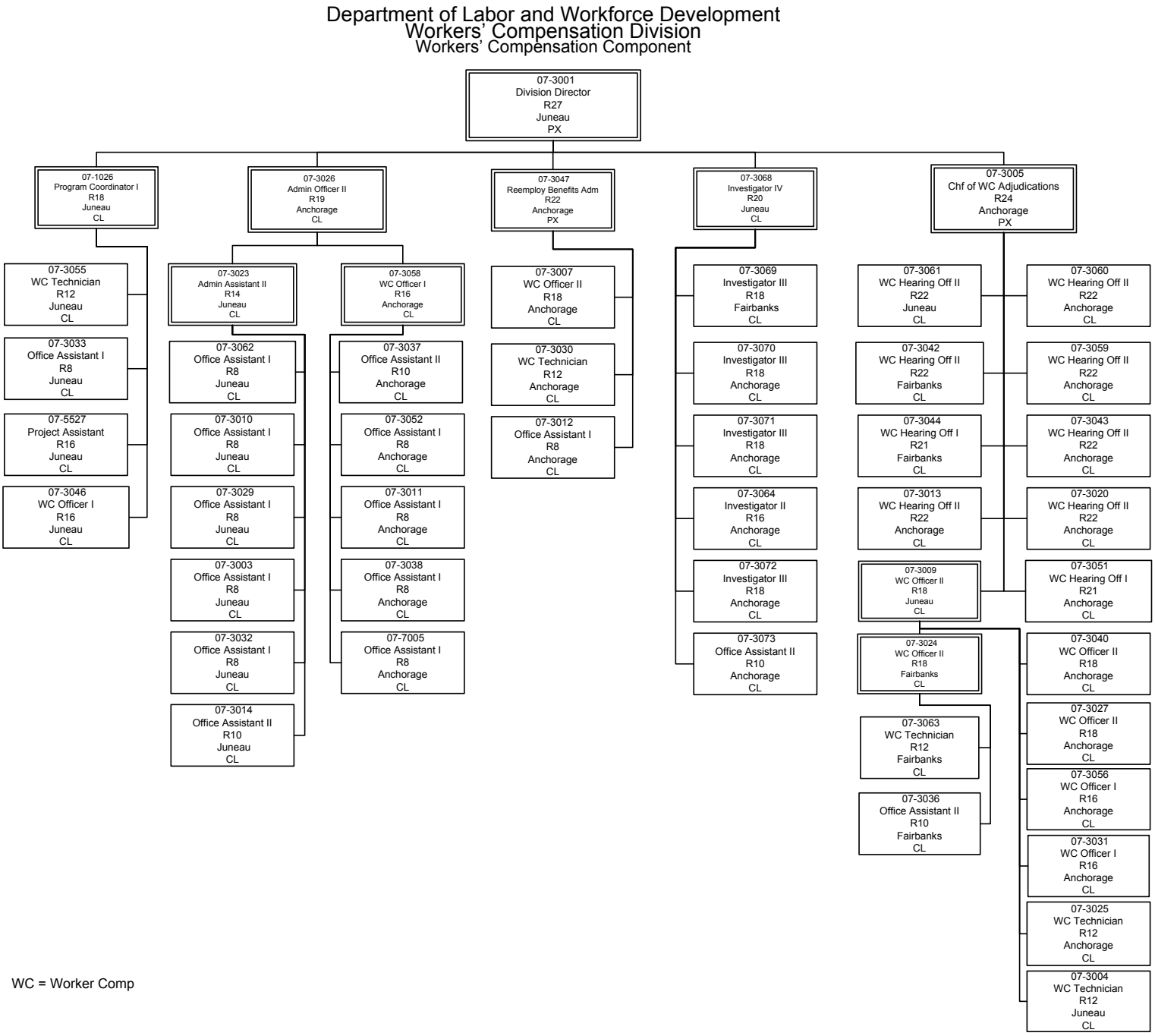
General Information

The Reemployment Benefits Section is responsible for administering the retraining program for injured workers in the Alaska workers' compensation system. The staff:

- works with injured workers and their employers/insurers to provide information about the program;
- assigns injured workers for eligibility evaluations to private sector rehabilitation specialists (counselors) as appropriate;
- reviews rehabilitation specialist reports to determine eligibility;
- assigns eligible injured workers who want retraining to rehabilitation specialists for development of a retraining plan;
- reviews retraining plans for approval or denial at the request of the injured worker or employer/insurer when they cannot agree on a retraining plan;
- works with injured workers and their employers/insurers to resolve disputes about retraining benefits without litigation; and
- conducts proceedings to determine if an injured worker has cooperated with the retraining plan.

Workers' Compensation Division: Organizational Chart

http://omb.alaska.gov/ombfiles/13_budget/Labor/Proposed/344%20-%20WC%20Component.pdf



WC = Worker Comp

Arizona

Arizona Industrial Commission

800 West Washington Street

Phoenix, Arizona 85007

(602) 542-4661 or (800) 544-6488

http://www.ica.state.az.us/

Agency

General Information

The Industrial Commission of Arizona (ICA) is an independent state agency responsible for administering and enforcing laws and regulations that relate to the protection of life, health, safety and welfare of employees within the State. These laws are found in Title 23 of the Arizona Revised Statutes.

A five-member Commission is responsible for determining the policy of the Industrial Commission of Arizona. Each Commissioner is appointed by the Governor to a five-year staggered term. The Commissioners serve on a part time basis and meet regularly to conduct business.

In addition to establishing the policy of the Commission, the Commissioners also perform a variety of other functions that include:

- Approving the issuance of occupational safety and health citations with penalties in excess of $2,500;
- Approving the issuance of cease and desist orders and penalties for youth employment law violations;
- Approving the adoption of agency rules;
- Authorizing self-insurance authority for qualified individual employers and workers' compensation pools;
- Licensing of employment agencies, career counseling services, and talent and modeling firms;
- Reviewing the Arizona Workers' Compensation Physicians' and Pharmaceutical Fee Schedule on an annual basis and establishing fees under that Schedule;
- Approving penalties for employers who fail to provide workers' compensation insurance for their employees;
- Acting on requests from injured workers to commute their permanent monthly workers' compensation awards to lump sum amounts;
- Acting on occupational safety and health discrimination complaints; and
- Establishing the annual tax and assessment rates on workers' compensation premiums to fund the Administrative Fund and Special Fund. (Annual Report, 2011)

Legislative and Regulatory Links

Arizona Statutes: http://www.ica.state.az.us/HomePage/HOME_Statutes.aspx
Arizona Rules: http://www.ica.state.az.us/HomePage/HOME_Rules.aspx

Budget and Financing

General Information

The ICA's administrative fund, which funds the day to day operations of the agency, is appropriated by the legislature and approved by the Governor. Functions funded by the Administrative Fund include activities that relate to the regulatory oversight of the workers compensation system such as:

- claims processing and monitoring,
- administration of insurance requirements,

- public information and education,
- management of information, and
- administration of Bad faith/Unfair Claims Processing statute.

The administrative fund also funds the operating expenses of multiple divisions within the agency, which includes the Special Fund Division (which is responsible for the payment of certain statutorily mandated workers' compensation benefits), the Administrative Law Judge Division (which adjudicates disputes) and the Legal Division (which represents the Agency in multiple areas).

Agency Funding Source

An administrative fund is established to pay for all expenses to operate the ICA. A premium tax, not to exceed 3%, is levied on insurers and self-insured employers (Arizona Revised Statute § 23-108).

2012-2013 Operating Budget/Staff Size

The ICA oversees an Agency with approximately 270 employees and a FY13 operational budget of approximately $19.9 million.

Funds

Secondary Injury Fund

The ICA's Special Fund is administered by the Director and financed by investment of Special Fund assets and discretionary taxes, which when combined do not exceed 2.5%. The Special Fund is responsible to pay a variety of statutorily mandated benefits, including payment of uninsured claims, vocational rehabilitation and apportionment. The apportionment provisions include reimbursement for one-half of unscheduled permanent benefits (indemnity) paid to an injured worker in cases meeting the notice and other statutory criteria.

Insurance Requirements and Resources

General Information

Under Arizona law, it is mandatory for employers to either purchase workers' compensation insurance for their employees or be approved by the ICA to self-insure. Workers' compensation insurance is not required for an independent contractor, or a worker whose employment is both casual and not in the usual business of the employer. Also, workers' compensation insurance is not required for a domestic servant who works in your home.

Private Insurance

The Arizona Department of Insurance regulates carriers and issues insurance licenses, setting rates, monitoring performance, and carrying out disciplinary measures related to the business of insurance. The ICA ensures that workers' compensation carriers handle and process claims in accordance with laws.

Arizona Department of Insurance
2910 N. 44th Street, Ste. 210 (2nd Floor)
Phoenix, Arizona 85018
(602) 364-2499 or (800) 325-2548 (In Arizona but outside the Phoenix area)

Self-Insurance

The ICA approves and regulates self-insurers by issuing Resolutions of Authorization to Self-Insure. The ICA regulates and monitors their performance, including the issuance of bad faith/unfair claims processing practices in the same manner as insurance carriers are regulated and monitored.

Individual Self-Insurance

To qualify as an individual self-insurer in Arizona:

- Annual payroll of at least $2,000,000 (this may include the payroll of included subsidiaries)
- Total assets of $50,000,000 or a cash flow ratio of at least 0.25
- Have conducted business in Arizona for a minimum of 5 years (business can be conducted through a domiciled subsidiary company)

Group Self-Insurance

Self-Insurance Requirements For Workers' Compensation Pools Organized Under A.R.S. § 23-961.01

Two or more employers, each of whom are engaged in similar industries, may enter into contracts to establish a workers' compensation pool to provide for the payment and administration of workers' compensation claims.

A pool shall ensure that the combined net worth of its members is at least $1 million at the time the pool files an initial application for authority to self-insure.

A pool shall obtain and maintain during all periods of self-insurance a statutory deposit in the amount of $200,000 or 125% of the total outstanding accrued liability, whichever is greater (the minimum cannot be offset by any excess insurance recoveries).

Workers' Compensation Pools Organized Under A.R.S. §§ 11-952.01(B) and 41-621.01 (Municipal Pools)

Two or more public agencies may enter into contracts or agreements pursuant to this article to establish a workers' compensation pool to provide for the payment of workers' compensation claims pursuant to title 23.

A municipal workers' compensation self-insured pool shall post a minimum statutory deposit in the amount of $100,000, or 125% of outstanding accrued liability, whichever is greater (the minimum cannot be offset by any excess insurance recoveries).

Penalties for Not Insuring

ICA assesses penalties against employers who do not have workers' compensation insurance. An employer who has failed to provide coverage may be assessed a $1,000 penalty, regardless of whether an employee has filed a workers' compensation claim. A second offense within five years increases the penalty to $5,000 and $10,000 for a third instance in that same period. An employer that fails to obtain the insurance may also be subject to an injunction by the ICA that can force the employer to cease business until the employer complies with the necessary workers' compensation coverage for its employees. The offense of failure to carry workers compensation insurance is considered a Class 6 felony. A.R.S. § 23-932.

Reporting Requirements

First Report of Injury

An employer is also required to notify their workers' compensation insurance carrier and the ICA within ten days after receiving notification of a work related injury or disease using the Employer's Report of Industrial Injury form which is available from the ICA and online at www.ica.state.az.us. For fatalities, an employer is required to notify the ICA Claims Division immediately by telephone or telegraph.

Other Reports/Claims Processing and Monitoring

The ICA is also responsible for investigating, processing and determining complaints of administrative bad faith and or unfair claims processing practices.

A notice of medical substantiation must be filed in order to terminate TTD benefits.

The ICA issues loss of earning capacity awards based upon physical limitations which may take into account the following factors:

- Impairment rating determined by attending physician;
- Employee's earning capability;
- Criteria as set forth by courts;
- Employee factors (age, education, training, etc.);
- Use of AMA Guide to Physical Impairment; and,
- Use of independent medical examiner

EDI Standards

Arizona does not use EDI.

Contested Case Handling

Levels in the hearing process are as follows:

1. Administrative Law Judge (ALJ) presides over hearing
2. Arizona Court of Appeals reviews the record and affirms or remands for hearing de novo
3. Arizona Supreme Court reviews the record and affirms or remands for hearing de novo.

Attorneys' Fees

The ICA approves attorneys' fees if it is requested to do so by either the claimant or the attorney. Limitations to an award of attorney fees is set forth in A.R.S. § 23-1069.

Medical Care and Evaluation

Fee Schedules

The ICA sets fees for physicians, physical therapists and pharmaceuticals, which are published in fee schedule.

http://www.ica.state.az.us/Director/DIR_FSSignUp.aspx

Criteria authorizing a change of physician are set forth in A.R.S. 23-1071. Directed Care: Only private self-insured employers are authorized to directed care.

Managed Care

Managed medical care organizations are used in Arizona in addition to fee-for-service.

Choice of Treating Physician

An employer can direct an injured employee to a physician of the employer's choice for a one-time evaluation. Following that visit, the injured worker may return to that physician or pursue treatment with a physician of his/her choice. There are exceptions to this rule for a self-insured employer that has complied with the requirements of A.R.S. § 23-1070.

Vocational Rehabilitation

General Information

Insurance carriers and the ICA's Special Fund pay for rehabilitation, which an injured worker qualifies for when he/she has a valid claim and cannot return to work.

Responsibilities of the ICA's rehabilitation section:

- Select private vocational rehabilitation firms
- Refer claimants to counselors
- Review and approve programs submitted by counselors
- Pay for educational courses and related expenses (i.e., books, school supplies, mileage reimbursement)
- Monitor placements

Claimant with unscheduled injury who is undergoing vocational rehabilitation with carriers' approval receives either TTD benefits or an advance of permanent disability benefits while in the program; all others receive permanent disability benefits. It is mandatory that claimants satisfactorily complete the course. In order to be considered "successful" the worker must be returned to work.

Arkansas

Arkansas Workers' Compensation Commission

324 Spring Street

P.O. Box 950

Little Rock, Arkansas 72203

(501) 682-3930 or (800) 622-4472

www.awcc.state.ar.us

Agency

General Information

The Arkansas Workers' Compensation Commission (AWCC) and the laws it administers were created effective December 5, 1940. Workers' compensation insurance is directed to the moral, social and economic benefits of protecting employers, employees, and their dependents from financial burdens imposed by job-related injury and disease. Arkansas law provides that employers in categories not specifically exempted must provide insurance coverage for employee costs incurred as a result of job-related accidents and disease.

The AWCC is not an insurance company. Rather, it enforces the workers' compensation laws to ensure that all covered employers secure insurance coverage from commercial carriers or through self-insurance programs. In addition, the AWCC regulates workers' compensation awards to insure that benefit providers make correct and timely payments to eligible claimants.

The AWCC, through its three Commissioners and a staff of Administrative Law Judges, adjudicates disputed workers' compensation cases with binding decisions that can be appealed to the Arkansas Court of Appeals and the Arkansas Supreme Court.

The three-member commission is responsible for the administration of the workers' compensation laws in Arkansas. The Commissioners are appointed by the Governor for a term of six years. One of the Commissioners represents the interest of labor, another management, and the Chairman acts as a neutral party, representing the interests of the public.

The administrative and regulatory functions of the Arkansas Workers' Compensation Commission include monitoring all claims and benefit payment to injured workers, processing settlements, lump sum payments, and requests for changes in physicians; ensuring that employers maintain required insurance coverage; approving applications of employers to act as self-insurers; and participating in programs to explain the functions of the Commission to the general public. The divisions that assist in carrying out these functions are: Adjudication, Administrative Services, Clerk of the Commission, Data Processing, Health and Safety, Legal Advisor, Medical Cost Containment, Operations and Compliance, Self-Insurer, Special Funds, and Support Services. All these divisions operate under the direction of a Chief Executive Officer.

Mission Statement

"The Mission of the Arkansas Workers' Compensation Commission is to provide a fair, efficient, and professional public agency to serve the people of Arkansas by administering actions required or authorized by Arkansas workers' compensation law."

Legislative and Regulatory Links

Arkansas Code: http://www.lexisnexis.com/hottopics/arcode/Default.asp
Arkansas Rules: http://www.awcc.state.ar.us/ruleind.html

Budget and Financing

General Information

AWCC's operating budget is appropriated by the legislature and approved by the Governor. Functions funded by the operating budget are:

- Claims processing and monitoring;
- Administration of special funds;
- Public information and education;
- Management information;
- Loss prevention/safety, and health;
- Administrative adjudication of disputes;
- Appellate functions to full Commission;
- Legal staff; medical cost containment;
- And compliance by public with rules and regulations.

Agency Funding Source

Workers' compensation insurance carriers pay a 3% tax on all premiums. Self-insured employers calculate what their premiums would have been in the standard market and pay 3% tax on that amount. The Commission may assess a third party administrator an annual fee of $100. (Arkansas Code Statute 11-9 (301-306))

2012-2013 Operating Budget/Staff Size

Operating Budget 2012-2013: approximately $12,000,000
Staff Size: 108

Funds

Secondary Injury Fund

The Second Injury Fund is managed by the Administrator of Special Funds and is financed by carrier and self-insured employer contributions, earned interest, and statutory penalties or fines. It is designed to insure that an employer employing handicapped workers will not, in the event of an injury to the worker, held liable for a greater disability or impairment than actually occurred while the worker was in the employers employment. In addition, the fund is not intended to pay for latent conditions not known to the employee or employer. Payment is a determination by an Administrative Law Judge (ALJ) or AWCC concerning compensation liability and the percentages attributable to the employer and Second Injury Fund.

Death and Permanent Total Disability Trust Fund

The Death and Permanent Total Disability Trust Fund is managed by the Administrator of Special Funds and financed by carrier and self-insured employer contributions, earned interest, and penalties or fines. It pays extended survivor and PTD indemnity benefits, on request, to anyone still entitled to benefits after respondent has paid the legally mandated maximum.

Insurance Requirements and Resources

General Information

Most employers in Arkansas with three or more employees are required by law to have workers' compensation insurance coverage for their employees. There are exceptions to the three-or-more requirement, so employers with fewer than three should check with authorities before assuming they do not fall under the workers' compensation laws.

Private Insurance

The Arkansas Insurance Department regulates carriers by issuing licenses, setting rates, carrying out disciplinary measures, and performing other regulatory activities.

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2600 or (800) 282-9134;
http://www.insurance.arkansas.gov/

Self-Insurance

The AWCC regulated workers' compensation self-insurers by: issuing licenses; carrying out disciplinary measures, and monitoring performance.

Qualifications to be a self-insurer include:

- may have to post bonds or securities;
- must participate in Guaranty Fund;
- must maintain proof of net worth, and must file required financial reports.

Both insurers and self-insurers must have and office in Arkansas with the authority to issue checks and makes necessary decisions if they do not meet AWCC monitored standards of performance.

Penalties for Not Insuring

Employers failing to comply with these laws may be subject to penalties by the state (fine up to $10,000) and, in addition, may lose protections afforded them by workers' compensation insurance and the laws of the state.

Reporting Requirements

First Report of Injury

The first reports are mandatory for all claims for death, permanent disability, or temporary disability of more than seven days (as required for medical only if controverted). This report must be filed within 10 days of employer's knowledge of injury. The penalty for not filing a first report is a $500 fine.

Other Reports/Claims Processing and Monitoring

Time limits for other reports:
Intent of Respondents Report: within 15 days
Final Report: within 30 days of last payment
Death and PTD reports: within the first year and annually thereafter until Special Funds Division agrees on date of its responsibility
Monthly for accepted medical-only case

Other Required Reports/Forms:
Follow-up
Medical
Supplemental Employer Report, if needed (necessary to terminate TTD benefits Form is filed for return-to-work)
Payment Suspension/Final Report (necessary for terminations)

The final administrative decision for determining a claimant's PPD rating is made by AWCC using the following factors:

- Impairment rating of attending physician,
- Employee's loss of wage earning capacity,
- Criteria as set forth by courts,
- Employee factors (age, education, training, etc.),
- Use of American Orthopedic Guide, use of the *AMA Guide to Evaluation of Permanent Impairment*, and use of independent medical advisor.

EDI Standards

The AWCC uses the IAIABC's Claims Release 1.0 standard for reporting on a voluntary basis.

Contested Case Handling

Levels in the hearing process are as follows:

1. Conference with a legal advisor
2. Hearing before an Administrative Law Judge
3. Review by the full commission

Attorneys' Fees

AWCC approves attorneys' fees of 25% of compensation for indemnity benefits. Half of the attorney's fee is paid by the respondents and the other half is deducted from the award.

Medical Care and Evaluation

Medical Fee Schedule

AWCC uses a medical fee schedule and has the authority to set medical and hospital fees.
http://www.awcc.state.ar.us/medfeetoc.html

Medical Treatment Guidelines

Arkansas does not have workers' compensation specific treatment guidelines.

Managed Care Organizations

AWCC adopted a Managed Care Organization (MCO) rule on July, 1, 1994 (last revised January 1, 2008). Managed care is in the statute and, when in place, affects all change-of-physician procedures. Procedures and regulations in AWCC Rule 33 must then be followed.

Choice of Treating Physician

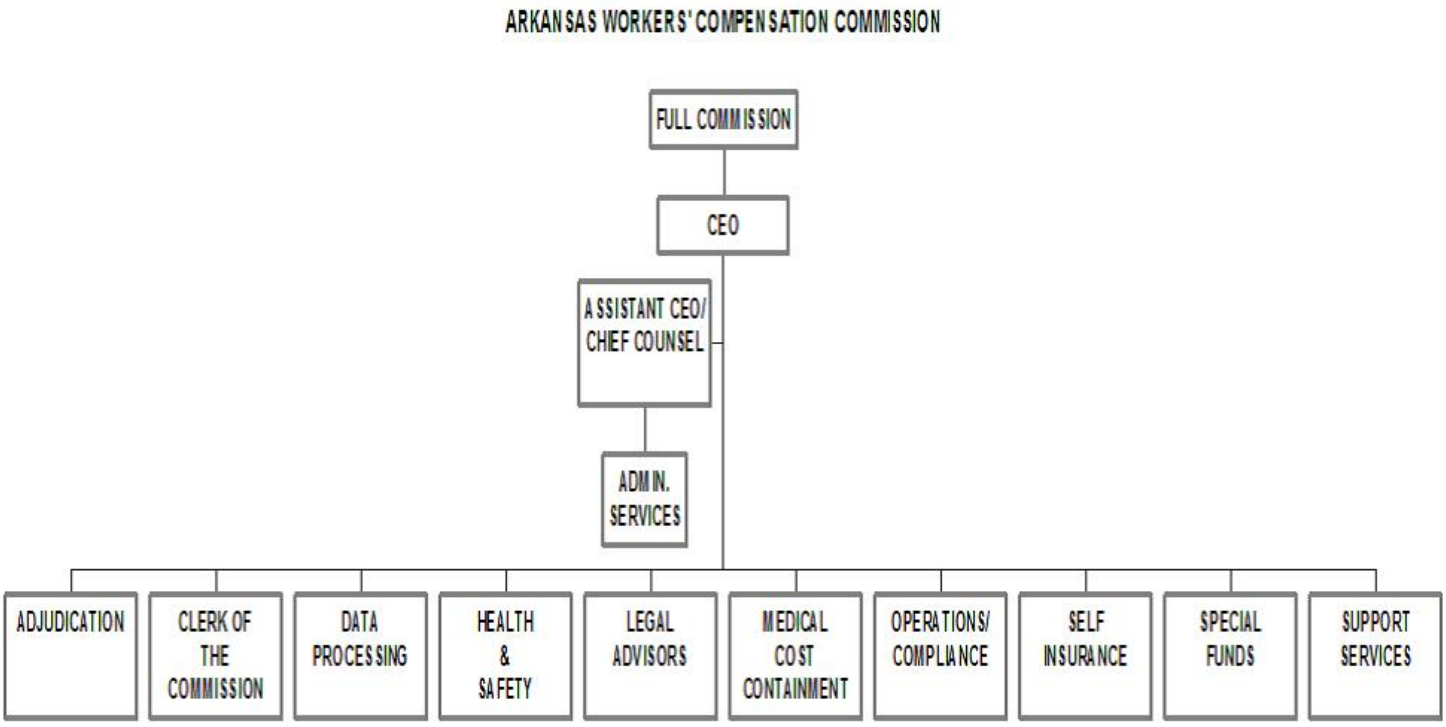
Employees will first go to the physician chosen by the employer or employer's workers' compensation insurance carrier. An employee must get approval from the carrier before receiving treatment. If an employee is not satisfied with the doctor first assigned, he/she may ask the claims handler or carrier to approve another doctor. The employee may also write to the Commission to request a Change of Physician.

Vocational Rehabilitation

General Information

Vocational and physical rehabilitation may be provided. AWCC will provide information and make referrals, but rehabilitation is paid for by insurers and employers. A claimant receiving disability benefits is under no obligation to accept vocational rehabilitation.

Workers' Compensation Division Organization Chart



California

California Division of Workers' Compensation

1515 Clay Street

Oakland, CA 94612

(415) 703-4413

http://www.dir.ca.gov/dwc

Agency

General Information

The Division of Workers' Compensation (DWC) monitors the administration of workers' compensation claims, and provides administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers' compensation benefits. In addition, the California Workers' Compensation Appeals Board has 24 district offices throughout California and provides claims adjudication, rehabilitation services, disability evaluations, and audit enforcement.

Mission Statement

DWC's mission is to minimize the adverse impact of work-related injuries on California employees and employers.

Legislative and Regulatory Links

California Labor Code:
http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=lab&codebody=&hits=20

California Code of Regulations:
http://ccr.oal.ca.gov/linkedslice/default.asp?SP=CCR-1000&Action=Welcome

Senate Bill 83

Senate Bill 863 was passed on Aug. 31, 2012 and was signed into law by Governor Brown on Sept. 18, 2012. The bill makes wide-ranging changes to California's workers' compensation system, including increased benefits to injured workers and cost-saving efficiencies. The bill takes effect on Jan. 1, 2013, although not all of its provisions will be effective immediately.
More information can be found at: http://www.dir.ca.gov/dwc/SB863/SB863.htm

Budget and Financing

General Information

DWC's operating budget is appropriated by the legislature and approved by the Governor of California.

The DWC's operating budget funds:

- Claims processing and monitoring;
- Administration of special funds;
- Public information and education; and,
- Rehabilitation

Agency Funding Source

The Workers' Compensation Administration Revolving Fund is funded by estimating annual assessable premium for the next calendar year. Assessable premium is charged after all rating adjustments (experience rating, schedule rating, premium discounts, expense constants, retrospective rating, etc.) Self-insured employers are assessed against the total amount of indemnity paid and reported in their self-insurance annual report (California Code Statute 50-62.5).

2013-2014 Operating Budget/Staff Size

The California Division of Workers' Compensation has a proposed staff of 1085.8. The proposed operating budget for FY 2013-14 is $197,968,000.

Funds

Subsequent Injuries Benefits Trust Fund

The Subsequent Injuries Benefits Trust Fund (SIBTF) is a source of additional compensation to injured workers who already had a disability or impairment at the time of injury. For benefits to be paid from the SIBTF, the combined effect of the injury and the previous disability or impairment must result in a permanent disability of at least 70 percent. The fund enables employers to hire disabled workers without fear of being held liable for the effects of previous disabilities or impairments. SIBTF benefit checks are issued to injured workers by the SIBTF Claims Unit after benefits are awarded by the Workers' Compensation Appeals Board.

Uninsured Employer's Benefit Trust Fund

The UEBTF is administered by the DWC Claims Unit and provides benefits to employees injured on the job while working for uninsured employers. The fund is financed by user funding assessments through WCARF and penalties assessed against illegally uninsured employers.

Insurance Requirements and Resources

General Information

California law requires employers to have workers' compensation insurance if they have even one employee. Out-of-state employers may need workers' compensation coverage if an employee is regularly employed in California or a contract of employment is entered into here.

Private Insurance

The California Department of Insurance regulates workers' compensation insurance carriers. The CDI issues licenses, settles rates, monitors performance, and carries out disciplinary measures.

California Department of Insurance
Office of the Ombudsman
300 Capitol Mall, Suite 1600
Sacramento, California 95814
(916) 492-3545
http://www.insurance.ca.gov/

Self-Insurance

California has one of the largest workers' compensation self-insurance programs in the nation. As of January 1, 2012, a total of 7957 California employers were actively self-insured, not counting past self-insured employers that were still paying claims from their periods of self-insurance.

Employers wanting to self-insure their workers' compensation liabilities must apply to the State of California, Office of Self Insurance Plans (SIP) for approval.

The private sector application process for a new employer (not currently self-insured in California) takes about three to four months. During that period, SIP evaluates the application to determine the applicant's financial strength, proposed benefit delivery system, and loss prevention program. Current regulatory financial requirements for an organization desiring entry into self-insurance are:

- $5.0 million shareholders equity.
- Average net profits of $500,000 per year for the last five years.
- Certified, independently audited financial statements.

Each subsidiary or affiliate company of a private applicant must file a separate application to become self-insured. They may apply with the parent company or individually, and the same application form is completed by the subsidiary/affiliate.

Group self-insurance by non-affiliated companies is permitted under California regulation, for both private and public sector employers. During 2001, group self insurers began forming in the private sector for the first time. The first such application was approved for new-car dealers, effective January 1, 2002.

Current regulations permit existing private self insurers of net worth over $10 million to add new subsidiary or affiliate companies with an application for an interim certificate. This provides immediate self-insurance for the new subsidiary/affiliate company and is valid for 180 days. During the 180-day period, a three-page application for a permanent certificate must be filed and approved prior to the expiration of the interim certificate.

Penalties for Failure to Insure

Failing to have workers' compensation coverage is a criminal offense. Section 3700.5 of the California Labor Code makes it a misdemeanor punishable by either a fine of up to $10,000 or imprisonment in the county jail for up to one year, or both. Additionally, the state issues penalties of up to $100,000 against illegally uninsured employers.

Reporting Requirements

First Report of Injury

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

Other Reports/Claims Processing and Monitoring

Other reports or forms required by DWC in addition to employer first report include a notice to the claimant regarding any start, stop, denial, delay, or other specified change of benefits and an annual report of claims inventory (reportable to the DWC Audit Unit).

EDI Standards

California uses the IAIABC's Release 1 standards for FROI/SROI, Medical Bill Payment Guide, Release 1.1

Contested Case Handling

Levels in the hearing process are as follows:

1. Trial before a workers' compensation judge
2. Petition for reconsideration the Workers' Compensation Appeals Board
3. Petition for writ of review to the Court of Appeals
4. Petition for review by the California Supreme Court

Medical Care and Evaluation

Medical Fee Schedules

http://www.dir.ca.gov/dwc/OMFS9904.htm

The Official Medical Fee Schedule (OMFS) is promulgated by the DWC administrative director under Labor Code section 5307.1 and can be found in sections 9789.10 et seq. of Title 8, California Code of Regulations. It is used for payment of medical services required to treat work related injuries and illnesses.

Medical Treatment Guidelines

http://www.dir.ca.gov/dwc/mtus/mtus_regulationsguidelines.html

* Treatment guidelines are a combination of ACOEM, ODG, and state specific guidelines

Managed Care Organizations

Employers and insurers are permitted to use certified managed care organizations to provide medical care to injured workers.

Choice of Treating Physician

Physicians are barred from referring patients to facilities in which the physician or a family member has a financial interest. The employer usually controls the selection of physician for the first 30 days post injury, unless notified of another physician preference prior to the injury. The employee may request a one-time change of physician during the employers' period of control, in which case the employer must promptly provide the employee with a panel of alternative physicians.

Medical Unit

Under the direction of an executive medical director, the Medical Unit performs a variety of services related to delivery of medical benefits in the workers' compensation system. It establishes policy and guidelines for the treatment and evaluation of injured workers. The unit examines and appoints physicians to be qualified medical evaluators (QMEs), who in turn examine injured workers to help determine the level of benefits they receive. It

also certifies and oversees groups -- medical provider networks (MPNs) and health care organizations (HCOs) -- that provide care to injured workers. The unit reviews utilization review (UR) plans and handles UR complaints and investigations jointly with the Audit Unit. It also assists the DWC administrative director with other issues affecting providers in the workers' compensation system, such as setting medical fee schedules, and undertakes medical care studies.

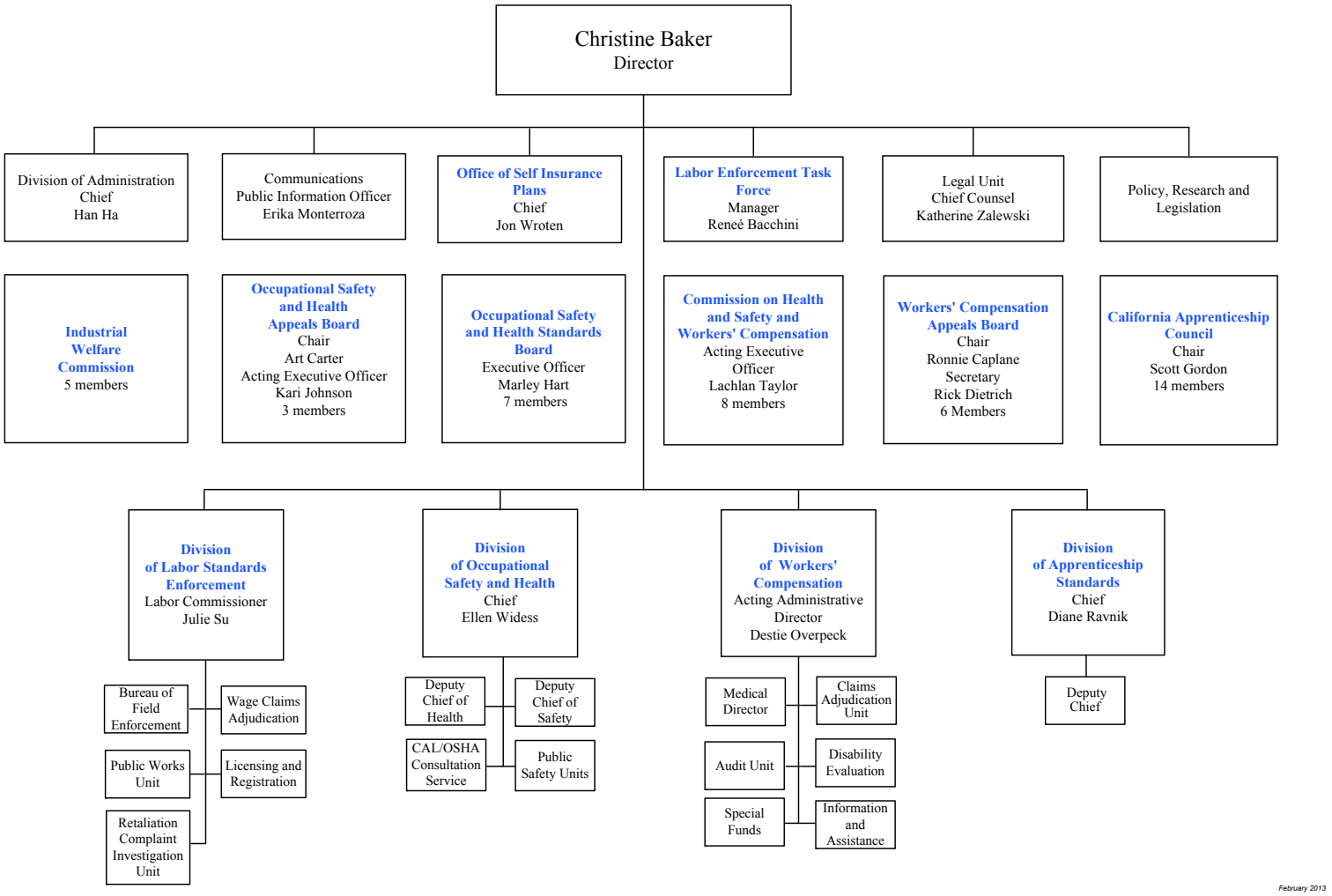
Vocational Rehabilitation

Supplemental Job Displacement Benefit (SJDB)

For injuries on or after 1/1/04 but before 1/1/13, the SJDB voucher is to be offered to an injured worker when his or her PD level has been determined, either by way of an agreement between the worker and the employer or insurance company, or by way of an award by a workers' compensation judge. Under SB 863, the voucher will be due 60 days after a treating doctor, agreed medical evaluator, or qualified medical evaluator declares the injured worker permanent and stationary, and issues a report outlining the worker's work capacities, if the employer does not offer the worker a job. The job must pay no less than 85 percent of the worker's earnings at the time of the injury, and must be expected to last at least 12 months. For injuries on or after 1/1/04 but before 1/1/13, the voucher amount ranges from $4,000 to $10,000, depending on the PD rating. For injuries occurring on or after Jan. 1, 2013, the voucher amount will be $6,000 across the board, regardless of the PD rating. The voucher can be used for training at a California public school or any other provider listed on the state's eligible training provider list. It can also be used to pay licensing or certification and testing fees, to purchase tools required by a training course, to purchase computer equipment of up to $1,000 and to reimburse up to $500 in miscellaneous expenses. Up to 10 percent, or $600 may be used to pay for the services of a licensed placement agency or vocational counselor.

Department of Industrial Relations

Director Christine Baker reports to the Secretary of the California Labor & Workforce Development Agency, Marty Morgenstern, who in turn reports to Governor Edmund G. Brown Jr. as a member of his Cabinet.



Colorado

Colorado Division of Workers' Compensation

633 17th Street, Suite 400

Denver, Colorado 80202

(303) 318-8700

http://www.colorado.gov/cdle/dwc/

Agency

General Information

The Colorado Division of Workers' Compensation (DOWC) is the state office responsible for administering the Colorado Workers' Compensation Act. In doing so, it recognizes the intent of the Colorado General Assembly to ensure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. (Director Tauriello's Welcome)

The Division of Workers' Compensation (DOWC) is part of the Department of Labor and Employment with authority for administration vested in a single administrator.

Legislative and Regulatory Links

Colorado Workers' Compensation Act (2012)
http://www.colorado.gov/cs/Satellite/CDLE-WorkComp/CDLE/1248095315983

Colorado Workers' Compensation Rules of Procedure (2012) http://www.colorado.gov/cs/Satellite/CDLE-WorkComp/CDLE/1248095315987

Budget and Financing

General Information

DOWC's operating budget is appropriated by the legislature and approved by the Governor of Colorado.

The DOWC's operating budget funds:

- Claims processing and monitoring;
- Insurance compliance;
- Public information and education; and,
- Management information;
- Medical and premium cost containment and monitoring;
- Administrative adjudication of disputes;
- Alternative dispute resolution;
- Administration of the DOWC;
- Review and authorization of self-insurance

Agency Funding Source

The Workers' Compensation Cash Fund is funded by collecting a surcharge of 1.6% on all premiums written. The surcharge for self-insured employers is based upon manual premium, adjusted by Pinnacol Assurance (the Colorado State Fund). Discounts for self-insurers are applicable for the surcharge period covered and modified by the experience rating factor as calculated by NCCI (Colorado Code Statute 8-44-112).

2012-2013 Operating Budget/Staff Size

The Division's operating budget for 2012-2013 is $ 19,871,670 with 118 full time employees.

Funds

General Information

For the purposes of funding the financial liabilities of the Subsequent Injury Fund as authorized under §8-46-102(2)(A)(I), C.R.S., and the Major Medical Fund under §8-46-202, C.R.S., for the period beginning July 1, 2012, and continuing indefinitely with annual review by the Director, the tax shall be assessed at .1 percent of the amount of Workers' Compensation premiums written, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, or the premium equivalent amount established in Section 2-3 of this rule, for Colorado Workers' Compensation insurance during the period of January 1, 2012, continuing indefinitely (Workers' Compensation Rules of Procedure).

Subsequent Injury Fund

The Subsequent Injury Fund is managed by the Special Funds Unit and covers:

- Specified occupational diseases resulting in permanent disability including:
    - Silicosis;
    - Asbestosis;
    - Anthracosis; and,
    - Poisoning or disease cause by radioactive materials.
- Permanent disability caused by more than one industrial injury

Payment out of the Subsequent Injury Fund is triggered by an administrative law judge, a stipulated agreement, or a voluntary admission. The employer pays that percentage of permanent total indemnity benefits attributed to the most recent injury. The Fund pays the percentage attributed to previous injuries. In the event of a specified occupational disease, the employer is liable for the first $10,000 of medical and indemnity benefits, and the Fund assumes total responsibility thereafter.

Major Medical Insurance Fund and Medical Disaster Fund

Both the Major Medical Insurance Fund and Medical Disaster Fund are managed by the Special Funds Unit. The purpose of the funds is to pay medical expenses above certain thresholds, which vary depending on the year of the injury, once the carrier has expended specified amounts. Medical care is provided by authorized treating physicians or other health care providers and paid by the Funds.

Insurance Requirements and Resources

General Information

All public and private employers in Colorado, with limited exceptions, must provide workers' compensation coverage for their employees if one or more full or part-time persons are employed. A person hired to perform services for pay is presumed by law to be an employee. This includes all persons elected or appointed to public sector service and all persons appointed or hired by private employers for remuneration. There are a few exemptions to this definition.

Private Insurance

The Division of Insurance and DOWC share regulatory authority over workers' compensation insurance carriers. The Division of Insurance issues licenses and sets rates, while the both agencies are in charge of carrying out disciplinary measures and monitoring performance.

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Self-Insurance

Qualification for self-insurance are as follows:
(a) Total assets of at least $100,000,000;
(b) The ratio of current assets to current liabilities of 1.5:1; or more
(c) The ratio of long term debt to tangible net worth of 1:1.5; or less
(d) Accounting ratios which equal or exceed industry standards.

In addition to the application, a favorable applicant must comply with all of the following:

(a) Submission of the applicant's most recent certified financial statement and certified financial statements for the immediate preceding four consecutive years.

(b) Evidence that the employer has been in business for a period of not less than five (5) years and can demonstrate sufficient financial strength and liquidity to assure that all obligations will be met promptly. An employer in business less than five (5) years may be considered if liability is guaranteed by a parent corporation with a business history of no less than five (5) years. If the applicant is an entity which has formed through merger, bifurcation or divestiture, the Executive Director may consider business history created prior to the applicants present formation as well as pro forma financial information.

(c) An insurance policy of specific excess insurance with policy limits and retention amounts acceptable to the Executive Director shall be required of each self-insured. Aggregate excess insurance may be required as a condition of approval of any self-insured program.

(d) An applicant for a permit shall provide security in the amount and in a manner prescribed by the Executive Director to insure payment of all workers' compensation claims required by the Act.

Penalties for not Insuring

For any business in the state that refuses to obtain workers' compensation insurance the Colorado Division of Workers' Compensation will levy a fine of up to $250 per day for the first offense. For subsequent violations, the employer will pay up to $500 per day in fines. If an employee suffers an injury and the employer has not obtained insurance, the Division of Workers' Compensation will require the employer to pay all medical and disability benefits out-out-pocket and another 50 percent of benefits for not having insurance.

Reporting Requirements

First Report of Injury

A first report of injury must be filed with DOWC for any injury resulting in lost work time in excess of three shifts or three days, a fatality, injury to three or more employees, a permanently or physically impairing injury. All other injuries shall be reported only by a monthly summary, or as otherwise requested by the Director. The first report must be filed with the DOWC within 10 days of the injury. In case of a fatality, immediate notice must be given.

Other Reports/Claims Processing and Monitoring

The DOWC monitors payment of claims. The DOWC also requires that an Admission or Denial of Liability report is required for any claim which is filed with the DOWC. When a Final Admission of Liability is predicated upon a medical report, the report must be attached. An insurer or self-insured employer may terminate TTD benefits without a hearing by filing an Admission of Liability report, together with other specific reports in accordance with the Rules of Procedure.

EDI Standards

The Colorado Division of Workers' Compensation (DOWC) started its Electronic Data Interchange (EDI) program using the IAIABC standard format for Proof of Coverage in 1994. In 1997, DOWC began to accept EDI submissions of the First Report of Injury (FROI). The DOWC's EDI program continues to evolve and the rate of EDI submissions continues to grow as the business community operates in an increasingly paperless environment.

The EDI program at DOWC has streamlined the submission of First Report of Injury data from our many trading partners; eliminating their need for paper FROI forms, while sharply reducing the number of paper forms processed by the DOWC. Our recent statistics show that approximately 42 percent of the initial First Report submissions and 100 percent of policy information are received via EDI. In addition to the FROI record, the DOWC accepts Subsequent Report of Injury Records (SROI) which includes the Denial and the Final Payment Notice.

A change in state statute has made certain filings mandatory as of July, 1, 2006. Beginning July 1, 2006, all FROI's and Denials (Notices of Contest) must be submitted electronically. Colorado uses the International Association of Industrial Accident Boards and Commission's Claims Release 1 Standards.

Contested Case Handling

DOWC is charged by statute to reduce litigation. Mediation services are available on a voluntary basis. Levels in the hearing process are as follows:

1. Administrative Courts, with an Administrative Law Judge
2. Industrial Claim Appeals Office (ICAO)
3. State Court of Appeals
4. Colorado Supreme Court

Attorneys' Fees

The Director of the Division of Workers' Compensation regulates attorney's fees by determining the reasonableness of such fees upon request. Fees for claimant's attorneys are taken out of the claimant's award.

Compromise and Release Agreements

Compromise and release (C&R) agreements are allowed when approved by the DOWC or the OAC. The agreement can terminate indemnity and medical benefits, and a claim can be reopened for reasons of fraud or mutual mistake of material fact.

Medical Care and Evaluation

Fee Schedules

DOWC sets fees for medical services, using benchmark evaluation and task force recommendations. DOWC also sets in-patient hospital fees and out-patient facility fees under Rule 18, Medical Fee Schedule.

Medical Fee Schedule: http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDLE-WorkComp%2FCDLELayout&cid=1251567882636&pagename=CDLEWrapper

Treatment Guidelines

Colorado does have medical treatment guidelines which are updated through an "evidence based approach" in a task force setting.

Colorado has state specific medical treatment guidelines which can be found at: http://www.colorado.gov/cs/Satellite/CDLE-WorkComp/CDLE/1248095316866

Managed Care

Managed care organizations are authorized in Colorado through insurance carriers.

Choice of Treating Physician

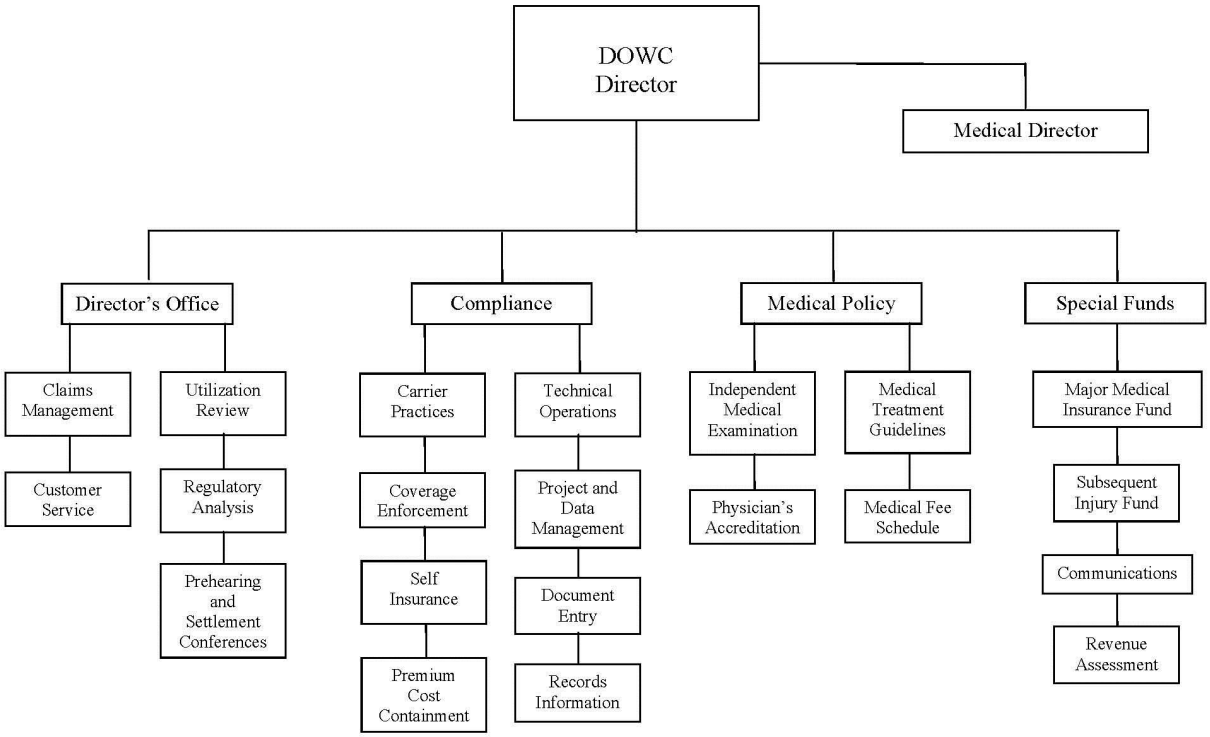
The worker's treating physician is selected by the employer or by the claimant if the employer fails to designate one. A change in physician can be mad through a hearing, Utilization Review Order, or at the request of the insurer or claimant

Vocational Rehabilitation

General Information

In Colorado, vocational rehabilitation is not mandatory under the law. However, claimants who refuse rehabilitation may be denied PTD benefits. While undergoing rehabilitation, workers continue to receive TTD benefits. Insurance is responsible for vocational rehabilitation costs.

Workers' Compensation Division Organization Chart



Connecticut

Connecticut Workers' Compensation Commission

21 Oak Street

Hartford, Connecticut 06106

(860) 493-1500

http://wcc.state.ct.us/

Agency

General Information

The Workers' Compensation Commission is the administrative agency created by the Workers' Compensation Act to administer the law. The Workers' Compensation Commission performs Administrative Hearings, with commissioners in eight (8) districts hearing disputed workers' compensation claims. The Workers' Compensation Commission (WCC) is and independent agency and administers the workers' compensation laws of the State of Connecticut with the ultimate goal of ensuring that workers injured on the job receive prompt payment of lost work time benefits and attendant medical expenses. To this end, the Commission facilitates voluntary agreements, adjudicates disputes, makes findings and awards, hears and rules on appeals, and closes out cases through full and final stipulated settlements.

Legislative and Regulatory Links

Connecticut Public Acts
http://wcc.state.ct.us/law/menus/pub-acts.htm

Connecticut Workers' Compensation Act
http://wcc.state.ct.us/law/menus/wc-act-2011.htm

Budget and Financing

The WCC's operating budget is appropriated by the legislature and approved by the Governor.

Agency Funding Source

Each insurer and self-insured employer, except the state or municipality participating in a group pool, is assessed based on the proportion of compensation paid in relation to the total compensation paid, including hospital, medical and nursing care expenses, in the preceding year. The assessment shall not exceed 4% of total compensation and payments made in the preceding year (Connecticut Code Statute 31-345).

2012-2013 Operating Budget/Staff Size

In 2013, the WCC has 117 full-time employees and an operating budget of $18,524,745.

Funds

Secondary Injury Fund

The Second Injury Fund covers per-existing conditions incurred prior to July 1, 1995, including any injuries incurred by accidental injury, disease, or congenital causes and any which may have manifested themselves prior to the compensable episode. In July of 1995, the Workers' Compensation Act is amended and Section 31-349(d) ends the transfer of "second injuries" to the Second Injury Fund. Injuries which occur on or after July 1, 1995 are no longer be transferred. The Act does not lessen the claimant's entitlement to benefits for a second injury. Rather, the Act merely stops the transfer to the Fund of those claims, so that the insurer must remain liable for the life of the claim.

Uninsured Employer's and Insolvent Self-Insurer's Funds

These funds are sub funds of the Second Injury Fund and pay compensation benefits to injured workers if the employer is uninsured or a self-insurer becomes insolvent.

Insurance Requirements and Resources

General Information

In Connecticut, all employees, whether part-time or full-time, are covered under the Workers' Compensation Act from the first day of their employment. Some exemptions apply.

Private Insurance

The Connecticut Insurance Department regulates carriers by issuing licenses, setting rates, and carrying out disciplinary measures.

Connecticut Insurance Department
153 Market Street, 7th Floor
Hartford, Connecticut 06103
(860) 297-3800 or 1 (800) 203-3447
www.ct.gov/cid/

Self-Insurance

To qualify as a self-insurer, an employer must be approved by WCC. An insurance carrier or self-insured employer is required to have a financially solvent company in Connecticut which has authority to issue checks and make necessary decisions, and that complies with the workers' compensation statutes.

Penalties for Not Insuring

WCC seek out employers who do not carry workers' compensation insurance in that state of Connecticut. An uninsured employer can be fined up to $50,000 and can be found guilty of a Class D felony.

Reporting Requirements

First Report of Injury

The filing of employer first reports is mandatory within one week for injuries involving one or more lost workdays and fatalities. There are sanctions for failure to file a first report and the award of compensation may be increased "proportionate to the prejudice that the employee sustained."

Please note that, pursuant to Chairman's Memorandum No. 2008-03, all First Reports of Injury submitted pursuant to Section 31-316 of the Workers' Compensation Act must be transmitted electronically to the Chairman's Office, either by using this online First Report of Injury Submission (FRIS) service or by EDI transmission.

Other Reports/Claims Processing and Monitoring

An employer has 28 days to contest a claim after written notice is received. Other required reports include: a notice of the claim to the employer and a voluntary agreement between employee and insurer.

In order to terminate TTD benefits, insurers must submit a termination form for WCC approval. A district commissioner makes the final administrative decision in determining a claimants' PPD rating.

EDI Standards

Connecticut has mandated use of IAIABC's Claims Release 1 standard.

Contested Case Handling

Appeals Process

Levels in the hearing process are as follows:

1. Informal hearing before responsible district commissioner
2. Formal hearing before responsible district commissioner
3. Compensation Review Board composed of a panel of three or the 16 district commissioners appointed by the chairman of the WCC, none which sat on the hearing levels of the case.
4. Appellate Court

Attorneys' Fees

Responsible district commissioner sets attorneys; fees on a case-by-case basis. The attorney's fee is normally paid by claimant with 20% cap, but if employer/carrier contest the case unreasonably, they may have to pay the attorney.

Compromise and Release Agreements

Compromise and release agreements are allowed in Connecticut.

Medical Care and Evaluation

Fee Schedules

WCC has the authority to set medical practitioner fees. Medical disputes (regarding payment) are resolved by the Commissioners on the Dispute Resolution Panel.

Treatment Guidelines

Connecticut has state specific treatment guidelines for workers' compensation that can be accessed at: http://wcc.state.ct.us/download/acrobat/protocols.pdf

Managed Care

Managed care is permitted, but not mandatory. Managed care is regulated by the WCC.

Choice of Treating Physician

A claimant may choose an attending physician after the initial visit with an employer-designated medical practitioner. If the employer does not participate in an approved medical care plan, the claimant may choose any medical practitioner who is licensed to practice in Connecticut, including practitioners of chiropractic, medicine,naturopathy, osteopathy, and podiatry.

A claimant whose employer does participate in an approved medical care plan must choose a physician from the list of doctors included in that plan. If the employee chooses a physician "outside" the plan, a workers' compensation Commissioner may suspend all rights to workers' compensation benefits. In either case, it is the injured worker who has the right to choose.

A claimant may change their attending physician, if dissatisfied with the medical treatment being rendered. There are three ways in which a claimant may effect a change of physician:

(1) Get a referral from the present attending physician,
(2) Obtain approval to change physicians from the workers' compensation insurance carrier involved (or the employer, if it is self-insured),
OR
(3) Write to the Workers' Compensation Commissioner in the District Office having jurisdiction. Indicate the name, address, and medical specialty of the present physician, as well as the name, address, and medical specialty of the "new" physician, and the reason(s) for requesting a change. In this case, the commissioner could reply by mail or set up an informal hearing.

[NOTE: If the claimant is covered by an approved employer medical care plan, the "new" physician MUST also be a participating practitioner in the plan.]

If a claimant does not have an attending physician's referral to another medical practitioner, or permission to change physicians from the insurer, self-insured employer, or Commissioner, they will most likely be liable to pay for any "unauthorized" medical bills which may arise.

Vocational Rehabilitation

General Information

The Vocational Rehabilitation Unit is part of the Bureau of Rehabilitation Services and is not managed by WCC.

Vocational and physical rehabilitation are provided when ordered by a physician. The Connecticut Rehabilitation Unit is responsible for counseling, testing, placement, and arranging for training programs. An injured worker is entitled to regular compensation or an education stipend (70% of the compensation rate) during rehabilitation training.

Delaware

Delaware Office of Workers' Compensation

4425 North Market Street, 3rd Floor

Wilmington, Delaware 19802

(302) 761-8200

http://dia.delawareworks.com/workers-comp/

Agency

General Information

The Office of Workers' Compensation (OWC) is a section of the Division of Industrial Affairs (DIA) of the Delaware Department of Labor, with authority for administration vested in a single administrator.

Legislative and Regulatory Links

Workers' Compensation Law (Title 19, Chapter 23, Delaware Code): http://delcode.delaware.gov/title19/c023/index.shtml#P-1_0

Rules of the Industrial Accident Board
http://dia.delawareworks.com/workers-comp/documents/Rules%20of%20the%20Industrial%20Accident%20Board.pdf

Budget and Financing

OWC's primary source of operating funds is from an assessment of insurers.

Agency Funding Source

Insurance carriers pay an assessment based on the amount of compensation payments and awards. Self-insured employers are assessed a 4% tax based on the amount of premium they would have paid based on the preceding year's payroll (Delaware Code Statute 23-10-2391-92).

2012-2013 Operating Budget/Staff Size

The OWC's FY 2013 operating budget is $3,922,000.

Funds

Workers' Compensation Fund

The Workers' Compensation Fund is managed by the OWC administrator and financed by an annual assessment on insurers of not more than 1% of premiums received. The Fund covers a combination of two permanent impairments which result in total disability (the second injury must be work related). The employer must have had knowledge of the pre-existing condition. Also, funding is issued when a petition is submitted to OWC with a medical report from an authorized physician. The medical benefits are paid by the employer.

Contingency Fund

The Contingency Fund is managed by the OWC Administrator and is financed by the special fund assessment. The Fund pays total disability and temporary partial compensation while a carrier's petition to terminate is pending. If the carrier is unsuccessful in their petition, they must reimburse the fund.

*Self-insurers do not participate in either of the funds above.

Insurance Requirements and Resources

General Information

Employers with one or more employees are required to carry workers' compensation insurance. Employers may not charge an employee any portion of the premium or expense of carrying workers' compensation insurance. Farm workers are exempt from the workers' compensation statute, however, these employers may elect to provide coverage.

Private Insurance

The Office of the Insurance Commissioner has regulatory authority over carriers. The Delaware Rating Bureau is in charge of setting rates for carriers.

Delaware Department of Insurance
Office of the Insurance Commissioner
841 Silver Lake Blvd.
Dover, Delaware 19904

Self-Insurance

The Delaware Department of Industrial Relations manages self-insurers in the state. In order to receive certification to self-insure, an employer must submit an application to the Department of Insurances with three years of past claims experience and a current financial statement. The staff attorney must decide on application approval. Self-insured employers must post a bond in the amount of $750,000 with the Insurance Commissioner.

Penalties for not Insuring

Pursuant to statute 19DelC§2374e:

(e) Whoever, being an employer, refuses or neglects to comply with the sections referred to in subsection (a) of this section on a continuing basis after notice by the Department of Labor shall be subject to a civil penalty:

(1) As described in subsection (d) of this section on the fifteenth day after notice to comply with subsection (c) of this section; and

(2) An assessment of $10 per day for each employee in the employer's service at the time when the insurance became due, but not less than $250 for each day of such refusal or neglect and until the same ceases.

(3) The employer shall also be liable to the employer's injured employees during continuance of such neglect or refusal, either for compensation under this chapter or in an action at law for damages. In such action, upon proof that the employer has not complied with this section, it shall not be a defense that the:

a. Employee was negligent; or

b. Employee had assumed the risk of the injury; or

c. Injury was caused by the negligence of a fellow employee.

Reporting Requirements

First Report of Injury

The employer must complete and file with their workers' compensation insurance carrier a first report of injury within 10 days of notice of a work accident resulting in personal injury. A first report is required no matter how minor the injury. An employer may be fined $100 to $250 for failure to file a first report of injury. Note: the report is not an admission of liability and cannot be used as evidence in a contested claim

Other Reports/Claims Processing and Monitoring

Other reports available at: http://dia.delawareworks.com/workers-comp/forms.php

EDI Standards

Delaware does not use EDI.

Contested Case Handling

Steps in the hearing process:

1. Hearing before two Industrial Accident Board members with staff attorney/Hearing Officer, or Hearing officer without the Board if this is agreed upon.
    * Pre-trial hearing
    * Hearing on the merits of an appeal petition
    * Hearing on a motion for re-argument
2. Appeal to Superior Court

Attorney Fees

The Industrial Accident Board can issue that attorneys' fees be paid by the employer (not to exceed 30% of the award or ten times the average weekly wage in Delaware, whichever is less. Also, claimant Attorneys' fees are paid out of awards.

Compromise and Release Agreements

OWC may approve lump-sum settlements that are determined to be in the best interest of the injured employee. Settlements terminate a claimant's future rights on the claims; however, medical may remain open. Where both parties are represented by legal counsel, the Director shall approve the settlement.

Medical Care and Evaluation

On January 17, 2007, Governor Ruth Ann Minner signed Delaware's first comprehensive workers' compensation reform into law.

Senate Bill 1 established the Health Care Advisory Panel (HCAP), a 17 member panel with representatives from the medical, legal, labor, business and insurance communities. The purpose of the Panel is to develop and maintain a health care system that eliminates outlier charges and streamlines payments pursuant to 19

Del.C §2322B(a).
The Health Care Payment System (HCPS) went into effect on May 23, 2008, and includes these five major components:

1. A Fee Schedule

2. Health Care Practice Guidelines

3. A Utilization Review program

4. A Certification process for health care providers
5. Forms for employers and health care providers

OWC has authority to set hospital fees for in-patient medical care and approve hospital room rates. The claimant has the right to select and change their treating physician.

Medical Fee Schedule

OWC has authority to set hospital fees for in-patient medical care and approve hospital room rates. Delaware's current medical fee schedule can be found at: http://dowc.ingenix.com/info.asp?page=rules

Treatment Guidelines

Delaware has state specific treatment guidelines for workers' compensation that can be found at: http://dowc.ingenix.com/info.asp?page=pracguid

Choice of Treating Physician

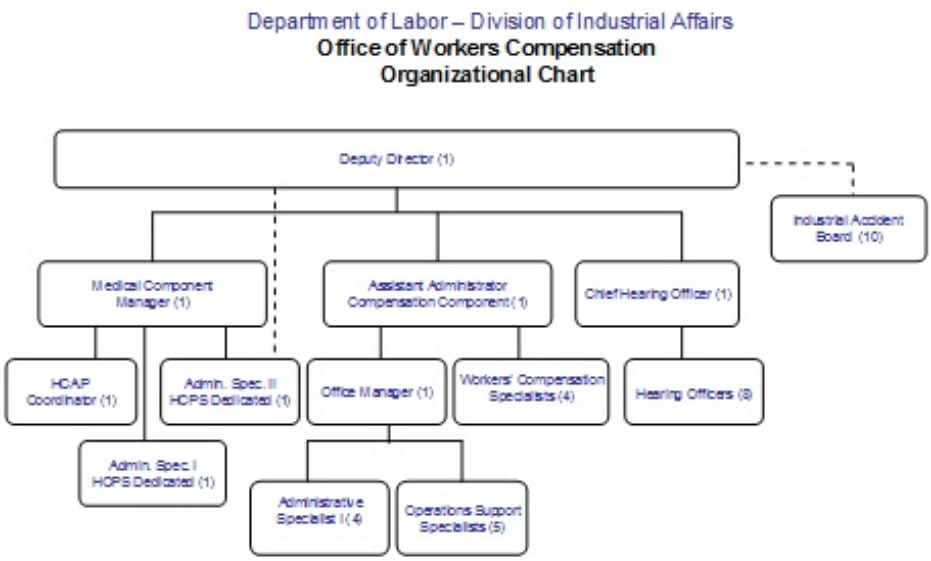
The Health Care Advisory Panel in accordance with 19 Del. C. §2322D, established a certification process for health care providers who treat Delaware's injured workers. The claimant has the right to select and change their treating physician.

Rehabilitation

General Information

The law in Delaware does provide for medical and vocational rehabilitation services for injured workers. The OWC does not operate its own rehabilitation facility. The employer or carrier is responsible for paying for rehabilitation services, full compensation, and additional subsistence benefits while the worker is undergoing rehabilitation. However, an injured worker can be penalized if he/she refuses rehabilitation services.

Workers' Compensation Division Organization Chart



District of Columbia

District of Columbia's Office of Workers' Compensation

4058 Minnesota Avenue, NE, Third Floor

Washington, DC 20019

(202) 671-1000

http://does.dc.gov

Agency

General Information

The District of Columbia's Office of Workers' Compensation (OWC) is part of the Department of Employment Services (DOES), Labor Standards Bureau. The Workers' Compensation Program processes claims and monitors the payment of benefits to injured private-sector employees in the District of Columbia. The office mediates disputes between claimants and employers (or their insurance carriers) and monitors employers to ensure compliance with insurance coverage requirements. The program administers the Special Fund, which provides benefits in cases of uninsured employers or in instances where an injury combines with a pre-existing disability to cause a substantially greater disability. Also, the program approves lump-sum settlements, assesses penalties and fines for non-compliance with the law and monitors vocational rehabilitation. OWC is served by an Association Director, selected under the DC merit system.

Budget and Financing

Budget is provided by assessments against insurance carriers and self-insured employers on approval by the Mayor.

Agency Funding Source

The Workers' Compensation Administration Fund is funded by assessments from insurers and self-insurers. Assessments are based on the gross claims for compensation and medical payments paid by carriers, self-insured employers, and group funds. The amount of assessment shall be based upon the proportion that the total gross claims for compensation and medical payments paid by the carrier and self-insured employer during the calendar year are in relation to the total gross claims during that period. The director determines that the assessment is a percentage of gross claims for compensation and medical payments. The assessment shall not exceed an amount reasonably necessary to defray the necessary administration expense.

2012-2013 Operating Budget/Staff Size

The total operating budget for fiscal year 2013 is $19,662,852 -- Administration: $15,862,852 and Special Fund $3,800,000.

Funds

Special Fund

The Special Fund provides wage loss and medical payments to claimants in cases where an uninsured employer defaults on payments due to insolvency or other circumstances precluding payments. The Fund provides reimbursements to self-insured employers and insurance carriers for compensation and medical payments associated with claims where a claimant with a pre-existing injury or disability receives a second injury which causes a substantially greater disability. The fund also arranges for independent medical evaluations and utilization reviews.

Insurance Requirements and Resources

Private Insurance

Carrying workers' compensation insurance is compulsory in D.C. through either private carriers or self-insurance. The Department of Consumer and Regulatory Affairs has authority over carriers in the areas of issuing licenses and establishing rates. OWC monitors carriers' performance and enforces requirements.

Department of Consumer and Regulatory Affairs
1100 4th Street SW
Washington, DC 20024
(202) 442-4400
http://dcra.dc.gov

Self-Insurance

Requirements for obtaining self-insurance in D.C. can be found in the District of Columbia Municipal Regulations, Title 7, Ch 2 Private Sector Workers' Compensation Program:

http://www.workerscompensation.com/regulations/stateitem.php?ID=2884&state=dc&Parent=342&title=

Penalties for not Insuring

Employers who fail to obtain workers' compensation coverage are guilty of a civil infraction punishable by a fine not less than $1000 and not more than $10,000.

Reporting Requirements

First Report of Injury

It is mandatory for employers to file a first report of injury within ten days of knowledge of the injury. Failure to file will result in fines. OWC monitors employers' first reports for timeliness of reporting and payment, and for unexplained denial.

Other Reports/Claims Processing and Monitoring

Upon notice of controversion or dispute, OWC has informal discussions with the parties involved in effort to mediate the dispute. If no agreement is reached, a conference may be held in which a claims examiner recommends ways to resolve the dispute. If recommendations are rejected, either party has 20 days to file for formal hearing. OWC makes the final decision for determining a claimants PPD rating and OWC used the AMA Guides to Physical Impairment.

EDI Standards

N/A

Contested Case Handling

The Hearings and Adjudication Section of the Labor Standards Bureau holds hearings on contested cases. Administrative Law Judges are responsible for 100% of adjudications. Any party of record can represent disputed claims and continuances may be permitted if good cause is shown. OWC may approve lump-sum settlements that are determined to be in the best interest of the injured employee. Even though settlements terminate a claimant's future rights on the claims, medical may remain open. When both parties are represented by legal counsel, the Director shall approve the settlement.

Medical Care and Evaluation

Fee Schedule

[Development of a link to the Medicare Fee Schedule is underway.]

Treatment Guidelines

There are no specific treatment guidelines for workers' compensation currently utilized in D.C.

Choice of Treating Physician

Claimants may choose their own physician. Once a claimant chooses a treating physician they may not change the physician unless they get approval from employer's insurance company or the Office of Workers' Compensation.

Florida

Florida Division of Workers' Compensation

200 East Gaines Street

Tallahassee, Florida 32399

(850) 413-1600

http://www.myfloridacfo.com/WC/index.htm

Agency

General Information

The Division of Workers' Compensation (DWC) is part of the Department of Financial Services with authority for administration vested in a single administrator. The agency head is given the title of Director and reports directly to the Deputy Chief Financial Officer of the Florida Department of Financial Services.

Mission Statement

To actively ensure the self-execution of the workers' compensation system through education and informing all stakeholders of their rights and responsibilities, leveraging data to deliver exceptional value to our customers and stakeholders, and holding parties accountable for meeting their obligations.

Legislative and Regulatory Links

Florida Workers' Compensation Statutes, Rules, and Forms: http://www.myfloridacfo.com/WC/forms.html

Budget and Financing

DWC's operating budget is approved by the Governor and the Chief Financial Officer of the Department of Financial Services, as appropriated by the legislature.

Agency Funding Source

The assessment is based on net premiums collected for insurers and the amount of premium calculated by the department for self-insured employers. The rate shall not exceed 2.75%. (Florida 440.51)

2012-2013 Operating Budget/Staff Size

DWC, in FY 2012-2013, has a staff size of 301 and an operating budget of $26,232,527.

Funds

Special Disability Trust Fund (Second Injury Fund)

The Special Disability Trust Fund is financed by assessment of insurance carriers and self-insured employers and is managed by the DWC Director. The Fund reimburses remedial medical care and attendance and indemnity benefits that the employer/carrier is required to pay the injured worker on account of the subsequent injury. The employer must have knowledge of the preexisting condition prior to the subsequent injury. In order to receive payment/reimbursement from the Fund, the employer/carrier must submit a Proof of Claim that documents all elements of eligibility, receive and accept an offer of reimbursement from the Fund, and file a fully documented Reimbursement Request form for auditing and approval from the Fund.

Workers' Compensation Administration Trust Fund

The WCATF is administered by DWC to fund the DWC operations.

Insurance Requirements and Resources

General Information

If the employer is unable to obtain coverage through the private insurance market, they may contact the Florida Workers' Compensation Joint Underwriting Association (FWCJUA) at (941) 378-7400 or go to their website at www.fwcjua.com. The employer may also consider leasing employees from a Professional Employer Organization or PEO. In this circumstance, the PEO becomes the employer and provides workers' compensation coverage to each employee who is paid by the leasing PEO.

Private Insurance

The DWC and the Department of Financial Services (DFS), Office of Insurance Regulation (OIR) both regulate workers' compensation insurance carriers, self-insurers, and group self-insurers.

Group Self-Insurance

Pursuant to chapter 624.462, F.S., a group of persons may form a commercial self-insurance fund for purposes of pooling and spreading liabilities for any commercial and/or casualty insurance. Authorization and regulation of commercial self-insurance funds is through the Office of Insurance Regulation.

Individual Self-Insurance

Pursuant to chapter 440.38, F.S., an employer may become individually self insured and secure the payment of workers' compensation by providing proof of financial strength necessary to ensure timely payments of current and future claims. Authorization and regulation of individual self-insurers is through the Division.

Qualifications for self-insurers include:

- Net Worth – The applicant's most recent audited Financial Statements shall show a Net Worth of the greater of $10 million U.S. or three times Standard Premium
- Financial Strength – A current Credit Rating of not less than "Ba3", "BB-", or "BB-" issued by Moody's Investors Services, Standard & Poor's or Fitch Ratings
- Financial Statements – An applicant shall have at least three years of Financial Statements in the name of the applicant
- Proof of approved servicing for claims, loss control and underwriting; and,
- Necessary security deposit and excess insurance

Penalties for not Insuring

The Compliance Bureau enforcement section identifies uninsured employers. Several statutory penalties can be enforced on employers who are found to be working in violation of the Workers' Compensation coverage requirements. These penalties include issuance of a Stop Work Order and criminal misdemeanor charges that may be referred for felony prosecution. A penalty equaling 1.5 times what the employer would have paid in premium for the preceding three years is assessed on employers who fail to secure workers' compensation coverage.

Reporting Requirements

First Report of Injury

Filing of the first report of injury is mandatory for injuries that involve a disability for eight or more days (unless otherwise states), denied lost-time cases, fatalities, cases involving an indemnity payment or payment of a settlement, compensable deaths with no known dependents, compensable volunteers, and medical only cases which become lost time cases . The employer must file a first report of injury with its carrier within seven days of knowledge of the injury (carriers must file electronically with DWC and receive a "Transaction Accepted" Acknowledgement Code within 21 days of knowledge). A fine of up to $1000 may be assessed for not filing a first report timely.

Other Reports/Claims Processing and Monitoring

Time limits for other reports:

- Electronic equivalent of the Notice of Action/Change: on or before 14 days after carrier's knowledge of the new or changed information. A paper copy must also be sent to the Employee and Employer.

- Electronic equivalent of the Notice of Denial: must be received by the Division and receive a "Transaction Acceptance" Acknowledgement Code within 21 days after carrier's knowledge of the injury or notice of death, if initially denying compensability at the time of filing the electronic First Report of Injury, or on or before 14 days after the date the claim administrator decided to deny benefits if totally denying the claim after initially accepting compensability. A paper copy must also be sent to the Employee and Employer.

- Electronic equivalent of the Claim Cost Report: within 30 days after six months from the date of the accident, and every six months thereafter until the claim is closed. If the claim is closed prior to six months after the date of accident, the electronic Claim Cost Report may be sent prior to six months after the date of injury as a final report.

Permanent Impairment and Permanent Total Disability ratings are determined based on medical evidence and utilizing the 1996 Florida Uniform Permanent Impairment Rating Schedule.

EDI Standards

Florida mandates the use of IAIABC Claims Release 3 and Proof of Coverage (POC) Release 2.1 for EDI reporting.

Contested Case Handling

Steps in the judicial process:

1. Petition for benefits filed with the Division of Administrative Hearings
2. Optional binding arbitration process
3. Mediator assigned
4. If mediation remains unresolved, a pretrial hearing is set.
5. If the mediation still remains unresolved, a hearing is set before the Judge of Compensation Claims.

Attorneys' Fees

Attorneys' fees come out of the claimant's award (specific regulations apply). If there is a written offer to settle 30 days prior to the trial, the attorney is entitled to fees based only on benefits secured above the settlement offer. The claimant is responsible for his/her Attorneys' fees. However, claimant's attorneys may also recover Attorneys' fees from the carrier or employer if awarded by a Judge of Compensation Claims.

Compromise and Release Agreements

Settlements agreements are allowed for all parties involved. A settlement agreement may terminate indemnity and medical benefits. Medical benefits may be maintained in settlements agreements. A claim cannot be reopened after a settlement agreement unless claimant shows that it was signed under duress or was not understood.

Medical Care and Evaluation

Fee Schedules

The three member panel determines statewide schedules of maximum reimbursement allowances for medically necessary treatments, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment.
http://www.myfloridacfo.com/WC/provider/reimbursement-manuals.html

Treatment Guidelines

Florida does not have treatment guidelines for workers' compensation.

Choice of Treating Physician

The employer or carrier will provide a list of authorized providers to the employee to choose from. A change of physician form the original one selected by the employer may be authorized by the carrier, except in managed care arrangements. Upon written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment.

Managed Care

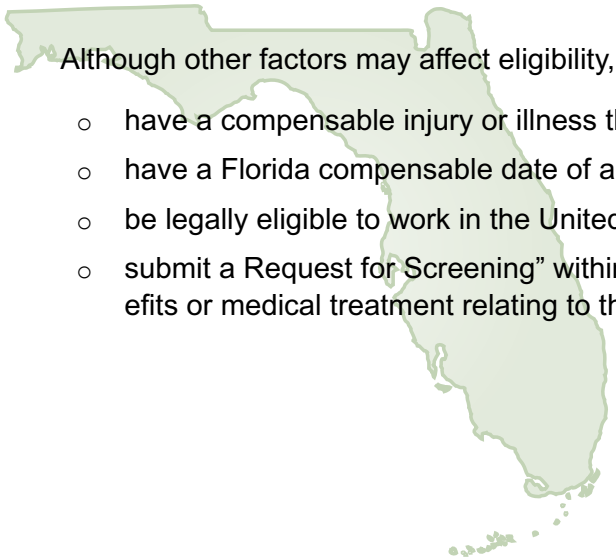
Managed care arrangements are allowed but are optional.

Rehabilitation

General Information

Vocational rehabilitation is a voluntary service provided under the law.

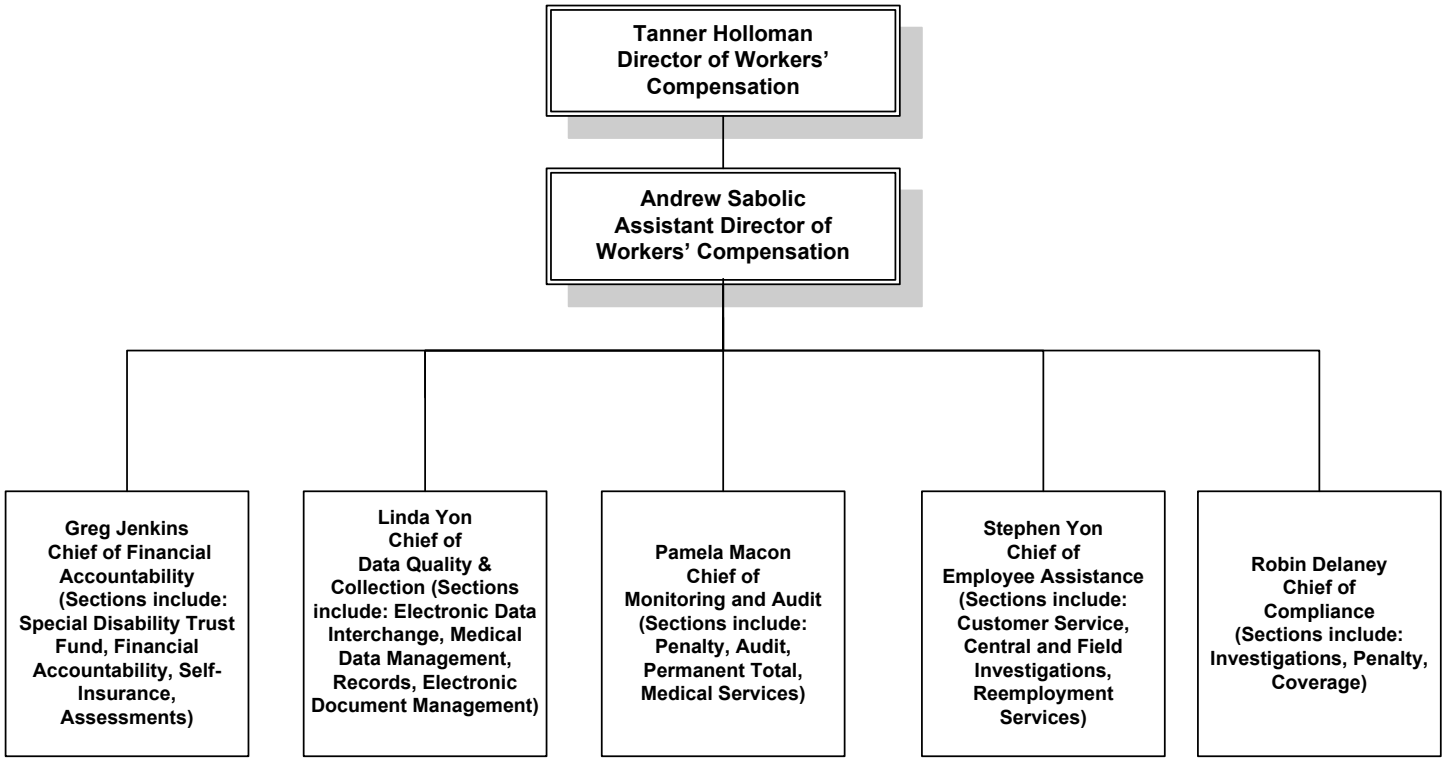
Reemployment services are services designed to help an injured worker return to work when their work-related injury or illness prevents them from returning to their usual line of work. Reemployment services may include vocational counseling, job-seeking skills training, job analysis, transferable skills analysis, selective job placement, training and education or other services deemed necessary and appropriate to help an injured worker return to work. The workers' compensation carrier may voluntarily provide these services or an injured employee may request these services from the Division of Workers' Compensation, Employee Assistance and Ombudsman Office.



Although other factors may affect eligibility, the injured worker must, at minimum,:

- have a compensable injury or illness that is covered under the Florida Workers' Compensation Law;
- have a Florida compensable date of accident on or after 10/01/1989;
- be legally eligible to work in the United States, and
- submit a Request for Screening" within one year (365 days) of last receipt of indemnity (lost wage) benefits or medical treatment relating to the injury.

Florida Division of Workers' Compensation – December 2012



Georgia

Georgia State Board of Workers' Compensation

270 Peachtree Street, NW

Atlanta, Georgia 30303

(404) 656-3875 or (800) 533-0682

http://sbwc.georgia.gov/

Agency

General Information

The Georgia State Board of Workers' Compensation (SBWC) is an independent agency. The responsibility for administration is vested in a three-member Board which is appointed to four year terms by the Governor. The Chairman of the Board serves as the head of the agency and reports to the Governor.

Legal functions for the central office are provided by branch offices in Augusta, Albany, Dalton, Columbus, Covington, Gainesville, Rome, Macon, and Savannah.

Mission Statement

To provide superior access to the Georgia Workers' Compensation program for injured workers and employers in a manner that is sensitive, responsive, and effective and to insure efficient processing and swift, fair resolution of claims, while encouraging workplace safety and return to work.

Legislative and Regulatory Links

Georgia Workers' Compensation Rules and Statutes: http://sbwc.georgia.gov/statutes-and-rules

Budget and Financing

Agency Funding Source

Insurers pay a pro-rated share of expenses based on their gross earned premium in the previous year. Self-insured employers pay a pro-rated share based on what their premiums would have been (Georgia 34-9-63). Funds are placed in Georgia's general fund for distribution by the legislature in the usual budgetary review.

2012-2013 Operating Budget and Staff Size

Staff Size: 146
FY13 Recommended Budget: $21,955,175

Funds

Subsequent Injury Trust Fund

On July 1, 1977, The Georgia General Assembly enacted legislation establishing the Subsequent Injury Trust Fund. It is designed to reduce the impact of singularly-large workers' compensation claims in the event a worker with a disability is injured on the job, and aggravates a pre-existing impairment.

The Fund helps workers with disabilities by providing employers, who are not subject to the Americans with Disabilities Act, with incentives to hire or retain qualified workers with disabilities, and assists all insured employers by keeping workers' compensation premiums under control. If an employer is self-insured, it keeps the workers' compensation exposure at the deductible levels. Although the Subsequent Injury Trust Fund is a separate state agency, the State Board of Workers' Compensation and the Fund work closely together.

The Fund is financed by annual assessments on insurers and self-insurers which equal an insurer's proportional share of 175% of the fund's total disbursement minus the fund's net assets for the preceding year.

Self-Insurers Guaranty Trust Fund

This Fund is managed by an administrator and governed by a board of trustees. The Fund is financed by an assessment on self-insurers. The purpose of the Fund is to provide the continuation of benefits due and unpaid in the event that a self-insured employer becomes insolvent.

More information available at: http://gaguaranty.com/

Insurance Requirements and Resources

General Information

Every employer, individual, firm, association, or corporation, regularly employing three or more persons, part-time or full-time, shall provide workers' compensation insurance coverage. Exempted officers of corporations or exempted members of limited liability companies shall not reduce the number of employees for this purpose.

The Enforcement Division employs compliance officers who conduct random and compliant based inspections of businesses to insure proper coverage or exemption. These inspections are aided with the cooperation of the State Department of Labor and the NCCI database.

Private Insurance

The Office of the Commissioner of Insurance regulates Georgia's active insurance carriers by issuing permits to write insurance and monitoring performance, reporting, and payment.

Georgia Office of the Commissioner of Insurance
Two Martin Luther King, Jr. Drive
West Tower, Suite 704
Atlanta, Georgia 30334
Main Telephone: (404) 656-2070
Toll Free: (800) 656-2298
Fax: (404) 657-8542

Self-Insurance

Employers desiring to be self-insured must file an application with the Board and include three years audited financial statements and a $500.00 application fee made payable to the Georgia Self-Insurers Guaranty Trust Fund. If the application is approved by both the Board and the Trust Fund, a surety bond or letter of credit will be required. The amount of security that is required is determined after a thorough review of the application and financial statements.

Penalties for not Insuring

Any person who willfully fails to file any form or report required by the Board, fails to follow any order of the Board, or violates any rule or regulation of the Board shall be assessed a civil penalty of not less than $100.00 or more than $1 ,000.00 per violation.

Any person who knowingly and intentionally makes any false or misleading statement for the purpose of obtaining or denying benefits or payment under the law may be assessed a civil penalty of not less than $1 ,000.00 or more than $10,000.00 per violation. The Board may assess a civil penalty of not less than $500.00 or more than $5,000.00 per occurrence for violation of an employer's duty to provide coverage under the Workers' Compensation Act.

Number of penalties assessed in FY2012: 514
Dollar amount of penalties assessed in FY2012: $508,958

Reporting Requirements

First Report of Injury

Immediately upon knowledge of an injury, an employer must complete and file with its insurer's or self-insurer's claims office an Employer's First Report of Injury or Occupational Disease. Injuries involving seven or more days of lost time must be reported to the Board within 21 days of the employer's knowledge of disability. Failure to file timely reports with the Board and/or make timely payment of income benefits will result in late payment penalties and may result in late filing penalties and the assessment of Attorneys' fees.

Other Reports/Claims Processing and Monitoring

Yearly Report of Medical Only Cases
Notice of Payment or Suspension of Benefits
Notice of Controvert
Case Progress Report
Wage Statement (filed when weekly benefit is less than the maximum).

The attending physician determines the PPD ratings. In controverted cases, an administrative law judge or the Appellate Division makes the final determination of a claimant's PPD rating using the AMA Guide to Physical Impairment.

EDI Standards

The SBWC Electronic Filing Mandate in 2009 requires that all new lost time claims with date of injury after June 30, 2009 or new lost time claim be submitted via EDI. The Board granted a final extension to organizations until September 1, 2010 to implement IAIABC Release 3.0 EDI transmission of all new lost time claims and the subsequent supported forms.

Contested Case Handling

Appeals Process

For a contested case, the levels of litigation are as follows:

1. Hearing before an Administrative Law Judge, Trial Division
2. Appellate Division accepts findings of the Administrative Law Judges when supported by a preponderance of competent evidence.
3. Appeal to Superior Court, mandatory review, any evidence standard.
4. Appeal to Court of Appeals, discretionary review, any evidence standard.
5. Appeal to Georgia Supreme Court, discretionary review, any evidence standard.

	Notes or Comments on Scope	Number in FY2012
Hearing before ALJ	Awards issued	710 Fiscal Year
Appeal to Superior Court		135
Appeal to Court of Appeals	Not filed with SBWC	
Appeal to Georgia Supreme Court	Not filed with SBWC	

Attorneys' Fees

SBWC approves attorneys' fees up to 25% of income benefits due to the claimant. Claimant's counsel will be paid a percentage of the claimant's benefits unless the Attorneys' fees are assessed against the employer/insurer for cause.

Compromise and Release Agreements

Compromise and release agreements are allowed. Stipulated settlement agreements must be approved by SBWC, and generally terminate entitlement to additional income and medical benefits due on that claim. The agreement is final once it has been approved by SBWC.

Medical Care and Evaluation

Fee Schedule

SBWC has the authority to set medical and hospital fees.
For more information of medical fee schedule visit: http://sbwc.georgia.gov/medical

Treatment Guidelines

Georgia does not have treatment guidelines for workers' compensation

Managed Care

Managed care is permitted and regulated by SBWC. However, it is not mandatory. For information on Managed Care in Georgia visit: http://sbwc.georgia.gov/managed-care-rehabilitation-0

Choice of Treating Physician

Employers must select ONE of the following three options to provide medical care for injured employees. The choices will be known as Option 1, Traditional Panel Of Physicians; Option 2, Conformed Panel Of Physicians and; Option 3, a panel listing a Workers' Compensation Managed Care Organization certified by the Board.

Option 1. The employer may maintain a Traditional Panel of Physicians that shall consist of at least six non-associated physicians, but is not limited to six. However, the Board may grant exceptions to the required size of the panel where it is demonstrated that more than six physicians or groups of physicians are not reasonably accessible. The minimum panel shall include an orthopedic physician, and no more than two physicians shall be from industrial clinics. This panel shall include a minority physician, where feasible.

Option 2. The employer may maintain a list of physicians that shall be known as the Conformed Panel of Physicians, which shall include a minimum of 10 physicians or professional associations. The physicians and groups listed on the panel shall be counted as a separate choice from the others listed only if they are not associated with other physicians or groups on the panel. This panel shall include the same physicians required in the Traditional Panel of Physicians plus a chiropractor and a general surgeon.

Option 3. The employer or workers' compensation insurer of an employer may contract with a Workers' Compensation Managed Care Organization certified by the Board. A "Workers' Compensation Managed Care Organization" means a plan certified by the Board that provides for the delivery and management of treatment to injured employees under the Georgia Workers' Compensation Act. The managed care organization must include minority providers.

Rehabilitation

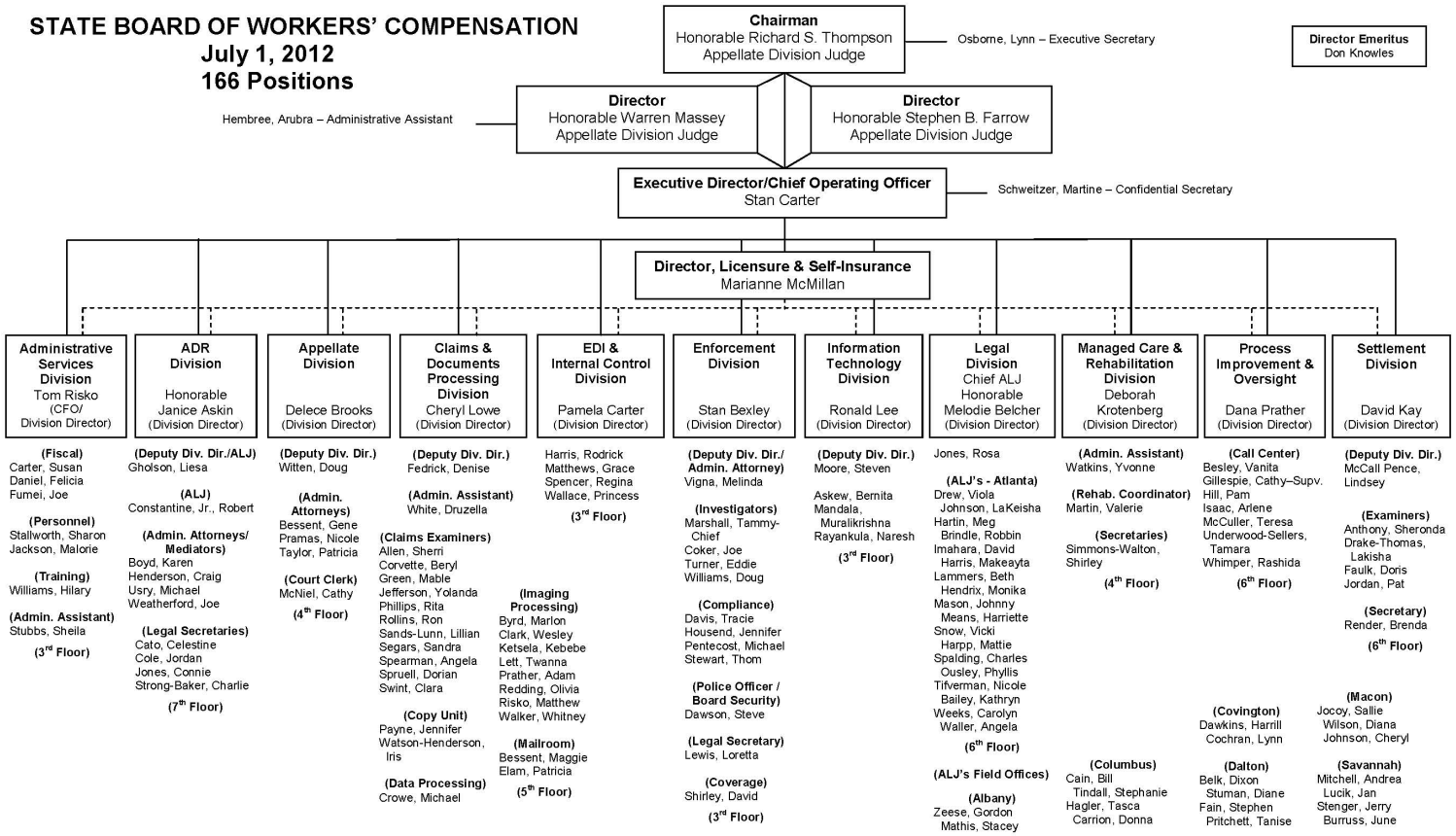
General Information

Vocational and physical rehabilitation are provided. Rehabilitation is mandatory in the event of a catastrophic injury. If an injury is not catastrophic, the parties may elect that the employer will provide a rehabilitation supplier on a voluntary basis for so long as the parties agree in writing.

SBWC must approve all catastrophic rehabilitation plans. Direct job placement must be ruled out before training is considered. TTD and medical benefits are provided during rehabilitation. insurers and self-insured employers pay for rehabilitation.

The SBWC uses the following criteria dot determine a successful rehabilitation case:
- return to work with the same of similar employer;
- retrain and place in another job; or
- achieve maximum independent living.

Workers' Compensation Division Organization Chart



Hawaii

Hawaii Disability Compensation Division

830 Punchbowl Street, Room 209

P.O. Box 3769

Honolulu, Hawaii 96813

(808) 586-9161

http://labor.hawaii.gov/

Agency

General Information

The Disability Compensation Division (DCD) is part of the Department of Labor and Industrial Relations and administers the Workers' Compensation (WC) law, the Temporary Disability Insurance (TDI) law, and the Prepaid Health Care (PHC) law. All employers with one or more employees, whether working full-time or part-time, are directly affected.

Mission Statement

To alleviate the economic hardships that result from the loss of wage income due to work or non-work connected disability and provide vocational rehabilitation opportunities and incentives for industrially injured workers.

Legislative and Regulatory Links

Hawaii Revised Statutes and Administrative Rules: http://labor.hawaii.gov/dcd/find-a-law/

Budget and Financing

Agency Funding Source

DCD's primary source of operating funds are the General Fund and the Special Compensation Fund that are appropriated by the legislature and approved by the Governor.

2012-2013 Operating Budget/Staff Size

Staff Size: 82
FY 2013 Operating Budget: $27,879,719.

Funds

Special Compensation Fund

The SCF is administered by the Director of Labor and Industrial Relations and is financed by assessment of insurance carriers, self-insured employers, and penalty payments.

The SCF is responsible in cases involving pre-existing injuries in which the employer has provided notice to the SCF. Employer liability for PPD, PTD, and death benefits compensation is limited to 104 weeks in certain second injury cases, after which the SCF assumes liability. The employer is responsible for medical and TTD benefits.

The Special Compensation Fund also provide workers' compensation benefits to employees of delinquent or bankrupt employers, benefit adjustment payments, and concurrent employment benefits.

Insurance Requirements and Resources

General Information

Any employer, other than those excluded below, having one or more employees, full-time or part-time, permanent or temporary, is required to provide workers' compensation coverage for the employees.

Excluded employment includes voluntary or unpaid workers for a religious, charitable, educational or nonprofit organization; student workers performing services for a school, university or college club in return for room, board or tuition; duly ordained, commissioned or licensed minister, priest or rabbi; domestic workers earning less than $225 (cash) per calendar quarter; domestic workers of public welfare recipients; certain twenty-five percent stockholders; all fifty percent stockholders; real estate salespersons and brokers paid solely on a commission basis; individuals and members with fifty per cent distributional interest of limited liability companies or limited liability partnerships; partners of a partnership; and sole proprietors. An employer may, however, elect to cover the excluded employees.

Private Insurance

Workers' Compensation insurance is provided by private insurance carriers. Call the Insurance Division (808) 586-2790 of the Department of Commerce and Consumer Affairs for names of authorized Hawaii WC carriers.

Self-Insurance

The director of labor and industrial relations approves applications for self insurance. The qualifications to self-insure in Hawaii include requirement pertaining to financial strength, securities, excess insurance and other factors.

Penalties for not Insuring

Penalties for not insuring include $250, or $10 for each employee for every day of noncompliance, whichever is greater, or possible injunction if default continues in excess of 30 days.

Number of penalties assessed in FY2012: 29

Dollar amount of penalties assessed in FY2012: $202,005.84

Reporting Requirements

First Report of Injury

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.)

Other Reports/Claims Processing and Monitoring

Other Reports:

http://labor.hawaii.gov/dcd/forms/

DCD monitors the payments of claims. In order to terminate TTD benefits, the employee and DCD must be notified in writing at least two weeks prior to date of last payment (a hearing is not always necessary). A claim may be settled by compromise and release agreement, or the DCD Director can make a final administrative decision for determining a claimant's PPD rating based on the following factors:

- Impairment rating of independent medical examination physician;
- Employee factors (age, education, training, etc.); and,
- Use of the AMA Guide to Physical Impairment.

EDI Standards

Hawaii does not use EDI for claims or medical reporting. Hawaii will implement mandatory POC 3.0 10/1/13

Contested Case Handling

For a contested case, the levels of litigation are as follows:

1. DD Hearing before a hearing officer

2. Labor Appeals Board

Attorneys' Fees

DCD approves attorneys' fees individually on the basis of experience, complexity of case, and size of award. The claimant's attorneys fees are a lien on the claimant's award.

Compromise and Release Agreements

Compromise and release agreements are allowed if approved by DCD. A C&R agreement may terminate indemnity and medical benefits. A claim cannot be reopened after a C&R agreement if reopening is waived.

Medical Care and Evaluation

Fee Schedule

For more information of medical fee schedule visit: http://labor.hawaii.gov/dcd/files/2012/11/2-28-11-MFS-Web-ver-4.18.13.pdf

Treatment Guidelines

The director of labor and industrial relations issues guidelines for the frequency of treatment and for reasonable utilization of medical care and services by health care providers that are considered necessary and appropriate under the WC law. These guidelines are published in the Hawaii Medical Fee Schedule Administrative Rules.

Choice of Treating Physician

Injured employees are allowed choice of treating physician. Injured employees must notify employer prior to first change of physician. Subsequent changes require prior approval by employer or DCD.

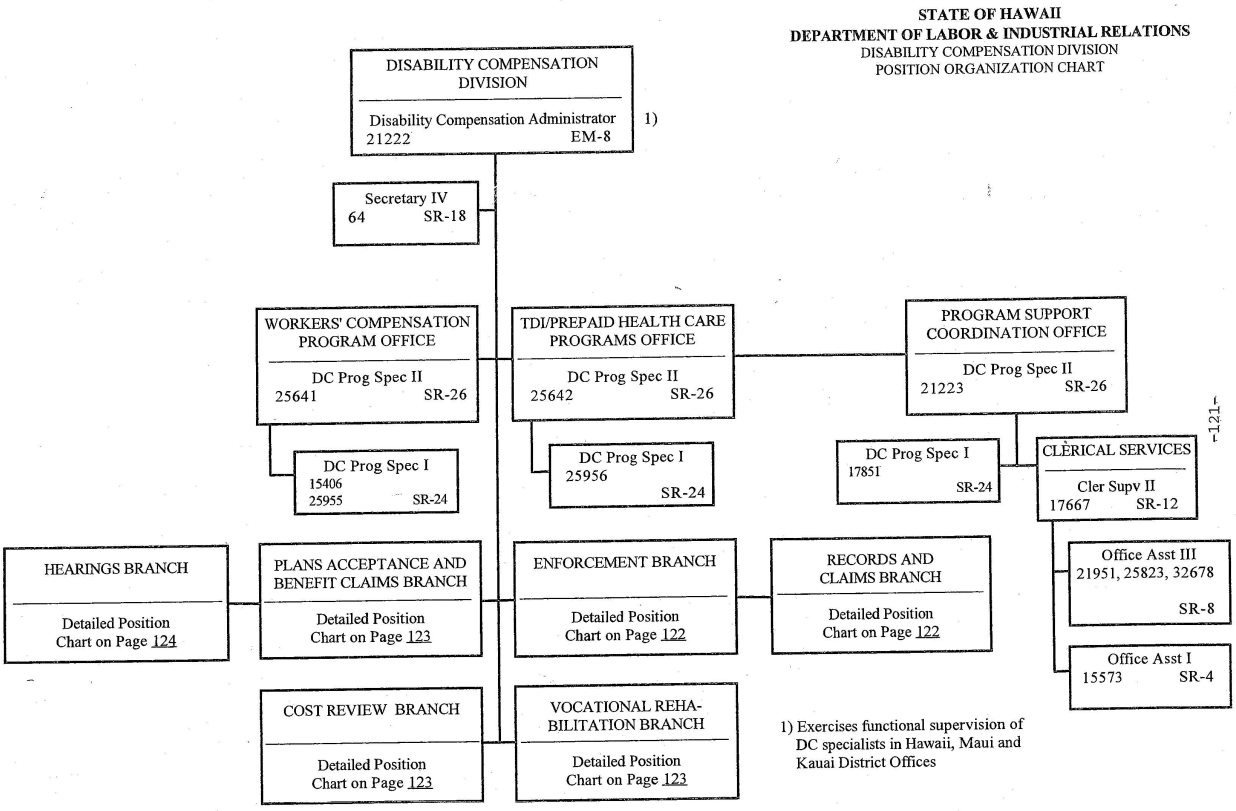
Rehabilitation

General Information

Vocational rehabilitation is provided and an injured worker qualifies for rehabilitation if he/she has or may have a permanent partial disability (PPD) and cannot return to work. Employee must be receiving temporary total disability (TTD) benefits.

The DCD's rehabilitation section insures that referrals are appropriate and provides quality control of services. DCD employs rehabilitation professionals in the private sector and must approve rehabilitation plans and has final authority over the claimant's acceptable progress and reemployment. Vocational rehabilitation is a voluntary program, during which claimants receive TTD benefits. Rehabilitation is paid by the DCD special fund, insurers, and employers.

Workers' Compensation Division Organization Chart



Idaho

Idaho Industrial Commission

700 S. Clearwater Lane

P.O. Box 83720

Boise, Idaho 83720

(208) 334-6000

http://www.iic.idaho.gov/

Agency

General Information

The Industrial Commission (IC) is an independent agency. The Industrial Commission receives guidance from the Workers' Compensation Advisory Committee. The Committee will seek public input and participation in its deliberations.

The Industrial Commission is the state agency responsible for:

- Regulating workers' compensation activities in Idaho, including companies licensed to issue workers' compensation policies.
- Settling disputes between injured workers and insurers.
- Deciding appeals for unemployment decisions from the Idaho Department of Labor.
- Ensuring that employers have workers' compensation coverage as required by law.
- Providing compensation to innocent victims of crime through the Crime Victims Compensation Program.

Mission Statement

To impartially and efficiently administer the Idaho Workers' Compensation Law in a manner that ensures compliance with insurance requirements, prompt and accurate benefit payments, equitable judicial review and dispute resolution, and quality vocational rehabilitation services for injured workers.

To assist innocent victims of crime recover from the traumatic effects of crime by providing financial assistance and community education in accordance with state and federal law.

Legislative and Regulatory Links

Idaho Rules and Laws: http://www.iic.idaho.gov/laws/laws.html

2012 links for legislation:

http://iic.idaho.gov/2012_legislation/2012_legislation.html

http://iic.idaho.gov/2013_legislation/2013_legislation.html

Budget and Financing

Agency Funding Source

The Industrial Administration Fund is funded by a premium tax on carriers and self-insured carriers. Each insurance carrier pays a 2.5% premium tax on net written premiums (less a 1.3% tax payable to the department of insurance). Each self-insured employer pays a 2.5% tax on what their premiums would have been. Assessments are collected every six months and can be no less than $75 per organization (Idaho 72-523).

2012-2013 Operating Budget/Staff Size

Staff Size: Average employee count for FY12 133.5 and FY13 was 135
FY 2013 Operating Budget: $2.5 million

Funds

Industrial Special Indemnity Fund

The Industrial Special Indemnity Fund (ISIF) is administered by the Department of Administration. This fund applies when pre-existing partial disabilities plus subsequent industrial partial he fund is financed by a prorated assessment on indemnity payments made by insurers and self-insured employers.

Read more about ISIF: http://adm.idaho.gov/indemnity/

Insurance Requirements and Resources

General Information

Employers with one or more full-time, part-time, seasonal, or occasional employees are required to maintain a workers' compensation policy unless specifically exempt from the law. Workers' Compensation is required to be in place when the first employee is hired.

Private Insurance

The Department of Insurance exercises regulatory authority over insurance carriers by issuing and revoking licenses and establishing premium rates and classifications.

Idaho Department of Insurance
700 West State Street
P.O. Box 83720
Boise, Idaho 83720

Self-Insurance

To qualify as a self-insurer in Idaho, an employer must demonstrate that it meets regulatory requirements of the IC. Once an audit is performed by the IC staff, self-insured status may be granted by the IC.

Penalties for not Insuring

Employers who operate without workers' compensation insurance can be liable for a penalty of $2.00 per day per employee or $25.00 per day, whichever amount is greater. The Workers' Compensation Law authorizes the Industrial Commission to file a lawsuit in district court to obtain an injunction prohibiting the employer from operating the business while in violation of the Workers' Compensation Law.

Operating a business without workers' compensation insurance is a misdemeanor under Idaho law and the employer may be subject to criminal penalties.

Number of penalties assessed in FY2012: 368 investigations
Dollar amount of penalties assessed in FY2012: $2,818,903

Reporting Requirements

First Report of Injury

The filing of employer first reports is mandatory when the injured employee requires physician treatment or loses one or more workdays. Initial reports must be filed with IC within 10 days after the accident or exposure to disease.

Other Reports/Claims Processing and Monitoring

Other Reports:
Supplemental reports must be filed upon terminations of disability, or within 60 days of occurrence if employee is still disabled.

Failure to file reports is a misdemeanor.

IC performs compliance audits to ensure that sureties are maintaining workers' compensation files in accordance with the IC's in-state adjusting rule, and it also audits closing documentation on indemnity claims.

Permanent disability and contested claims are subject to IC approval. The IC makes final administrative decisions for determining a claimant's PPD rating in contested claims. The factors that are used to determine a claimant's PPD rating are as follows:
- Impairment rating of attending physician
- Employee factors (age, education, training, etc)
- Loss of wage earning capacity due to anatomic impairment

EDI Standards

Idaho uses IAIABC's EDI Claims Release 1 standards to report on a voluntary basis and mandates of use of the IAIABC Proof of Coverage 2.1 standard for reporting. Idaho has plans to move to Claims Release 3 and POC Release 3 in the future.

Contested Case Handling

To read more about the disputed case handling in Idaho, visit: http://iic.idaho.gov/disputed_claims/disputed_claims.html

Hearings are held upon application or when ordered by IC to determine issues. Cases are heard by Commissioners or attorney referees. Final decisions of the Commissioners are appealable directly to the Idaho Supreme Court.

	Notes or Comments on Scope	*Number in FY2012*
Hearing before a Hearing Officer		95 hearings held
Labor Appeals Board		951 Unemployment Appeals

Attorneys' Fees

Attorneys' fees are generally paid out of the claimant's award. As penalty for unreasonable denial, delay or defense of claims, the IC may award attorneys' fees to the claimant from the employer/insurer.

Compromise and Release Agreements

Idaho Code requires that a lump sum settlement be approved by the Industrial Commission before it can be a legally binding document. Settlements must be in the best interests of all parties, and must be approved by at least two of the three Commissioners.

The Commission may request additional information or action regarding the claim. Parties have the right to request a hearing to review the settlement and the Commission's decision. If a settlement is not approved the claim remains in pre-settlement status.

Medical Care and Evaluation

Fee Schedule

IDAPA 17.02.09 governs payments for medical services under the Idaho Workers' Compensation Law. The FY 2012 annual adjustment to the medical fee schedule has been made in accordance with Section 72-803, Idaho Code, and is effective July 1, 2012.

Proposed Rule Change

The Commission has submitted a Proposed Rule, Docket No. 17-0209-1201, including an annual adjustment to the physician fee schedule and the establishment of a pharmaceutical fee schedule.

Treatment Guidelines

No treatment guidelines specific to workers' compensation.

Managed Care

Idaho's rule doesn't address managed care.

Choice of Treating Physician

Under the Idaho workers' compensation system, the employer/surety may assign a medical provider to treat the injured worker. However, the worker may appeal that assignment to the Idaho Industrial Commission.

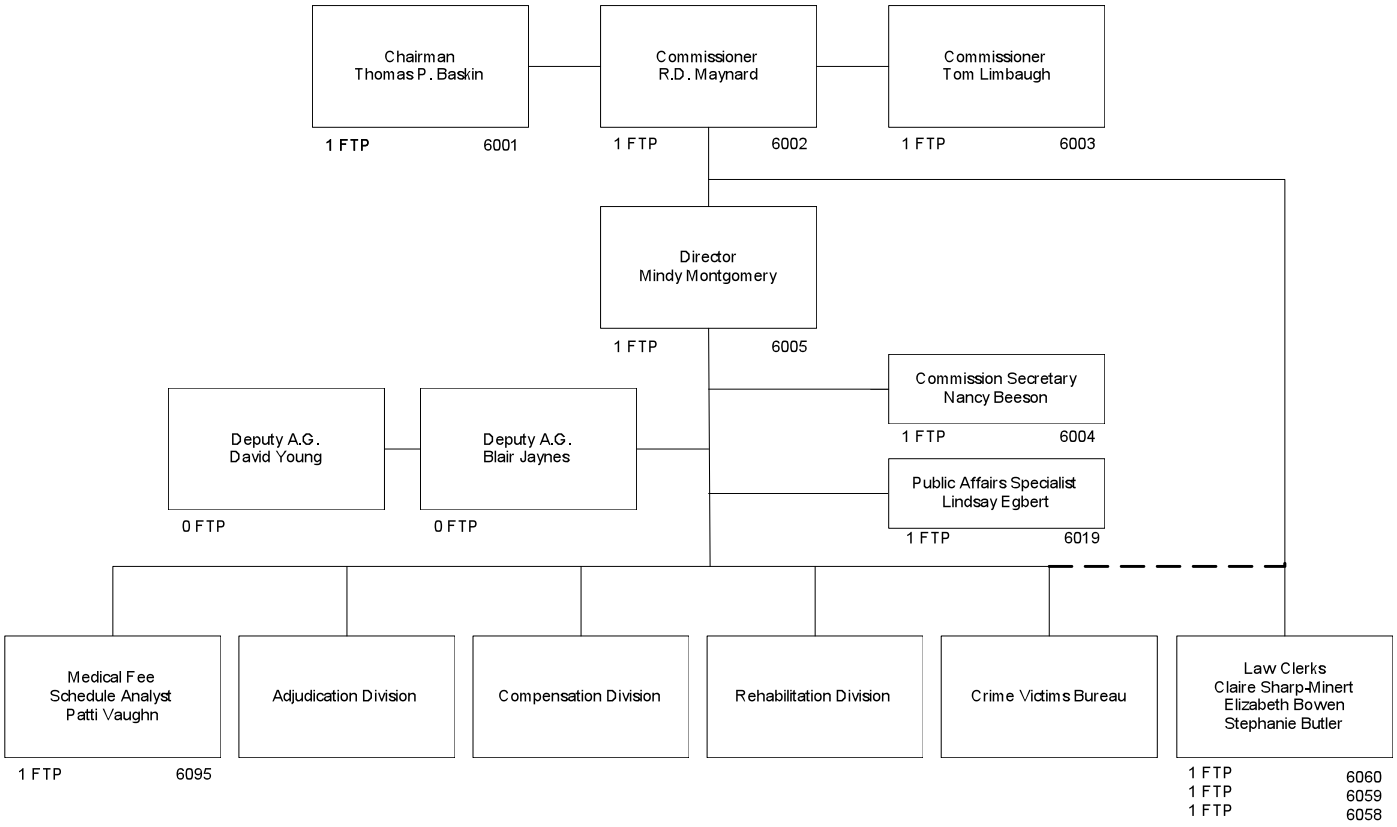
Rehabilitation

General Information

Voluntary vocational and rehabilitation is provided. IC administers and employs rehabilitation consultants. Claimants who unreasonably refuse rehabilitation or persist in practices which imped recovery may have compensation suspended or reduced. Retraining expenses are paid by the employer/carrier. When a worker is sent to an IC-approved facility, they are paid a daily subsistence allowance to cover reasonable expenses of board, lodging, and transportation. If IC orders retraining, the claimant is paid TTD or TPD benefits during the retraining period.

IDAHO INDUSTRIAL COMMISSION

February 1, 2013



Idaho Industrial Commission Organization Chart, Page 1

Illinois

Illinois Workers' Compensation Commission

100 W. Randolph Street, #8-200
Chicago, Illinois 60601
(312) 814-6611
http://www.iwcc.il.gov/

Agency

General Information

The Illinois Workers' Compensation Commission (IWCC) is an independent State agency responsible for the administration of the Workers' Compensation Act and Workers' Occupational Diseases Act. Administration is vested in ten commission members. The head of the agency is the Chairman, who reports to the Governor.

Mission Statement

The Illinois Workers' Compensation Commission resolves disputes that occur between injured workers and their employers regarding workers' compensation. The Commission strives to assure financial protection to injured workers and their dependents at a reasonable cost to employers.

The Commission performs four main functions:

1) Resolves disputes. The Commission strives to provide a fair, timely process by which disputed claims may be resolved.

2) Ensures compliance with the law. The Commission protects the rights of employees and employers under the Illinois Workers' Compensation and Occupational Diseases Acts.

3) Administers self-insurance. The Commission evaluates and approves eligible employers that wish to insure themselves for their workers' compensation liabilities.

4) Collects statistics. The Commission compiles information on work-related injuries and diseases in order to encourage sound risk management and work safety programs.

The Commission strives to accomplish these goals while looking constantly for ways to improve the quality of service and treating the public and co-workers with respect. The success of this organization depends on the commitment and full participation of every member.

Legislative and Regulatory Links

Illinois Workers' Compensation Act: http://www.iwcc.il.gov/workers.htm
Illinois Workers' Compensation Rules: http://www.iwcc.il.gov/rules.htm

Budget and Financing

IWCC's operating budget is appropriated by the legislature and approved by the Governor.

Agency Funding Source

Insurance carriers: Each year, the Illinois Department of Insurance (IDOI) collects a 1.01% surcharge on workers' compensation insurance premiums from insurance carriers. It sends out an assessment letter each July. Payment is due 30 days after the assessment is sent.

Self-insured employers: Each year, the IWCC collects an assessment of .0075% of payroll from self-insured employers.

2012-2013 Operating Budget/Staff Size

Staff Size: Currently there are 166 employees, including the chairman and commissioners.

FY 2013 Operating Budget: The recommended FY 2013 operating appropriation for IWCC is $24,695,300

Funds

Second Injury Fund

Illinois Compiled Statutes, Chapter 820, Paragraph 305, Sections 7-8

First established in the 1950s, the Second Injury Fund provides an incentive to employers to hire disabled workers. Illinois' SIF is more narrowly constructed than most other states. If a worker who had previously incurred the complete loss of a member or the use of a member (one hand, arm, foot, leg, or eye) is injured on the job and suffers the complete loss of another member so that he or she is permanently and totally disabled (PTD), the employer is liable only for the injury due to the second accident. The fund pays the amount necessary to provide the worker with a PTD benefit.

Injured Workers' Benefit Fund

The Injured Workers' Benefit Fund was created in 2005 (820 ILCS 305/4(d)).

When the Commission collects penalties and fines from uninsured employers, it deposits these monies into the IWBF. The IWBF then pays workers' compensation benefits to injured employees whose uninsured employers failed to pay.

Since 2006, the Commission has collected over $7 million in fines and brought over 700 uninsured employers with thousands of workers into compliance. The Commission has paid $6.8 million in workers' compensation benefits to 157 injured workers whose uninsured employers failed to pay them. Without the IWBF, these workers and their medical providers might not have received the benefits they were due.

Rate Adjustment Fund

The Rate Adjustment Fund was created in 1975 to pay cost-of-living increases to individuals who are either permanently and totally disabled or the survivors of fatally injured workers. Individuals who receive awards for permanent and total disability or death benefits are eligible. Benefits are paid each month, beginning on July 15 of the second year after the award is entered by the Commission. Recipients are given an amount equal to the percentage increase in the statewide average weekly wage, as calculated by the Department of Employment Security.

Self-Insurers Security Fund

Illinois Compiled Statutes, Chapter 820, Paragraph 305, Sections 4a-5, 4a-7

The Self-Insurers Security Fund was created in 1986 to pay benefits to employees of private self-insurers that became insolvent after 1986.

Self-insured employers pay assessments based on their compensation payments, up to a maximum of 1.2% of compensation payments, excluding hospital, surgical, or rehabilitation payments, made during the preceding year.

Insurance Requirements and Resources

General Information

Illinois law requires employers to provide workers' compensation insurance for almost everyone who is hired, injured, or whose employment is localized in Illinois. Sole proprietors, business partners, corporate officers, and members of limited liability companies may exempt themselves. Overall, it is estimated that 91% of Illinois employees are covered under the Workers' Compensation Act.

Private Insurance

The Division of Insurance has regulatory authority over workers' compensation insurance carriers.

Illinois Division of Insurance
320 West Washington Street
Springfield, Illinois 62767
(217) 782-4515

Self-Insurance

IWCC regulates individual self-insurers by granting the self-insurance privilege and handling outstanding workers' compensation claims of insolvent self-insurers.

Qualifications to self-insure:

- Employer must file an application, submit a current audited financial statement and pay a non-refundable application fee of $500 per entity.
- Employer must demonstrate financial strength sufficient to meet workers' compensation obligations and furnish security, indemnity, and/or surety bonds.
- Employer may be required to purchase excess liability or catastrophe insurance.

Penalties for not Insuring

An employer that knowingly and willfully fails to obtain insurance may be fined up to $500 for every day of non-compliance, with a minimum fine of $10,000. Corporate officers can be held personally liable if the company fails to pay the penalty. Fines are deposited into the Injured Workers' Benefit Fund.

In addition, corporate officers who are found to have negligently failed to obtain insurance are guilty of a Class A misdemeanor; if they are found to have knowingly failed to obtain insurance, they are guilty of a Class 4 felony.

An employer that knowingly fails to obtain insurance loses its protections under the Workers' Compensation Act. An employee who is injured during the time the employer was uninsured may sue the employer in civil court, where benefits are unlimited. In addition, during the trial the burden will be upon the employer to prove it was not negligent.

The Commission may issue a work-stop order on an employer that has been found to have knowingly failed to provide insurance. The employer must then stop all business operations until it provides proof of insurance.

Statute: Section 4(d)

Number of penalties collected in FY2012: 218 employers paid penalties
Dollar amount of penalties collected in FY2012: $1.0 million

Reporting Requirements

First Report of Injury

The First Report of Accident is mandatory for injuries involving more than three lost workdays and all fatalities. In accidental death cases, reports should be filed no later than two working days after death; all other initial reports required within a month). Failure to file a first report is a petty offense.

Other Reports/Claims Processing and Monitoring

An Employer's Supplemental Report is also required.

EDI Standards

Illinois uses the IAIABC's Claim Release 1 for filing on a voluntary basis.

Filing a Claim

If an employee chooses to file a claim, the case is assigned a case number and scheduled for a status call. Cases may be continued for three years or longer, if warranted. The IWCC adjudicates disputed claims and holds hearings. (There can be any number of issues.) Commission members make the final administrative decision for determining a claimant's PPD rating based on:

- A physician's report based on the latest version of the AMA Guides.
- The occupation of the injured employee;
- The age of the employee at the time of the injury;
- The employee's future earning capacity; and
- Evidence of disability corroborated by the treating medical records.

Contested Case Handling

Levels in the hearing process include:

1. Arbitration
2. Commissioners' review

	Number in FY2011 (FY12 not available)
Arbitration	3,171 decisions, 43,081 settlements
Commissioners' Review	1,405 decisions, 243 settlements

Attorneys' Fees

IWCC approves attorneys' fees subject to guidelines that fee shall not exceed 20% of disputed benefits recovered, or in PTD cases, 20% of 364 weeks of compensation. Fees for claimant's attorneys are paid out of award. Fees may be assessed against employer or insurance carrier in cases of unreasonable and vexatious delay of benefits.

Compromise and Release Agreements

Compromise and release (C&R) agreements are allowed when approved by the IWCC. The C&R agreement may terminate indemnity and medical benefits if so agreed by the parties. Claim may be reopened after a C&R agreement, if the parties agree. Generally, the right to reopen is waived by the agreement.

Medical Care and Evaluation

Fee Schedule

IWCC has the authority to set medical and hospital fees.
https://iwcc.ingenix.com/download.asp

Treatment Guidelines

Illinois does not currently have treatment guidelines for workers' compensation.

Managed Care

Managed care organizations are not prohibited, subject to employee's choice of physician rights.

Choice of Treating Physician

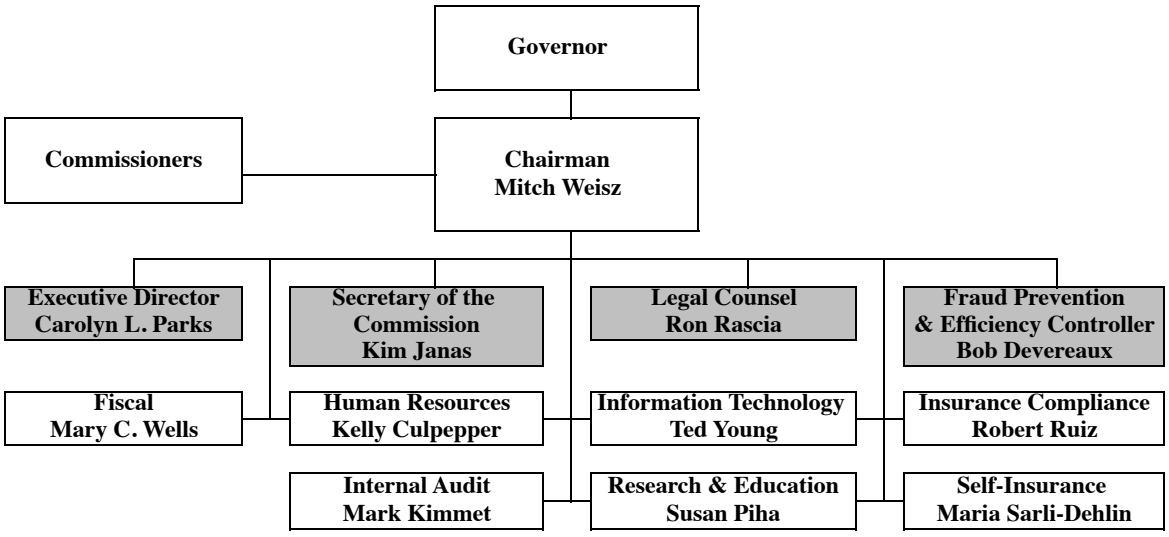
Employer must pay for all reasonable and necessary treatment rendered by the employee's first two choices of physicians and all physicians in the chain of referral from the first two physicians.

Rehabilitation

General Information

Vocational and physical rehabilitation are provided under the statute when the employee is unable to work for more than 120 continuous days or when it can be reasonably determined that worker can return to work. Benefits may be terminated if the employee fails to cooperate in rehabilitation. While undergoing therapy, a worker receives maintenance at the TTD rate. Rehabilitation is paid for by the insurers and employers.

Workers' Compensation Division Organization Chart



Indiana

Indiana Worker's Compensation Board

402 West Washington Street Room W-196

Indianapolis, Indiana 46204

(317) 232-3809

http://www.in.gov/wcb/

Agency

General Information

The Workers' Compensation Board of Indiana (WCB) is an independent agency with the responsibility for workers' compensation vested in a seven-member board.

Mission Statement

To provide efficient dispute resolution for injured workers and employers by administering both formal adjudication and informal dispute resolution services; to serve the public by answering inquiries regarding the Indiana Worker's Compensation system; and to collect statistical information regarding workplace injuries in Indiana.

Legislative and Regulatory Links

Indiana's Workers' Compensation Act: http://www.state.in.us/legislative/ic/code/title22/ar3/

Budget and Financing

Agency Funding Source

WCB's primary source of operating funds is the state's general fund which is appropriated by the legislature and approved by the state budget agency and the Governor.

2012-2013 Operating Budget/Staff Size

The FY 2012-13 operating appropriation for WCB was $4,832,965
http://www.in.gov/sba/files/ap_2011_all.pdf

Funds

Second Injury Fund

Second Injury Fund Report 2012: http://www.in.gov/wcb/files/2012_SECOND_INJURY_FUND_REPORT.pdf
The Second Injury Fund covers subsequent loss or loss of use of a hand, arm, leg, foot, or eye that the employee had previously lost or lost the use of. The employee is liable only for the second injury; the Fund pays the resulting permanent and total disability caused by the combined injuries. No formal notification to the employer of the pre-existing condition is required. The Fund pays continuing benefits in increments of 150 weeks to a permanently and totally disabled worker who has exhausted the maximum compensation permitted by the Act. It also pays for the lifetime repair or replacement of artificial members, braces or prosthodontics resulting from the amputation of a body part, enucleation of an eye, or loss of natural teeth occurring as a result of a compensable injury.

The Fund is financed by assessment on insurers and self-insurers at a maximum amount of 2.5% of the total compensation paid for the prior year.

Supplemental Administrative Fund

This fund provides an additional source of operating revenue and comes from annual fees paid by self-insured employers and individuals filing Independent Contractor Clearance Certificates.

Insurance Requirements and Resources

General Information

Indiana employers are required to carry insurance to cover their liability for workers' compensation medical benefits and disability compensation. Employers who wish to be self-insured must apply to the Worker's Compensation Board for authorization. Employers are prohibited from using payroll deductions to cover the cost of worker's compensation insurance. An employee's right to worker's compensation may not be waived.

Private Insurance

The Indiana Compensation Rating Bureau and the Department of Insurance have regulatory authority over insurance carriers.

Indiana Compensation Rating Bureau
5920 Castleway, West Drive
Indianapolis, IN 46250
317.842.2800 or 800.622.4208
Fax: 317.842.3717

The Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN, 46204.
Main Phone: (xxx) xxx-xxxx.

Self-Insurance

WCB regulated self-insurers in the state. WCB determines whether an employer can obtain self-insured status by examining the employer's financial statements and comparing net worth to prior loss experience to determine the employer's ability to meet obligations.

Indiana's self-insured employers: https://wcbnec03.wcb.state.in.us/si_list.asp

Penalties for not Insuring

Indiana's penalties for not carrying workers' compensation insurance include a fine of up to $10,000, injunctions, and employees injured while working for an uninsured employer may be entitled to double compensation.

Reporting Requirements

First Report of Injury

The electronic filing of employer first reports is mandatory for all injuries involving one or more lost workdays or fatalities. Reports must be filed within seven days of the injury or knowledge thereof.

Other Reports/Claims Processing and Monitoring

Other report time limits:

Request for an independent medical examination: within 7 days after the employee receives notice of denial.

Report of last payment or lump-sum award- within 10 days of payment.

WCB is in charge of monitoring the payment of claims for their promptness. WCB also is responsible for approving agreements regarding a claimant's PPI rating, based on medical evaluation. Factors for determining PPI ratings include: use of the American Orthopedic Guide; and use of the AMA Guide to Physical Impairment.

EDI Standards

Indiana mandates use of the IAIABC's Claim Release 1 and Proof of Coverage.

The IWCB will use standards set forth by the International Association of Industrial Accident Boards and Commissions. These standards allow for consistency and continuity for reporting concerns. The Board will accept both flat and ANSI X12 formats with a preference for flat files. The Board feels that flat files provide a simpler model of the file format and provide easier integration into our system.

Contested Case Handling

Levels in the hearing process include:

1. Formal hearing held by a member of WCB
2. Formal review hearing before the full Board.
3. Court of Appeals, with appeal to the Supreme Court.

	Notes or Comments on Scope	*Number in FY2012*
WCB Formal Hearing		3741
Full Board Formal Review		141
Court of Appeals		150
Supreme Court		

Attorneys' Fees

Attorneys' fees are paid from awards and are subject to approval by the WCB.

Compromise and Release Agreements

Compromise and Release Agreements are allowed if approved by the Chairman of WCB. If so stated, a C&R agreement terminates indemnity and medical benefits. A claim may be reopened after a C&R if allowed by the agreement.

Medical Care and Evaluation

Treatment Guidelines

Indiana does not have specific treatment guidelines for workers' compensation.

Managed Care

Managed care organizations are authorized and may be selected by the employer.

Choice of Treating Physician

The employer has the right to select an employee's physician. Second opinions are at the claimant's expense, unless an insurer agrees to pay. Any change of physician requested by an employee must be approved by WCB if the employer rejects the request.

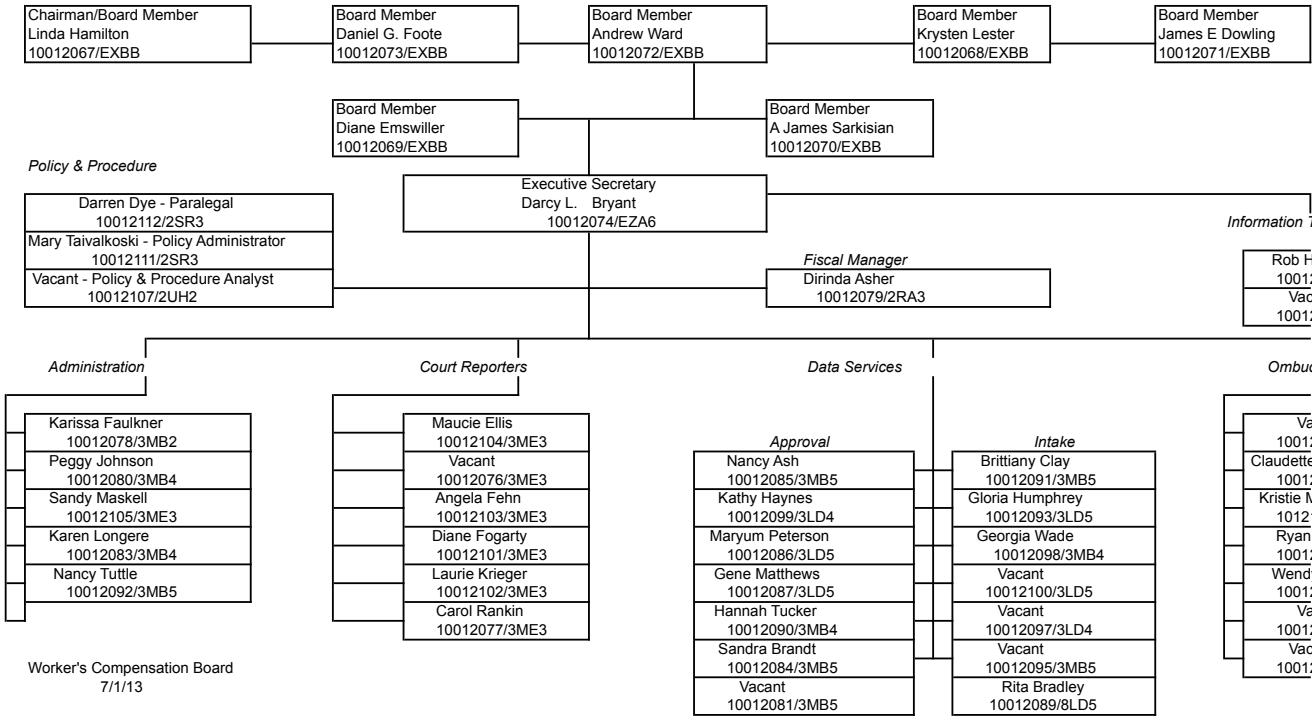
Rehabilitation

General Information

Vocational rehabilitation is provided and appropriate cases are referred to the State Office of Vocational Rehabilitation, which pays for the program if the claimant is eligible.

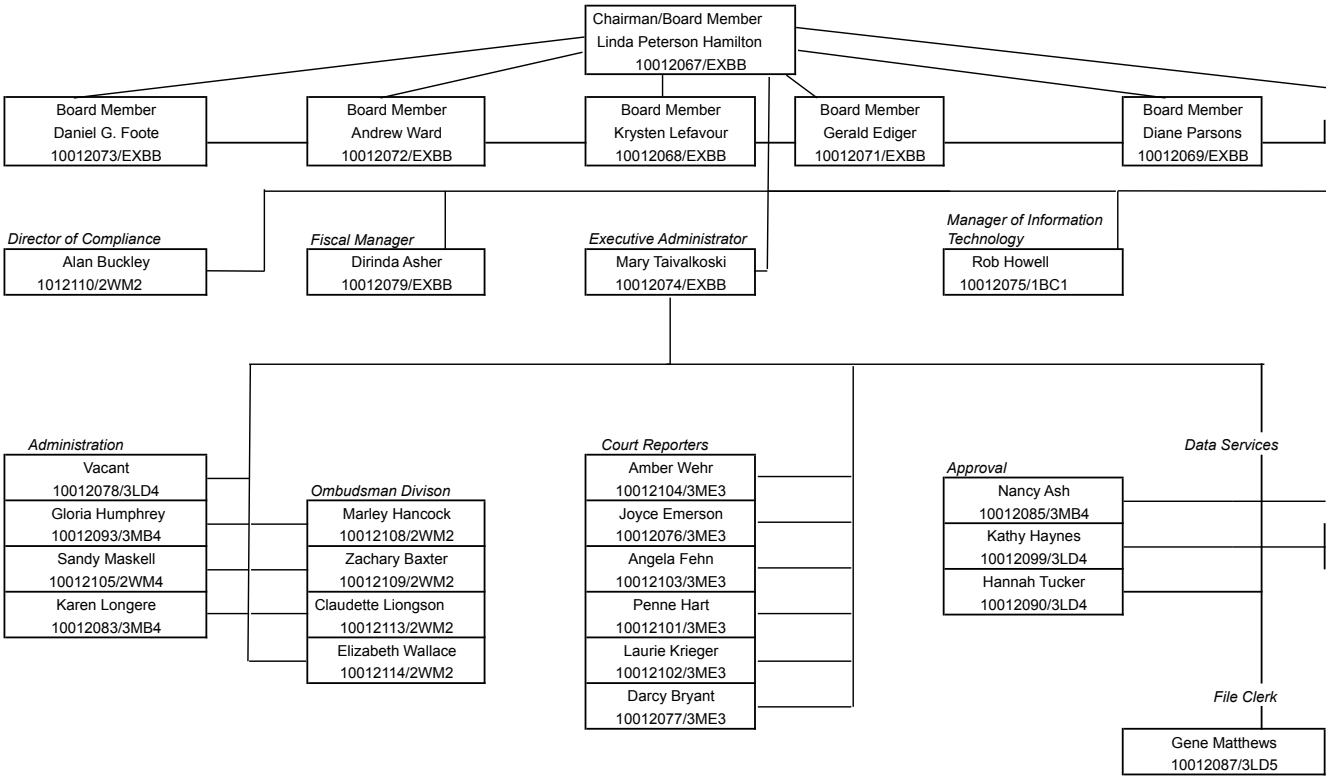
Workers' Compensation Division Organization Chart

Worker's Compensation Board Current Organizational Chart



Agency Telephone Number: (317) 232-3808
Toll Free Telephone Number: 1-800-824-2667 (COMP)

Worker's Compensation Board Current Organizational Chart



Agency Telephone Number: (317) 232-3808
Toll Free Telephone Number: 1-800-824-2667 (COMP)

Iowa

Iowa Division of Workers' Compensation

1000 East Grand Avenue
Des Moines, Iowa 50319
(515) 281-5387 or (800) JOB-IOWA
http://www.iowaworkforce.org/wc/

Agency

General Information

Iowa's Division of Workers' Compensation (DWC) is part of the Workforce Development Department. The responsibility for workers' compensation is vested in a single administrator, the Workers' Compensation Commissioner.

The Workers' Compensation Division performs three core functions: adjudicating disputed workers' compensation claims, enforcing compliance standards and educating Iowans about workers' compensation law and procedures. Iowa's Workers' Compensation Commissioner, oversees this division of Iowa Workforce Development. The Workers' Compensation Division is working on the development of a new system that will create a truly electronic and paperless system for Iowa. Division staff continued an emphasis on providing statewide educational presentations on the topic of workers' compensation and the division website continues to provide information to thousands of visitors.

Mission Statement

Iowa Workforce Development (IWD) strives to improve the income, productivity and safety of all Iowans. In conjunction with state and local economic development efforts, IWD also assists businesses to fulfill their workforce needs. The majority of IWD services are mandated by state and federal laws and regulations.

Iowa Workforce Development (IWD) will contribute to Iowa's economic growth by providing quality customer-driven services that support prosperity, productivity, health and safety for Iowans. (Mission Statement: Iowa Workforce Development).

Legislative and Regulatory Links

The Iowa Workers' Compensation Laws under Iowa Code Chapters: 85, 85A, 85B, 86 & 8

Iowa Workers' Compensation Rules: http://search.legis.state.ia.us/nxt/gateway.dll/ic?f=templates&fn=default.htm

Budget and Financing

Agency Funding Source

DWC's primary source of operating funds is the State's general fund, which is appropriated by the legislature and approved by the Governor.

2012-2013 Operating Budget/Staff Size

Staff Size: 24

FY 2013 Operating Budget: The Governor's 2013 recommended appropriations for DWC is $2,949,044

Appropriation Goals

Administer, regulate, and enforce the Workers' Compensation Occupational Disease and Occupational Hearing Loss laws. Develop and implement a scheduling program which allows for speedy resolution of Worker's Compensation Occupational Disease and Occupational Hearing loss issues while protecting the rights of the litigants. Maintain a computerized index system for litigated Workers' Compensation cases. Reduce the time between the filing of a contested Workers' Compensation case and filing of a final decision. Monitor claims to assure compliance with the law. Conduct and take part in conferences and training sessions in relation to WC.

Provide vocational rehabilitation counseling and referral services. Develop recommended amendments to the Workers' Compensation Laws. Reduce litigated claims by encouraging information exchange between parties. Conduct alternate dispute resolution conferences with the goal of speedy resolutions of contested cases.
http://www.dom.state.ia.us/index_files/Complete_FY2013_Budget_Report.pdf

Funds

Second Injury Fund

Iowa's Second Injury Fund compensates for the loss of major body scheduled members, excluding fingers and toes, when there has been a prior loss of a different member. The employer is liable for only the degree of disability which would have resulted from the latter injury if there had been no pre-existing disability.

The Second Injury Fund is funded by assessment on fatal injuries, a surcharge on all employers, and compliance penalties. The state treasurer has responsibility for administering the fund.
The Iowa Insurance Division has announced that sufficient funds are not available to meet the liabilities of the Second Injury Fund. Therefore, an assessment will be imposed upon insurers and self-insured employers in the State of Iowa. The assessment is $5.6 million. Notices were e-mailed from the office of the Iowa Insurance Division on September 10, 2012. The assessment amount is due pursuant to the mailed notices by October 10, 2012.

Insurance Requirements and Resources

General Information

Most employers are required to purchase workers' compensation liability insurance. Insurance is mandatory if you have eligible employees, unless you apply to the Iowa Insurance Commissioner to become self-insured.

Private Insurance

The Iowa Insurance Division has regulatory authority over insurance carriers.

Iowa Insurance Division
330 Maple Street
Des Moines, Iowa 50319
(515) 281-5705

Self-Insurance

The Iowa Insurance Division also exercises regulatory authority over self-insured employers. To quality as a self-insurer, the applicant must exhibit the financial ability to pay claims to a self-insurance examiner appointed by the Insurance Commission.

Penalties for not Insuring

Willful violation of the workers' compensation insurance requirement is a Class "D" felony in Iowa. Uninsured employers may be liable for employee's benefits and damages in a civil action suit.

Number of penalties assessed in FY2012: Not applicable
Dollar amount of penalties assessed in FY2012: Not applicable

Reporting Requirements

First Report of Injury

Filing of employer first reports is mandatory if the injury results in more than three lost workdays or a fatality. First reports are required within 11 days of notice or knowledge of injury or death. There is a civil assessment of $1000 for failure to file a first report.

Other Reports/Claims Processing and Monitoring

Electronic report of first and subsequent reports of injury is mandatory as of July 1, 2001.

DWC monitors payment of claims primarily through adjudicated cases. Claimants are allowed to initiate inquiries into denials or delays by insurers. Termination of TTD benefits results when the employee has returned to work or is medically capable of returning to employment substantially similar to the employment in which the employee was engaged in at the time of the injury, whichever occurs first. The Workers' Compensation Commissioner is in charge of making the final decision for determining a claimant's PPD rating in adjudicated claims. The factors that DWC uses to determine a claimant's PPD rating are:

- Impairment rating of attending physician;
- Employee's loss of wage earning capacity;
- Criteria as set forth by courts;
- Employee factors (age, education, training, etc); and,
- Use of the AMA Guide to Physical Impairment.

EDI Standards

Iowa has been accepting Employers First Reports of Injury via EDI since 1996. This is under Release 1 of the IAIABC's EDI Program. Release 1 provides for one transmission for the Employers First Reports of Injury and one transmission for Supplemental Reports.

In August of 1997 Iowa became the first state to receive the IAIABC's Release 2 Beta EDI Program for testing. Release 2 is an enhancement of Release 1 that expands the information that can be transmitted and combines the Employers First Reports of Injury and Supplemental Report into a single transmission.

The Beta program was tested in partnership with Employers Mutual Insurance Companies, Inc.. This test was completed in May of 1998. Release 2 was released for production nationwide following successful completion of the Beta in Iowa. Iowa placed Release 2 into production on July 1, 1999, with the Employers Mutual Insurance Companies, Inc..

Iowa has mandated use of the EDI Release 2 standards for reporting of First Reports of Injury and Supplemental Reports of Injury. Effective July 1, 2001, the state of Iowa will no longer accept paper forms for the reporting requirements for work injuries in Iowa.

Contested Case Handling

Levels in the hearing process include:

1. Hearing before a Deputy Workers' Compensation Commissioner
2. Review by the Workers' Compensation Commissioner
3. District Court
4. Iowa Supreme Court

	Notes or Comments on Scope	Number in FY2012
Hearing before Deputy WC Commissioner		623
Hearing before WC Commissioner	Appeal cases pending	282
District Court	Appeal cases pending	110
Iowa Supreme Court	Appeal cases pending	29

Attorneys' Fees

DWC approves attorneys' fees. Approval is only required in disputed cases.

Compromise and Release Agreements

C&R agreements are allowed with the approval of the Workers' Compensation Commissioner or designee. The agreement terminates indemnity and medical benefits and the claim cannot be reopened.

Medical Care and Evaluation

Fee Schedule

No medical fee schedule

Treatment Guidelines

Iowa does not have treatment guidelines for workers' compensation

Managed Care

Authorization of managed care organizations (PPOs or HMOs) is implied by the employer's right to select care.

Choice of Treating Physician

The employer selects the worker's treating physician. To change physician, the employee must petition DWC for alternative care. DWC has independent medical examination overseen by both parties. One medical examination is paid by the employer and the employee selects the physician. If more examinations are needed, the employee must pay.

Rehabilitation

The Iowa Division of Vocational Rehabilitation Services (DVRS) assists eligible individuals with disabilities to prepare for, obtain and maintain employment. An employee may be entitled to a payment of $100.00 ($20.00 for injuries occurring prior to September 7, 2004) per week (up to 13 weeks) if the employee is actively participating in a vocational rehabilitation program. An additional 13 weeks may be paid if approved by the workers' compensation commissioner.

Criteria for successful rehabilitation is determined when an employee can return to work.

Kansas

Kansas Division of Workers' Compensation

401 Southwest Topeka Blvd, Suite 2

Topeka, Kansas 66603

(785) 575-1460

Toll-free (800) 292-6333

http://www.dol.ks.gov/WorkComp/Default.aspx

Agency

General Information

The Kansas Division of Workers Compensation (DWC) is a division of the Kansas Department of Labor. The responsibility for administration is vested in the DWC Director, who is appointed by the Secretary of Labor.

Mission Statement of Kansas Department of Labor

"We enhance the economic wellbeing of all Kansans through responsive workforce services."

Legislative and Regulatory Links

Kansas Workers' Compensation Laws and Regulations: http://www.dol.ks.gov/Files/PDF/lawsRegs.pdf

Budget and Financing

Agency Funding Source

Each insurance carrier, self-insurer group or group-funded workers' compensation pool is assessed annually based on benefits paid in the previous year. The statutory cap on the maximum amount collected from each carrier, self-insured employer or group funded pool is 3% of their total benefits paid by that organization.

2012-2013 Operating Budget/Staff Size

Staff Size: 85
FY 2013 Operating Budget: $10,900,000

Funds

Workers' Compensation Fund

Kansas' Workers' Compensation Fund is administered by the Kansas Insurance Department. This fund pays uncollectible benefits to employees of insolvent and uninsured employers.

Insurance Requirements and Resources

General Information

The present law (see K.S.A 44-505) covers all Kansas employers except for those in certain agricultural pursuits or those with a gross annual payroll of $20,000 or less. All payroll is taken into account, including that paid outside Kansas. If the employer is a sole proprietor or a partnership, the wages paid to the owners and any of their family members are not used in the computation of the gross annual payroll.

Employment categories excluded from the law are:

- Certain agricultural pursuits
- Realtors who qualify as independent contactors
- Firefighters belonging to a firefighters relief association which has waived coverage under the workers' compensation law
- Sole proprietors and partners

Private Insurance

The Kansas Insurance Department regulates workers' compensation insurance carriers .

Kansas Insurance Department
420 SW 9th Street
Topeka, Kansas 66612
(785) 296-3071

Self-Insurance

DWC regulates individual self-insurers:

- Reviews applications by individual employers who wish to operate as a self-insured entity.
- Annually reviews existing permits to see if each company still meets the criteria to be self-insured in the State of Kansas, pursuant to K.S.A 44-532 and K.A.R 51-14-4

To qualify as a self-insurer in Kansas, an employer must furnish proof of a substantial financial rating and ability to pay all necessary benefits; and, post a surety bond or letter of credit up to amount of potential outstanding liability.

Penalties for not Insuring

Failure to secure payment of workers' compensation is a class C misdemeanor and is subject to fines of $25,000 or twice the annual premium, whichever is higher.

Reporting Requirements

First Report of Injury

Injured workers are required to report injuries within the earliest of 30days of the accident, 20 days from obtaining treatment, or if no longer working for the employer, within 20 days of the last day of actual work for the employer. . Also, occupational diseases must be reported within 90 days of disablement. Employers are required to file accident reports with the Division within 28 days. The Division has adopted mandatory electronic accident reporting using IAIABC Release 3 to be phased in during 2013.

Other Reports/Claims Processing and Monitoring

DWC is in charge of monitoring accident reports, and employees are advised to contact the Ombudsmen or Claims Advisory Section if claims are not handled correctly.

Factors that are used to determine a claimant's PPD rating include:

- Impairment ratings based on AMA Guides to Evaluation of Permanent Impairment, 4th Edition.
- Employee's loss of wage earning capacity; and,
- Employee's loss of ability to perform work tasks that employee performed during the 5 years previous to the incident.

EDI Standards

EDI FAQs: http://www.dol.ks.gov/WorkComp/FAQedi.aspx

Kansas utilizes the IAIABC Claims Release 1.0 standard for reporting of the First Report of Injury (FROI) and Subsequent Report of Injury (SROI) on a voluntary basis. Plans are in the works to implements Claims Release 3.0 in 2013.

Contested Case Handling

Levels in the hearing process include:

1. Formal hearing before an administrative law judge
2. Appeals before the Workers' Compensation Appeals Board
3. Appeal to Kansas Appellate Courts

	Notes or Comments on Scope	*Number in FY2012*
Hearing before and ALJ	Prevailing Factor Standard	5,961 Hearings
Appeal before the Workers' Compensation Board	De Novo on the Record	357 Decisions

Attorneys' Fees

Administrative Law Judges have the authority to approve or disapprove attorneys' fees. The fees may not exceed a specified percentage of the award.

Compromise and Release Agreements

Compromise and Release agreements are allowed unless disapproved by the Director. The agreement may terminate indemnity and medical benefits, and a claim may be reopened in cases of fraud, misconduct, or undue influence.

Medical Care and Evaluation

Fee Schedule

http://www.dol.ks.gov/WorkComp/MedFee.aspx

Treatment Guidelines

Kansas uses ODG's Treatment in Workers' Compensation Guidelines which became effective in 2008. http://www.dol.ks.gov/wc/odg.aspx

Choice of Treating Physician

The employer or carrier has the choice of physician. The claimant may appeal to DWC for a change of physician and is entitled to $500 of unauthorized medical expenses.

Rehabilitation

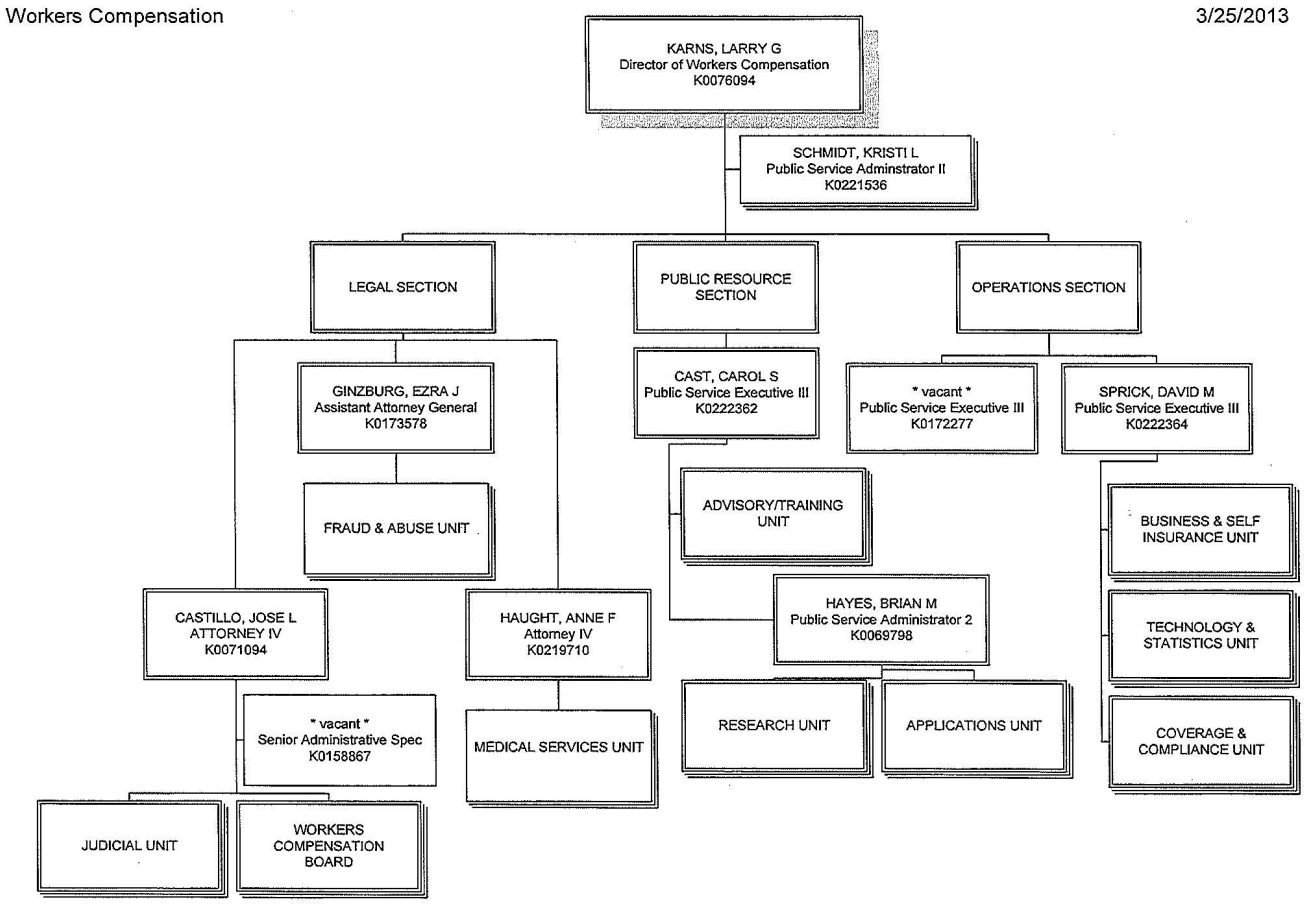
General Information

Vocational rehabilitation benefits are discretionary on accidents occurring after 7/1/1993.

Information on from Kansas' Vocational Rehabilitation Section: http://www.dol.ks.gov/WorkComp/MedFee.aspx

Workers' Compensation Division Organization Chart

The Kansas Division of Workers Compensation has five sections: Adjudication, Public Resources, Operations, Fraud and Abuse, and Medical Services.



Kentucky

Kentucky Department of Workers' Claims

657 Chamberlin Avenue

Frankfort, Kentucky 40601

(502) 564-5550

http://www.labor.ky.gov/workersclaims

Agency

General Information

The Department of Workers' Claims is the agency primarily charged with the administration of the Kentucky workers' compensation program and has exclusive jurisdiction over workers' compensation claims.

Mission Statement

Resourceful administration of Kentucky's workers' compensation program with equitable and expedient processing of workers' compensation claims.

Key Personnel and Organizational Breakdown http://www.labor.ky.gov/workersclaims/personnel_and_organiation/Pages/Key-Personnel-And-Organizational-Breakdown.aspx

Legislative and Regulatory Links

Kentucky Workers' Compensation Statutes and Regulations: http://www.labor.ky.gov/workersclaims/Pages/Statutes-and-Regulations.aspx

Budget and Financing

Agency Funding Source

The Kentucky Workers' Compensation Funding Commission manages the Special Fund liabilities, the Kentucky Coal Workers' Pneumoconiosis Fund and Uninsured Employers Fund and finances the administrative operations of the Kentucky Department of Workers' Claims. For 2013, employers will pay a 6.28% assessment on their workers' compensation premiums to fund all of these accounts (Kentucky 342-12).

2012-2013 Operating Budget/Staff Size

FY 2013 Operating Budget: FY 2013 budget is $16,860,600.00
Staff Size: 163

http://www.osbd.ky.gov/NR/rdonlyres/28C22F94-8799-47C4-9627-3CF8B40C388F/0/1214ExecBudBudInBrief.pdf

Funds

Special Fund and Coal Workers' Pneumoconiosis Fund

The Division of Workers' Compensation Funds (formerly Division of Special Funds) is responsible for the administration of the Special Fund and Coal Workers' Pneumoconiosis Fund. The Special Fund is liable for part of the income benefits awarded for occupational injuries and diseases resulting from incidents or last exposures occurring prior to December 12, 1996, while the coal fund is liable for 50 percent of the income and retraining benefits awarded for coal workers' pneumoconiosis claims arising from last exposures occurring after December 12, 1996. The Division pays about $70 million in benefits per year to approximately 7,000 disabled workers or surviving dependents.

Benefits are funded by assessments on workers' compensation insurance premiums and taxes on severed coal collected by the Kentucky Workers' Compensation Funding Commission. For more information on the Kentucky Workers' Compensation Funding Commission, visit their web site at http://www.kwcfc.ky.gov/.

Uninsured Employers' Fund

The Uninsured Employers' Fund is administered by the Office of Attorney General and pays claims to workers of uninsured employers who default. This fund is financed by premium assessments and the collection of fines and penalties.

Individual Self-Insurance Guaranty Fund

The Guaranty Fund is mandatory for all non-coal individually self-insured employers. Its purpose is to secure workers' compensation liability of all individual self-insureds and is funded by member assessments and, in the event of a default, the surety maintained by the Department of Workers' Claims.

Goal Employers Self-Insurance Fund

Individually insured coal employers must belong to the Kentucky Coal Employers Self-Insurance Fund. Its purpose is to secure workers' compensation liability of all individual self-insureds and is funded by member assessments and, in the event of a default, the surety maintained by the Department of Workers' Claims.

Group Self-Insurance Fund

All self-insurance groups or associations must belong to the group self-insurance fund.

Insurance Requirements and Resources

General Information

All Kentucky employers, both public and private, are required by state law to provide workers' compensation coverage for their employees, including corporation executives (KRS 342.640, 342.340). This coverage may come in the form of insurance or an organization shall furnish to the Commissioner satisfactory proof of its financial ability to pay directly for the compensation amount and manner when due. Excluded from coverage are federal employees, some domestic workers, and most farm workers and car-pool participants during commuting (KRS 342.650). Business owners and qualifying partners may elect to be covered (KRS 342.012). Employees continue to be covered when they are sent out of Kentucky on temporary work assignments (KRS 342.375, 342.670).

Kentucky employers generally have four options for coverage:

1. Individual Self-insurance, upon approval by the Commissioner of the Kentucky Department of Workers' Claims. Self-insured employers are required to deposit an acceptable security in the form of letters of credit, security bonds or escrow accounts to secure potential liability in the event of a default. Starting in 2006, the individual self-insurance certificates remain in effect until revoked or modified by the Commissioner of the Department of Workers' Claims. Employers must be able to provide as often as necessary evidence of compliance with the provisions of the self-insurance statutes. Certificates are reviewed annually for continued compliance and as necessary modifications made to the security amount (KRS 342.340, 342.345, 803 KAR 25:021).

2. Join a self-insurance group, on approval by the Commissioner of the Kentucky Department of Insurance. Self-insurance groups consisting of 20 or more employers with a common interest or membership in a bona fide trade organization or two separate governmental entities to enter into agreements to pool their liabilities under KRS 342 for the purpose of qualifying as a workers' compensation self-insured group under KRS 304.50-010 and KRS 342.350.

3. Purchase coverage from private insurance companies. A separate insurance policy for a specific plant or work site may be authorized by the Commissioner of the Department of Workers' Claims. Workers' compensation insurance coverage in Kentucky is provided by private insurance companies on a competitive basis. Kentucky insurance laws prohibit standard workers' compensation rates set by rate-making bureaus, and each insurance carrier that provides workers' compensation coverage in the state files its own rate schedule with the KY Department of Insurance Commissioner. Employers seeking workers' compensation insurance coverage in Kentucky may wish to solicit quotations from several competing insurance companies (KRS 342.340, 342.375, 342.380).

4. Purchase coverage from the Kentucky Employers' Mutual Insurance Authority, (KEMI) a nonprofit, independent, self-supporting de jure municipal corporation (KRS 342.803) and sometimes referred to as a competitive state fund. KEMI began selling workers' compensation insurance coverage to Kentucky employers on September 1, 1995 (KRS 342.801-843).

Penalties for Not Insuring

The Compliance Branch consists of two sections. They are the Administrative Processing Section and the Enforcement Section. The Administrative Processing Section is responsible for certifying coverage, maintaining records for certain project types and registering employee leasing organizations. The Enforcement Section investigates the status of insurance coverage through on-site visits to Kentucky employers. This ensures that workers within the Commonwealth are protected in the event of a workplace injury.

If not insured, an employer can be fined and enjoined from operating in Kentucky. Fines are authorized by statute to be $100.00 to $1000.00 per occurrence.

Number of penalties assessed in FY2012: 772
Dollar amount of penalties assessed in FY2012: Amount of penalties collected at 1,360,663.00.

Reporting Requirements

First Report of Injury

Employer's first reports are mandatory for injuries causing a loss of work for more than one (1) day and fatalities within seven days after injury has resulted in more than one day of disability or date employer learns of injury. The initial report is to the carrier or party responsible for payment, who in turn must report it to the DWC within three (3) days. If the employer fails to file the first report, a fine is assessed of not less than $100 and not more than $1000.

Other Reports/Claims Processing and Monitoring

After the first reports, an employer must also file subsequent reports to notify the Department of Workers' Claims of the start and termination of income benefits. Fines to timely file these reports are the same fine as noted above relating to First Reports of Injury.

An Administrative Law Judge (ALJ) makes the final administrative decision for determining a claimants PPD rating, based on the following factors:

- A multiplication factor; and,
- Use of the *AMA Guide to the Evaluation of Permanent Impairment*, Fifth Edition

EDI Standards

Kentucky mandates the use of the IAIABC Claims Release 3.0 and IAIABC Proof of Coverage 2.1 standards for reporting.

Contested Case Handling

Levels in the hearing process include:

1. Formal hearing before an ALJ
2. Parties may appeal initially to the Workers' Compensation Board and thereafter to the Kentucky appellate courts.

	Notes or Comments on Scope	*Number in FYE 2012*
Hearing before an ALJ	Formal proof filing and evidentiary requirements.	1,981
Appeal to Workers Compensation Board or Appellate Court	Appeals are 'legal' only and neither the Board nor the Courts are authorized to re-weigh or re-evaluate the evidence relied upon by the Judge.	Board – 347 Court of Appeals – 89 Kentucky Supreme Court - 27

Attorneys' Fees

Attorneys' fees are paid out of claimant's award.

Compromise and Release Agreements

Compromise and Release Agreements must be approved by an ALJ. Agreements terminate indemnity benefits. Claims may be reopened in case of mistake, change of condition or discovery of new evidence. Also, a claim may be reopened at any time based on a claim of fraud. Future medicals may be settled, but this rarely occurs.

Medical Care and Evaluation

Fee Schedule

DWC uses fees schedules for medical treatment, hospital care, and pharmacy charges.
http://www.labor.ky.gov/workersclaims/mscc/Pages/Physicians-Fee-Schedule.aspx

Treatment Guidelines

KRS 342.035(8) authorizes the adoption of guidelines, but only very limited practice parameters of treatment of acute low back pain have been adopted.

Managed Care

Any managed care system may file a managed care plan for approval with the Commissioner of the Department of Workers' Claims. Systems may operate more than one managed care plan. Employers and insurers may contract with multiple systems in order to maximize employee access. There is no application fee. Applications for certification must meet all of the components of the regulation 803 KAR 25:110.

More Information on MCOs in Kentucky: http://www.labor.ky.gov/workersclaims/mscc/Pages/Managed-Care.aspx

Choice of Treating Physician

The injured workers have the right to select their treating physician and hospital. The worker also has the right to change the physician one time. After one change, the payer must approve any further changes. If the employer is certified as part of an approved managed care group, some limitations on selection may be appropriate.

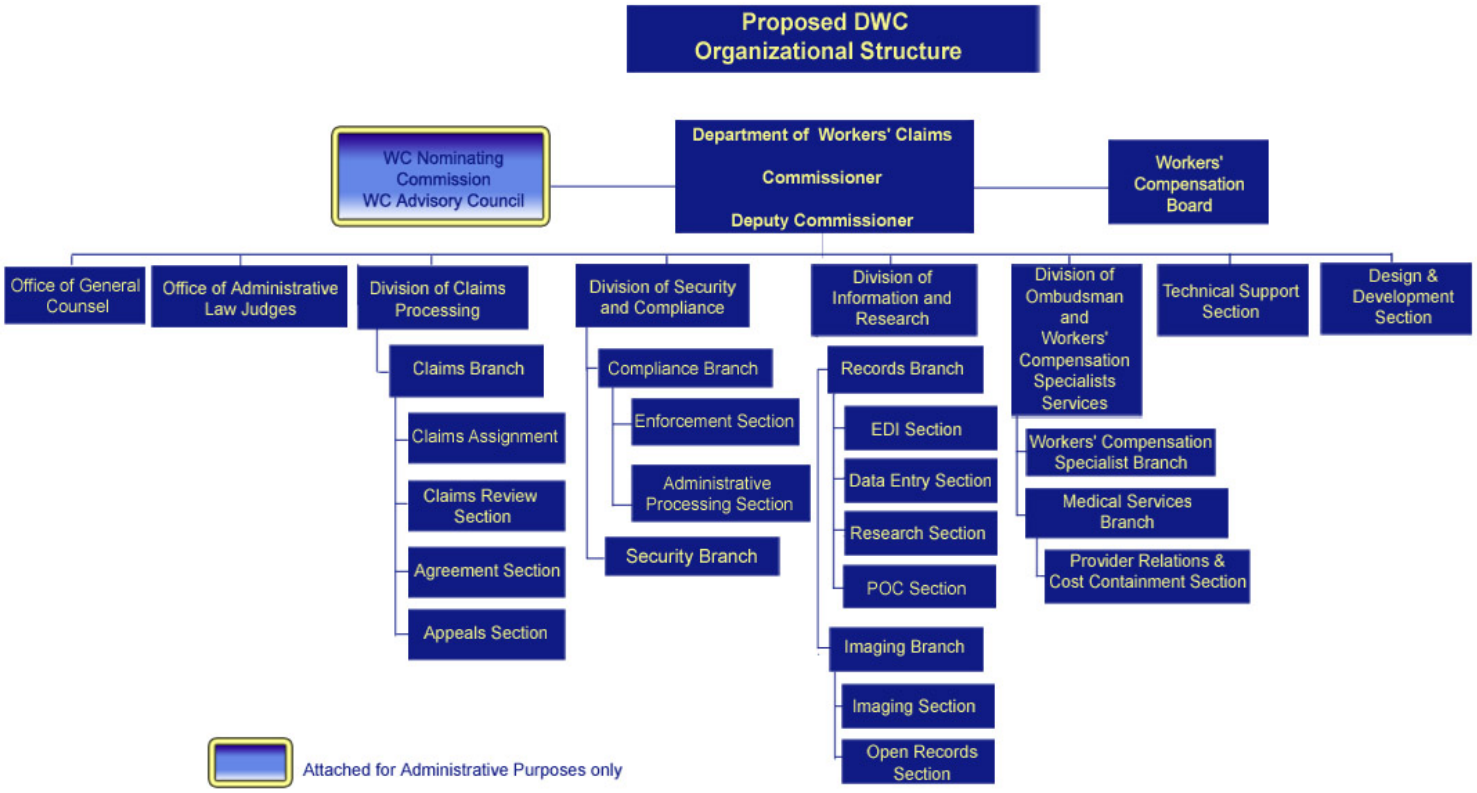
Rehabilitation

General Information

The Vocational Rehabilitation Program is a partnership among the Kentucky Department of Workers' Claims, an injured worker and local educational institutions. The goal of this partnership is to ensure the injured worker has the skills necessary to return to gainful employment.

Any injured worker may apply for vocational rehabilitation services. The worker may be eligible for retraining benefits if he/she has recovered from a work-related injury, but has not regained the physical capacity to return to the job held before the injury. Kentucky's workers' compensation laws determine who is eligible for vocational rehabilitation services.

Workers' Compensation Division Organization Chart



Louisiana

Louisiana Office of Workers' Compensation Administration

P.O. Box 94040

Baton Rouge, Louisiana 70804-9040

(225) 342-7555

http://www.laworks.net/WorkersComp/OWC_MainMenu.asp

Agency

General Information

The Office of Workers' Compensation Administration (OWCA) is part of the Louisiana Workforce Commission. Responsibility for the administration is vested in a single administrator, the Assistant Secretary and the Director of Workers' Compensation.

Mission Statement

The mission of the Office of Workers' Compensation is to ensure a manageable, cost effective workers' compensation system.

Legislative and Regulatory Links

Louisiana Workers' Compensation Laws and Regulations: http://www.davidbuie.com/b/louisiana_workers_compensation_act.html

Budget and Financing

Agency Funding Source

The Office of Workers' Compensation Administrative Fund is funded by assessments of insurers and self-insured employers. The assessment rate, determined each year by the director, is based on the amount of workers' compensation benefits paid in the previous year by each insurer or self-insured employer. (Louisiana 23.1291.1)

2012-2013 Operating Budget/Staff Size

Staff Size: 138
FY 2013 Operating Budget: $14 Million

Funds

Second Injury Fund

The Second Injury Fund is a state agency which reimburses employers or, if insured, their insurance carriers for part of the workers' compensation costs in certain instances when an employee with a pre-existing permanent partial disability is inured on the job. The fund is administered by five Board members (State Treasurers, Commissioner of Insurance, Director of Office of Workers' Compensation, Secretary of State, and the Secretary to the Department of Social Services). Every property and casualty insurers, individual self-insurer, and group self-insurance fund that has paid workers' compensation benefits makes annual payments to the fund. To use the Funds, an injured employee must have a pre-existing permanent partial disability, and the employer must have knowledge of the pre-existing condition.

More information of Louisiana's Second Injury Fund: http://www.laworks.net/Downloads/OWC/sibbrochure.pdf

Louisiana Insurance Guaranty Fund (not located within OWCA or under its authority)
Description on LIGA website: "[LIGA is a] non-profit entity designed to create a safety net for insurance consumers if their insurer becomes insolvent during the period of their policy coverage. LIGA steps in to pay certain statutorily defined claims and claims for unearned premiums. The payment of claims by LIGA has been a continuing source of reliability and relief to thousands of families and companies whose loss would have otherwise gone unpaid. LIGA covers property and casualty insureds only." http://www.laiga.org/index.html

LIGA is financed by annual assessments on all admitted property and casualty insurance carriers.

Louisiana Workers' Compensation Corporation

http://www.lwcc.com/default.cfm
LWCC is funded by policyholders and contractual services. It serves as a market of last resort and operates as a non-profit, self-funding mutual insurance company. LWCC is managed by a 12 member Board of Directors, appointed by the Governor.

Insurance Requirements and Resources

General Information

Most employees in Louisiana are covered from the day they start employment. Employees may be full-time or part-time, seasonal or minors. Subcontractors and certain independent contractors may be considered employees if they are involved in the pursuit of the employer's trade, business or occupation or if they are performing substantial manual labor.

The law does contain some limited exemptions. Domestic employees, most real estate salespersons, uncompensated officers and directors of certain non-profit organizations, and public officials are specifically exempted. Most volunteer workers would not be entitled to benefits. Employers are required to insure their workers' compensation obligation or to be approved to self-insure.

Private Insurance

The Louisiana Department of Insurance regulates workers' compensation insurance carriers and group-self insurers.

Louisiana Department of Insurance
Post Office Box 94214
Baton Rouge, LA 70804
General Information: 1-800-259-5300 or 1-800-259-5301
Direct Telephone numbers: (225) 342-5900

Self-Insurance

Qualification for and individual Self-insurer:

- Not works of not less than $750,000, or a surety bond with OWCA that shall be considered to be part of the net worth of the employer;
- Deposits of at least $100, 000 in securities or a surety bond with the Director of OWCA or insurer providing excess workers' compensation coverage may satisfy security requirements for its insureds by depositing and maintaining with the OWCA a single surety in the amount determined by the OWCA.

- Proof of excess coverage for losses over $250,000 per incident.

Penalties for not Insuring

In Louisiana, a civil penalty of not more the $250 per employee is assessed for the first offence. That penalty increases to not more than $500 per employee for subsequent offences. The maximum civil penalty is $10,000. Willful violation is a felony and may be subject to a fine of not more than $10,000 and/or one year in jail, without hard labor, and an injunction against further business operations.

Number of penalties assessed in FY2012: 120
Dollar amount of penalties assessed in FY2012: $200,000

Reporting Requirements

First Report of Injury

Employer's first reports of injury are mandatory for injuries involving seven or more lost workdays, or a death. The reports must be filed within 10 calendar days of injury or employer's knowledge of injury or occupational illness.

Other Reports/Claims Processing and Monitoring

The Workers' Compensation Judge is responsible for making a final administrative determination of a claimant's PPD rating using the AMA Guide to Physical Impairment.

OWCA can assess penalties for "arbitrary and capricious" denials.

EDI Standards

Currently, Louisiana plans to implement the IAIABC's Claims Release 3.0 on a voluntary basis in 2013 and First Report of Injury (FROI) in 2014.

Contested Case Handling

Levels in the hearing process include:

1. Mediation Conference with a Mediator
2. Formal hearing before a Workers' Compensation Judge.
3. Court of Appeals, with appeal to the Supreme Court.

	Notes or Comments on Scope	*Number in FY2012*
Mediation Conference		2126
Formal hearing before a Workers' Compensation Judge		2793
Circuit Court of Appeals		200
Supreme Court		

Attorneys' Fees

OWCA regulates attorney's fees. Fees must be pre-approved by a Workers' Compensation Judge. The maximum award is 20% of the amount recovered.

Compromise and Release Agreements

Compromise and Release (C&R) agreements are allowed if approved by a Workers' Compensation Judge. The agreement may not release the right to future benefits. Reopening of the case is limited to proof of error or fraud.

Medical Care and Evaluation

Fee Schedule

http://doa.louisiana.gov/osr/lac/40v01/40v01.pdf (Page 117)

OWCA has the authority to promulgate rules setting reimbursements for medical services.

Treatment Guidelines

Louisiana has state specific treatment guidelines that were adopted by the legislature in 2009 and became effective July 13, 2011. The treatment guidelines cover carpal tunnel syndrome, cervical spine injuries, chronic pain disorder, complex regional pain syndrome/reflex sympathetic dystrophy, low back pain, lower extremity, shoulder injury, and thoracic outlet syndrome.

http://www.laworks.net/WorkersComp/OWC_MedicalGuidelines.asp

Managed Care

Managed care organizations are used in Louisiana.

Choice of Treating Physician

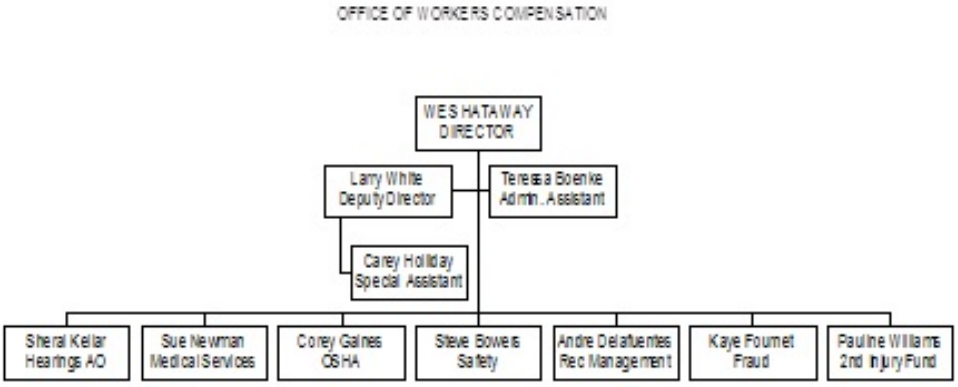
An injured employee has the right to select one treating physician in any field or specialty area. After the initial choice, the employee must obtain prior written consent from the insurer to change physician within the same specialty area.

Rehabilitation

General Information

Vocational rehabilitation (up to 26 weeks) is provided by the insurer or self-insurer. The Workers' Compensation Judge may extend this period or parties may agree to do so. Benefits may be reduced by half for claimants who refuse rehabilitation.

Workers' Compensation Division Organization Chart



Maine

Maine Workers' Compensation Board

27 State House Station

Augusta, Maine 04333

(207) 287-3751 or 1-888-801-9087

http://www.maine.gov/wcb/

Agency

General Information

The Workers' Compensation Board (WCB) is an independent State agency with the responsibility for administering of workers' compensation vested in a seven member board. The Governor appoints the Executive Director subject to confirmation by the Legislature. The Executive Director reports back to the Governor.

Mission Statement

The general mission of the Maine Workers' Compensation Board is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation.

Legislative and Regulatory Links

Maine Revised Statutes: http://www.mainelegislature.org/legis/statutes/39-A/title39-Ach0sec0.html

WCB Rules and Regulations: http://www.maine.gov/wcb/rules/RulesAndRegs.htm

Budget and Financing

Agency Funding Source

Each employer pays an assessment based on their premium base. The premium base is calculated as the payroll times the filed manual rate times the experience modification factor (if applicable). Insurers collect this assessment for each of their policyholders. Self-insured employers pay an assessment based on the aggregate benefits paid by each member. (Maine Statute 154).

Funds

Employment Rehabilitation Fund

Maine's Employment Rehabilitation Fund is administered by the Deputy Director of Medical/Rehabilitation Services. This Fund pays wage incentives to employers who hire rehabilitated workers. Additionally, it pays for reimbursement of benefits paid on second injury to rehabilitated workers. It is financed by an assessment against employers, by compensable fatal injuries which leave no dependents, and by fines assessed against uninsured employers.

Insurance Requirements and Resources

General Information

The law requires almost all public and private employers to have workers' compensation coverage. The law defines employers as "private employers, public employers, water districts, other quasi-public corporations, municipal school committees, school union committees, and design professionals."

Private Insurance

The Bureau of Insurance, Department of Professional and Financial Regulation has regulatory authority over workers' compensation insurance carriers.

Department of Professional & Financial Regulation
Bureau of Insurance
76 Northern Avenue
Gardiner, Maine 04345
800-300-5000 (toll free in Maine) or 207-624-8475

Self-Insurance

The Bureau of Insurance also has regulatory authority over self-insurers. To qualify as a self-insurer in Maine, an employer must be able to meet compensation payments and deposit cash, securities, or a surety bond approved by the WCB.

Penalties for not Insuring

The Insurance Coverage Unit assists with problem claims including the proper identification of insurance coverage, the proper identification of employers, as well as identifying address changes for employers. This is done to properly process and assign claim files to the appropriate regional offices. The Coverage staff works closely with the Abuse Investigation Unit regarding problems associated with coverage enforcement. The Unit cooperates with the MAE program to identify carriers and self-insureds who consistently fail to file required information in a timely manner. And, it assists the Bureau of Labor Standards to maintain an accurate and up-to-date employer database, utilized by both departments.

The Unit also researches the history of employer insurance coverage in order to certify the accuracy of these records. This is particularly important for many of the claims at formal hearing, especially where there is a controversy as to the liability for the payment of the claim. Since workers' compensation coverage in Maine is mandatory, the Unit routinely provides assistance to the public regarding insurance coverage requirements.

An employer who does not insure for workers' compensation coverage may be assessed with:

- A Class "D" crime punishable by imprisonment for up to one year, or a fine of up to $1,000 for individuals, and $5,000 for corporations;
- A civil penalty of up to $10,000 or 108% of the premium that should have been paid; and/or
- Revocation of corporate status, or license, certification or registration.

Reporting Requirements

First Report of Injury

The filing of employer's first reports with the WCB is mandatory for injuries/illnesses involving one or more lost workday, and for fatalities. Medical only injuries are not reported to the WCB, however, the employer retains a copy of this form one copy goes to the insurer and one copy goes to the employee. Employer's first reports are due within seven days after notice or knowledge of injury or illness.

Failure to report is considered a civil penalty and the employer can be assessed with a fine not to exceed $100.

Other Reports/Claims Processing and Monitoring

Additional Reports and Forms:
Memorandum or Payment
Wage Statement; Schedule of Dependent(s) and filing status statement
Notice of Controversy
Discontinuance or Modification of Compensation
Certificate of Discontinuance or Reduction of Compensation
Lump Sum Settlements
Statement of Compensation Paid
Employee's Return to Work Report
Request for Expedited Proceeding

The WCB monitors the initial payment, ongoing payment activity, last payment ,and promptness of payments.

The final administrative decision for determining a claimants permanent partial disability/ total disability rating is made by the WCB. The factors used to determine a rating are:

- Impairment rating of the attending physician
- Employee's loss of wage earning capability
- Criteria as set forth by the Court
- Employee factors such as age, education, training, etc
- Use of the AMA Guide to Physical Impairment
- Use of an independent medical examiner

EDI Standards

The 121st Maine Legislature enacted legislation that required the State of Maine Workers' Compensation Board to adopt rules mandating electronic filing. The legislation directed the Board to proceed by the consensus based rulemaking process. A committee was formed consisting of representatives from the insurance community, self insureds, WC Board of Directors, and WCB staff. Recommendations were forwarded and unanimously approved by the Board of Directors.

The WCB uses the International Association of Accident Boards and Commissions (IAIABC) Claims Release 3 for all claims EDI filings and IAIABC POC Release 2.1 for all proof of coverage EDI filings. Currently the WCB requires two types of claims reports to be filed electronically: First Report of Injury and Notice of Controversy. The WCB also requires the WCB-1A form to be filed electronically. Fax transmission is not an accepted method to meet the context of electronic filing discussed above. The production deadline for the electronic submission for each of the forms is identified in the Electronic Filing/EDI Rule.

Additional documentation will be posted on the WCB website as it becomes available.

The links below provide the actual rules approved by the Board pertaining to claims EDI filing and proof of coverage EDI filing.

Contested Case Handling

Levels in the hearing process include:

1. Troubleshooting
2. Mandatory mediation
3. Decision by a hearing officer or voluntary arbitration
4. Alternative appeal routes; direct to state Supreme Court

Attorneys' Fees

The WCB approves and regulates attorneys' fees. An attorney can receive up to 30% of employee benefits retained or a percentage of the final settlement.

Compromise and Release Agreements

Compromise and Release agreements are allowed, but they must be approved by the WCB. A C&R can terminate medical and indemnity benefits. A claim can be reopened after a C&R due to fraud or mistake of fact.

Medical Care and Evaluation

Fee Schedule

On December 11, 2011, Chapter 5 of the Board's Rules and Regulations became effective. The new rule repeals and replaces the former rule and establishes schedules of maximum reimbursement for inpatient, outpatient and ambulatory surgical center facility fees in accordance with P.L. 2011, Ch. 338. The rule text and appendices are located at http://www.maine.gov/wcb/rules/newlyadopted.htm.

Treatment Guidelines

Maine has state specific treatment guidelines that cover Carpal Tunnel Syndrome, Cervical Spine Injury, Chronic Pain Disorder, Complex Regional Pain Syndrome, low back pain, lower extremity, shoulder injury, and Thoracic Outlet Syndrome.

http://www.maine.gov/wcb/departments/omrs/omrs/ur.htm

Managed Care

Authorization of managed care organizations (PPOs or HMOs) is implied by the employer's right to select care.

Choice of Treating Physician

The employee may not change health care providers more than once without the approval of the employer or WCB

Rehabilitation

General Information

The WCB has a rehabilitation department whose primary function is administrative oversight. No direct services are provided by WCB. Vocational rehabilitation is an entitlement under the Workers' Compensation Act. The WCB has general approval authority over vocational rehabilitation plans. Claimants who refuse WCB ordered vocational rehabilitation will have benefits reduced or suspended. The Employment Rehabilitation Fund pays for Board ordered rehabilitation plans. If vocational rehabilitation plan is successful, employer must reimburse the Fund.

Maryland

Maryland Workers' Compensation Commission

10 East Baltimore Street

Baltimore, Maryland 21202

(410) 864-5100

http://www.wcc.state.md.us/

Agency

General Information

The Maryland Workers' Compensation Commission (WCC) is an independent unit of the State government. The Commission administers the Workers' Compensation Law and adjudicates claims for compensation arising under the law (Code Labor and Employment Article, secs. 9-301 through 9-316). Reports of accidents are received and processed by the Commission which hears contested cases throughout the State. Claimants requiring rehabilitation are referred by the Commission to appropriate rehabilitation service providers.

Appointed by the Governor with Senate advice and consent, the Commission's ten members serve twelve-year terms. The Governor names the chair (Code Labor and Employment Article, secs. 9-101 through 9-1201).

Work of the Commission is carried on by three divisions: Finance; Information Technology; and Operations. The Commission also is aided by the Advisory Committee on the Registration of Rehabilitation Practitioners.

Claims filed in FY 2012: 22,909

Mission Statement

The Maryland Workers' Compensation Commission seeks to secure the equitable and timely administration of the provisions of the Maryland Workers' Compensation law on behalf of its customers, the injured workers and their employers, by providing an efficient forum for the resolution of individual claims.

Legislative and Regulatory Links

Code of Maryland Regulations (COMAR Online): http://www.dsd.state.md.us/comar/comar.aspx
Annotated Code of Maryland, Labor & Employment Article, Title 9.

Budget and Financing

Agency Funding Source

Each insurer or self-insured employer is assessed a percentage based on the payroll of their insured policyholders. The percentage is calculated by dividing the total Commission expenses by the total payroll of all insurers. (Maryland, 9-316 (d))

2012-2013 Operating Budget/Staff Size

Staff Size (FY 2012): 132.25
FY 2013 Operating Budget (Appropriated): $13,878,789 ($13,963,984 in FY 2012)

Funds

Subsequent Injury Fund

Maryland's Subsequent Injury Fund (SIF) is an independent agency. Pursuant to the enabling legislation in the Labor and Employment Article of the Maryland Annotated Code, Section 9-802, this agency exists to encourage the hiring of workers with pre-existing disabilities by assuming financial responsibility for the combined effects of a pre-existing disability and an accidental workplace injury.

The Subsequent Injury Fund (SIF) reviews and investigates workers' compensation claims that involve pre-existing health conditions that substantially increase the disability of injured workers. The liability of employers' insurers is limited to compensation for the damages caused by the current injury, and the SIF incurs all additional liability from the combined effects of all injuries and/or conditions.

The SIF manages a non-budgeted fund from which workers' compensation benefits are paid to eligible claimants. The income to the Fund is derived from assessments based upon awards of compensation for permanent disability which are paid by workers' compensation employers/insurers. The SIF's costs of operation are supported by the assessments mentioned above, making it a Special Fund agency.

http://www.mdsif.state.md.us

Uninsured Employers' Fund

In 1983, the Uninsured Employers' Fund Board was created to protect workers whose employers are not insured under Workers' Compensation (Chapter 576, Acts of 1983). The Board reviews and investigates claims by employees, or by their dependents in case of death, where the employer is uninsured and has defaulted. The Board also supervises the operation and administration of the Uninsured Employers' Fund.

Insurance Requirements and Resources

General Information

Employers in the State of Maryland are required to obtain workers' compensation insurance from an authorized insurance company licensed to write workers' compensation insurance in Maryland, the Injured Workers' Insurance Fund, by becoming a self-insured employer (requires prior approval of the Workers' Compensation Commission), participating in a governmental self-insurance group or participating in a self-insurance group of private employers. The law allows certain officers of closed corporations, corporations deriving 75 percent of income from farming, members of limited liability companies, officers of professional associations, partnerships, and sole proprietors (independent contractors) to elect to be excluded or covered under Maryland Workers' Compensation Law.

Private Insurance

Insurance carriers are regulated by the Maryland Insurance Administration. All workers' compensation policies are approved by the Workers' Compensation Commission. There were 634 licensed insurers writing workers compensation insurance in Maryland in FY 2012.

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Phone: (410) 468-2000
Toll Free: 1-800-492-6116

Self-Insurance

Individual and governmental group self-insurers are regulated by the Workers' Compensation Commission. Group private self-insurance is administered by the Maryland Insurance Administration. In FY 2012, there were 103 (including one group) self-insured employers in Maryland. These self-insured employers covered 420,000 employees in Maryland.

Requirements for individual self-insurance include:

- Audited financial statements for up to five fiscal years
- Minimum security of $100,000
- Excess insurance from an “A” or higher rated insurer

To see more requirements for individual self-insurance in Maryland see: http://www.wcc.state.md.us/PDF/PDF_Forms/eA05.pdf

Penalties for not Insuring

Employers failing to secure workers’ compensation insurance as required by law shall be guilty of a misdemeanor, and shall be subject to a fine of not less than $500 nor more than $5,000 or by imprisonment for not more than one year, or both fine and imprisonment. If the employer is a corporation, the officer of the corporation having the responsibility for the general management of the corporation in the State shall be liable for such fine and imprisonment as herein provided. The entire cost of workers’ compensation insurance must be borne by the employer. Any employer who deducts any portion of this premium from the wages of his/her employee, entitled to the benefits under this Law, shall be guilty of a misdemeanor.

Reporting Requirements

First Report of Injury

If an accident occurs to an employee that results in disability for a period of more than 3 days, it shall be the responsibility of the employer to report this accident to the Workers’ Compensation Commission on a “First Report of Injury” form within 10 days after notice of such accident, whether oral or written. Copies of this report must also be sent to the insurance carrier and to the Department of Labor, Licensing & Regulation, Division of Labor and Industry .

Other Reports/Claims Processing and Monitoring

Individual and governmental group self-insureds are required to report at least annually to the Workers’ Compensation Commission.

In non-contested cases, compensation is paid after a claim is filed, as required by statute. Medical treatment may be provided prior to a claim being filed.

The Commission has the responsibility for the final administrative decision on determining a claimant’s permanent partial disability (PPD) award. Disability ratings are provided in medical reports required to consider six factors (pain, atrophy, weakness, loss of endurance, loss of function, and range of motion), to be in accordance with the AMA Guide for Evaluation of Physical Impairment, and testimony from the hearing conducted on nature and extent.

EDI Standards

Planning on IAIABC Claims Release 3.0. currently using Claims Release 3.0 with IWIF only.

Contested Case Handling

Levels in the hearing process include:

1. Hearing held by Commissioner
2. Appeal can be made to Circuit Court de novo or on the record.
3. Further appeals can be taken to other courts of appeal on questions of law.

	Notes or Comments on Scope	*Number in FY2012*
Hearing set by Commission		41,558
Circuit Court Appeals		2031
Appeals to a Higher Court		N/A

Attorneys' Fees

The attorney fee is paid out of a claimant's award allowing a payment of monetary benefit and must be approved by the Commission

Compromise and Release Agreements

Final compromise settlements must have a Commissioner's approval. Payments are made weekly or in a lump sum. Past and future benefits may be terminated by agreement. A claim may be reopened if designated in the settlement.

Medical Care and Evaluation

Fee Schedule

Maryland Guide to Medical and Surgical Fees: http://www.wcc.state.md.us/PDF/MFG/COMAR_MFG_Reg_2008.pdf

Treatment Guidelines

No treatment guidelines for workers' compensation

Choice of Treating Physician

The claimant has free choice of his/her attending physician.

Rehabilitation

General Information

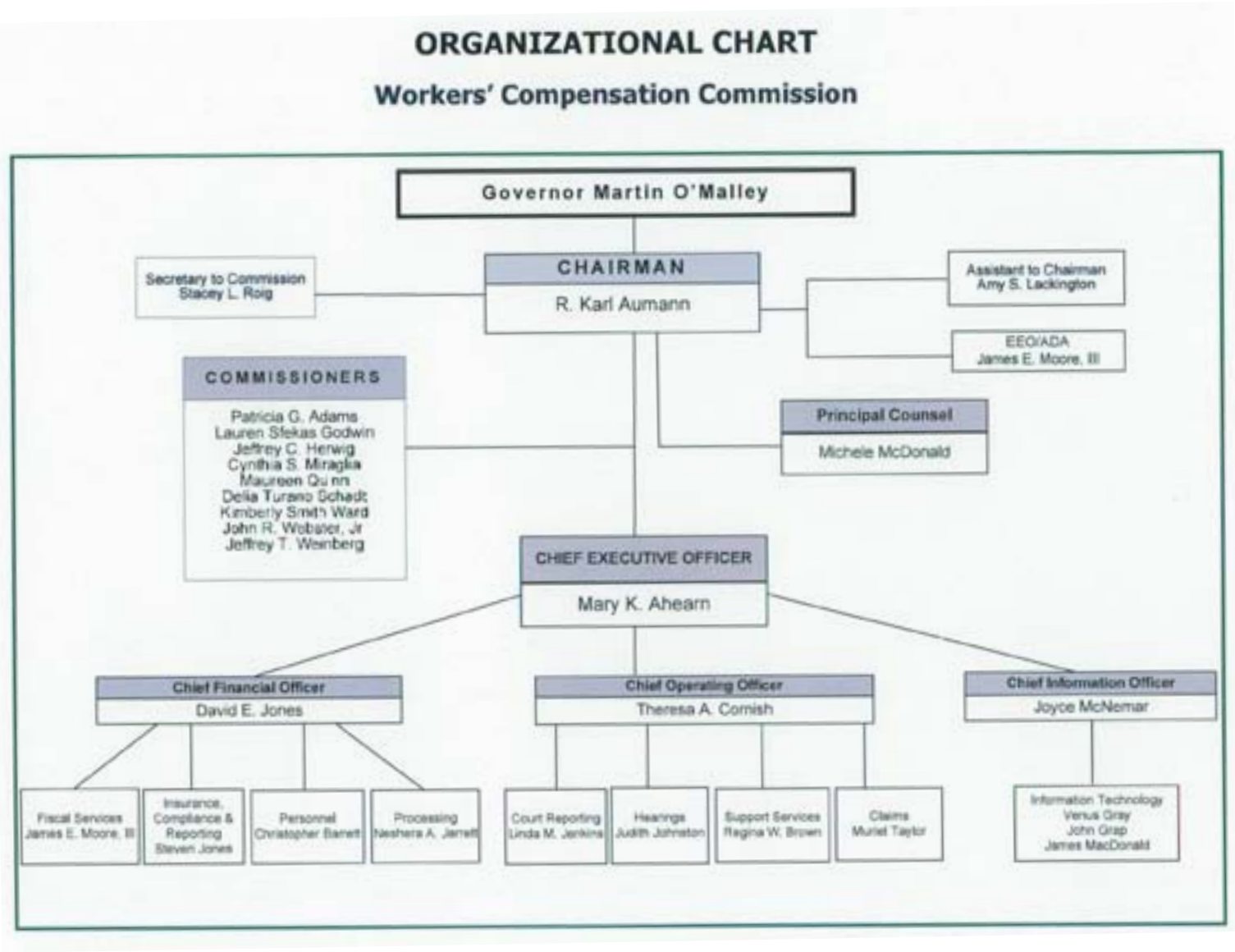
Vocational rehabilitation services provide job placement with no time limit. In addition, the claimant can also receive up to 24 months of training.

In Maryland there are both public (Maryland Division of Rehabilitation Services - DORS) and private rehabilitation counselors. Maryland Law requires registration for all private practitioners serving injured workers and you may request a copy of the registration if you are assigned to work with a private provider. DORS is a recognized provider but exempt from the practitioner registration requirement; however, DORS will work with eligible Maryland residents. Your attorney may select DORS or a private counselor to provide vocational rehabilitation services. It is important that you advise the DORS counselor that you have a Workers' Compensation claim. The DORS counselor must inform the Commission that DORS is working with you.

TYPICAL VOCATIONAL REHABILITATION TIMELINE

Step One -	Interview with the counselor. The counselor will take a complete history of your background, physical limitations and other information such as your prior work experience, hobbies and personal interests that might affect your employability.
Step Two -	Development of Plan and Goals. The counselor will create a customized plan with specific goals tailored to your individual needs.
Step Three -	Obtain agreement. All parties must agree that the plan and goals are acceptable or the matter will be presented to a Commissioner for a determination as to the appropriateness of the plan.
Step Four -	Action. After the parties have agreed to the plan and the plan has been submitted and approved by the Commission, with the counselor's assistance you will begin to pursue job leads or training.

Workers' Compensation Division Organization Chart



Massachusetts

Massachusetts Department of Industrial Accidents

1 Congress Street, Suite 100
Boston, Massachusetts 02114
(617) 727-4900 or (800) 323-3249
http://mass.gov/dia

Agency

General Information

The Department of Industrial Accidents (DIA) is part of the Executive Office of Labor and Workforce Development. The responsibility for administration of workers' compensation is vested in a single Director (agency head), who reports to the Secretary of Labor and Workforce Development.

Mission Statement

Pursuant to M.G.L. Chapter 152, the Mission of the Department of Industrial Accidents is to administer the Commonwealth's Workers' Compensation system and provide prompt and fair compensation to victims of occupational injuries and illness, and to see that medical treatment to injured workers is provided in a timely manner while balancing the needs of employers to contain workers' compensation insurance costs.

- To provide dispute resolution of workers' compensation cases through due process and adjudication.
- To administer the Special, Private, and Public Trust Funds.

Legislative and Regulatory Links

Massachusetts's Workers' Compensation Act: http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXI/Chapter152

Massachusetts's Workers' Compensation Regulations: http://www.mass.gov/dia

Budget and Financing

Agency Funding Source

The Workers' Compensation Special Fund and Workers' Compensation Trust Fund are both funded by assessments. The assessment base amount for all employers is based on the losses paid in the previous calendar year (Massachusetts, 152-65).

2012-2013 Operating Budget/Staff Size

Staff Size: 242 full and part time staff as of Jan. 1, 2013
FY 2013 Operating Budget (Actual): $24,000,000

Funds

Second Injury Fund

The Second Injury Fund covers injuries where a previously known physical impairment that is likely to be a hindrance to employment, coupled with a subsequent injury, results in a substantially greater disability. The Fund is financed by assessments on employers. The benefits paid by the Fund include: compensation for medical services received, and compensation for wage loss.

Number of claims filed in FY2012: 286
Dollars paid in FY2012: $24,198,415

Special Fund

This Fund is financed by assessments to employers on annual insurance premiums and provides funding for the operation of the DIA.

Trust Funds (Public and Private)

The Trust Fund is financed by assessments to employers on annual insurance premiums and provides workers' compensation benefits to injured employees in cases where the employer is uninsured; provides reimbursement to insurers pursuant to corresponding provisions of the Act. Benefits provided include: indemnity and medical benefits to injured employees, reimbursement for all or part of the amounts paid out by the insurers for cost of living adjustments, latent disability, and subsequent injury.

Insurance Requirements and Resources

General Information

All employers in Massachusetts are required to carry workers' compensation insurance covering their employees, including themselves if they are an employee of their company. This requirement applies regardless of the number of hours worked in any given week, except that domestic service employees must work a minimum of 16 hours per week in order to require coverage.

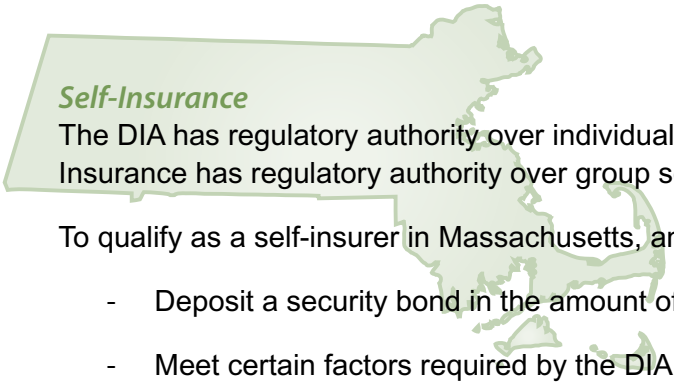
Employers are required to notify their employees of the name of the workers' compensation insurance carrier. A Notice To Employees Posters poster must be posted in a common area of the work place in English and other appropriate languages. The poster can be obtained by calling the Department of Industrial Accidents (DIA), downloading it from our website, or from your insurance company. Failure to post this information may subject the employer to a fine of $100.

Members of a Limited Liability Company (LLC), partners of a Limited Liability Partnership (LLP), and partnerships or sole proprietors of an unincorporated business are not required to carry workers' compensation insurance for themselves. However, under a change to the law in 2002, such members, partners and sole proprietors may now choose to purchase workers' compensation insurance coverage for themselves. To obtain coverage, the member or partner should contact an insurance broker and state that they wish to obtain a policy. Please be advised that optional coverage applies ONLY to such members, partners or sole proprietors. Any employee of such an entity, who is not a member or partner in the business, MUST be covered by workers' compensation insurance.

Private Insurance

The Massachusetts Division of Insurance has regulatory authority over workers' compensation insurance carriers.

Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200
(617) 521-7794
www.mass.gov/doi



Self-Insurance

The DIA has regulatory authority over individual corporations licensed as self-insurers; and the Division of Insurance has regulatory authority over group self-insurers.

To qualify as a self-insurer in Massachusetts, an employer must:

- Deposit a security bond in the amount of $100,000 minimum;
- Meet certain factors required by the DIA;
- Have been in business for at least five years;
- Provide the DIA with a financial study and cash flow analysis, as well as an actuarial study and risk managements study;
- Have a three-year history of profitability; and
- Have not been declared insolvent or discharged from Federal bankruptcy proceedings in the past five years.

Penalties for not Insuring

Employers operating without workers' compensation insurance will be issued a STOP WORK ORDER by the Department of Industrial Accidents' (DIA) Office of Investigations and shall be assessed a minimum fine of $100 per day commencing on the date of the issuance of the STOP WORK ORDER and accruing until the date insurance coverage becomes effective and the fine is paid as authorized under MGL c. 152, s. 25C. In addition, the employer may be subject to criminal sanctions including not more than one-year imprisonment and/or up to a $1500 fine upon conviction. Uninsured employers are also subject to debarment from public contracts for a period of three years.

Number of penalties assessed in FY2012: 2,637
Dollar amount of penalties assessed in FY2012: $1,381,085

Reporting Requirements

First Report of Injury

The Employer's First Report of Injury Or Fatality - Form 101 must be submitted to the DIA, the insurance carrier and the employee. This form must be sent to the DIA within seven calendar days (not including Sundays and legal holidays) from the fifth full or partial day the employee has been disabled. Submission of this form does not constitute an admission of liability.

Any employer who does not file this form on time three or more times in any given year shall be punished by a fine of $100 for each violation. Failure to pay the fine within 30 calendar days of receipt of an invoice from the DIA shall be considered a separate violation. The fines progressively escalate with each failure to pay, with a penalty of $100 increments.

Other Reports/Claims Processing and Monitoring

The DIA monitors initial payment, last payment, and promptness of payments of workers' compensation claims. The DIA also monitors the denial behavior of insurers.

Conciliators or Administrative Law Judges make determinations permanent loss of function and disfigurement. Factors used to make a determination include:

- Uses of the AMA Guide to Physical Impairment; and
- Use of the DIA's rating guide for disfigurement

EDI Standards

DIA uses IAIABC EDI Claims 3.0 standards for accepting data from insurance carriers for specific filings, namely First Reports of Injury. Participation is voluntary as of this publication.

Contested Case Handling

Levels in the dispute resolution process include:

1. Conciliation- Conciliator
2. Conference with an Administrative Judge
3. Hearing with an Administrative Judge (same judge that presided over Conference)
4. Review Board

	Notes or Comments on Scope	*Number in FY2012*
Conciliation	Informal meeting to resolve dispute. If matter cannot be resolved it is forwarded to a Conference before an Administrative Judge.	13,648
Conference	Informal proceeding before an Administrative Judge. Oral arguments and documents are submitted. Judge orders binding order which may be appealed by either party. An appeal triggers and impartial exam to determine the extent of the injury, disability and if injury is work related.	6,450
Hearing	Formal hearing before an Administrative Judge (the same Judge that presided over the Conference). Evidence taken, witnesses testify and full verbatim transcript is recorded. Judge issues Hearing Decision at the close of the matter.	3,353
Review Board	Appellate body that hears appeals of Hearing decisions. Appeals are on matters of law only.	209

Attorneys' Fees

The DIA has the authority to approve attorney fees which are set by law. The attorney fees are not paid out of the claimant's award. The attorney receives a percentage out of lump sum settlement for all dates of injury on or after 11/1/86.

Compromise and Release Agreements

Compromise and release agreements are allowed and approved by Conciliators for "completeness" and by judges "in best interest of employee." C&R agreements terminate indemnity benefits and medical benefits (for injuries occurring prior to 11/1/86). A claim cannot be reopened after a C&R agreement.

Medical Care and Evaluation

Fee Schedule

Medical Fee Schedule is set by the Massachusetts Division of Health Care Finance and Policy.

Treatment Guidelines

The Medical Treatment Guidelines are drafted by a group of highly respected expert clinicians that represent pertinent specialties in the medical community. A member of the Health Care Services Board (HCSB) will chair each guideline's drafting group. The drafting group bases the treatment guidelines on the best available medical evidence and on what reasonable practitioners in the community are recommending. After guidelines are drafted, they are subject to further review by medical societies, labor, insurers, employers groups, the general public and HCSB. Before each guideline is endorsed by the HCSB and adopted by the DIA, a notice for public comment will be published in four newspapers. After it has been approved, it will be presented to utilization review agents and insurers.

The guidelines provide guidance to clinicians, insurers, utilization review agents and other concerning what falls into an acceptable range of treatment.

The treatment guidelines are not mandatory and it is expected that up to 10% of treatments may deviate from the guidelines.

Managed Care

PPA's are governed by 211 CMR 112.00, promulgated by the Division of Insurance. PPA's are allowed to perform the initial assessment.

Injured workers have the right to choose treating physicians outside of HMO and MCO plans.

Limitations on physician choice apply on to the first scheduled visit on these plans per MGL c. 152, § 30.

Choice of Treating Physician

The injured workers choose their physicians and may change physicians once. Any subsequent changes must be approved by the insurer. Even though the treating physician is selected by the employee, the insurer is permitted to retain the option to designate an initial health care provider within a preferred provider plan.

Rehabilitation

General Information

The mission of Department of Industrial Accidents, Office of Education and Vocational Rehabilitation (OEVR) is to assist injured workers who have accepted or established liability under MGL c. 152 to return to meaningful through the delivery of vocational rehabilitation services.

To qualify for these services, an injured worker must have residual restrictions due to their work related injury that prohibits a return to his/her pre-injury job. The goal of vocational rehabilitation services delivered to injured workers, under MGL c. 152, § 30, is to return an employee to their pre-injury average weekly wage. OEVR is the overseeing authority for these services. It facilitates agreements to return workers to meaningful and gainful employment with a focus on wage replacement.

http://www.mass.gov/lwd/docs/dia/publications/vr-english.pdf

Workers' Compensation Division Organization Chart

Philip Hillman, Director

Office of Legal Counsel	*Div. of Administration*	*Div. of Dispute Resolution*
Dep. Dir./Gen. Counsel	**Dep. Dir. For Operations**	**Senior Judge**

Michigan

Michigan Workers' Compensation Agency

State Secondary Complex, General Office Building

7150 Harris Drive, 1st Floor, B-Wing

P.O. Box 30016

Lansing, Michigan 48909

http://www.michigan.gov/wca

Agency

General Information

The Michigan Workers' Compensation Agency (WCA) is a part of the State Department of Licensing and Regulatory Affairs (LARA).

Mission Statement

The mission of the Workers' Compensation Agency is to efficiently administer the Workers' Disability Compensation Act of Michigan, which includes carrier and employer compliance, timely benefit payments and the prompt transfer of contested claims involving Michigan's injured workers to the Michigan Administrative Hearings System (MAHS).

Legislative and Regulatory Links

Michigan Workers' Compensation Laws and Regulations: http://www.michigan.gov/wca/0,4682,7-191-26919---,00.html

Budget and Financing

Agency Funding Source

Michigan has a general fund. The workers' compensation revolving fund is funded through fees from settlements.

2012-2013 Operating Budget/Staff Size

WCA's operating budget is appropriated by the legislature and approved by the Governor.
Staff Size: 64 filled FTEs
FY 2013 Operating Budget: Appropriated $7,646,100

Funds

Second Injury Fund

The Second Injury Fund in Michigan is administered by the Fund's Administrator under the direction of three trustees (two are Governor appointed and one is the director of WCA).

The Funds Administration consists of the Second Injury Fund; the Silicosis, Dust Disease and Logging Industry Compensation Fund; and the Self-Insurers' Security Fund. The Funds, created in Chapter 5 of the Michigan Workers' Disability Compensation Act, are managed by a board of trustees. The board is made up of two trustees that are appointed by the Governor with the advice and consent of the Senate. The first represents employers authorized to act as self-insurers in Michigan and the second represents the insurance industry. The third trustee is the director of the Workers' Compensation Agency. The funds are administered by a Funds Administrator.

Dollars paid to workers in FY 2012: $11,017,125.07
Dollars reimbursed to carriers in FY 2012: $4,955,749.92

Insurance Requirements and Resources

General Information

Employers in Michigan are required to have Workers' Compensation Insurance if they:

- Regularly employ three or more part-time employees at one time
- Or employ one or more persons for at least 35-hours per week for at least 13-weeks during the preceding 52-weeks

Workers' Compensation benefits ordinarily are not paid by the State of Michigan. Workers' Compensation is the responsibility of an employer. Benefits are paid either directly by a self-insured employer or through an insurance company on behalf of an employer.

The majority of employers in Michigan obtain Workers' Compensation through commercial insurance companies. Self-insurance is an alternative for large companies that have been granted the privilege of paying Workers' Compensation benefits from general company operating funds. Group self-insured programs are available to smaller employers seeking an alternative to commercial insurance.
http://www.michigan.gov/business

Private Insurance

Michigan has a competitive workers' compensation system, allowing market forces to set insurance rates. The Michigan Department Of insurance & Financial Services has regulatory authority over workers' compensation insurance carriers.

The Michigan Department Of insurance & Financial Services
611 West Ottawa Street, 3rd Floor
Lansing, Michigan 48933
(517) 373-0220 or (877) 999-6442 (Toll-Free)

Self-Insurance

WCA has regulatory authority over workers' compensation self-insurers.

Individual Self-Insurance

To qualify as an individual self-insurer in Michigan, the employer must demonstrate reasonable solvency and the ability to pay claims directly to the injured worker. The employer must also have been in business for at least five years. Generally, specific and aggregate excess insurance is required. Applicants, except governmental entities, will be required to post a bond or letter of credit. The minimum amount is $100,000.

Approved Individual Self-Insurers FY 2012: 423

Group Self-Insurance

Michigan statute allows two or more employers in the same industry with combined assets of $1,000,000 or more to enter into an agreement to pool their liabilities under the Michigan Worker's Disability Compensation Act of 1969, as amended, for the purpose of qualifying as self-insurers. A blanket fidelity bond in an amount of at least $1,000,000 will be furnished to cover all individuals, including employees of the service company, who

will be involved in the handling of monies of the group. A surety bond or financial security endorsement will also be required. The amount will be determined after the application and supporting documentation have been provided. The decision for granting group self-insured authority is based on the individual financial condition of each member applying for membership on the inception date, together with the overall financial condition of the members taken as a whole. The group must demonstrate that it will collect sufficient premium to fully fund all administrative expenses and the loss fund (as estimated by the aggregate excess insurer).
Approved Group Self-Insurers FY 2012: 31

Finally, the employer may be subject to a fine of $1,000 or imprisonment for no less than 30 days or more than 6 months, or both. Each day for which the employer is uninsured is considered a separate offense.

Dollar amount of penalties collected in FY2012: $186,000

Penalties for not Insuring

There are severe penalties for the failure of an employer to provide workers' compensation coverage. First of all, if a worker is injured, he or she may sue the employer for civil damages in the civil court system. If the employer was at fault for the injury, this might result in the payment of a great deal of money by the employer.

Secondly, the Workers' Compensation Agency actively enforces the Workers' Disability Compensation Act. It has the authority to go into court and seek an order prohibiting the company from employing any persons in their business until such time as proper workers' compensation insurance coverage is obtained.

Reporting Requirements

First Report of Injury

The filing of the employer's first reports with the Agency is mandatory for all injuries over seven days lost time, specific injuries, and fatalities. First reports are due within 30 days of the injury or fatality.

Other Reports/Claims Processing and Monitoring

WCA monitors the initial payment, periodic payments, and last payments of workers' compensation claims for accuracy and promptness.

The Agency and the employee must be notified before temporary total disability benefits can be terminated.

Additional reports required by WCA include the Notice of Dispute (Form 107) and the Application for Reimbursement from the Compensation Supplement Fund (Form 114). The Claims Processing Division with WCA is also responsible for monitoring, collecting, and reporting all redemption fees paid from the parties involved in redemption settlements/agreements.

EDI Standards

The Michigan Claims EDI implementation process has been suspended pending analysis and probable replacement of the WORCS data system. We will incorporate Claims EDI into any new system that we implement. Proof of Coverage EDI, however, will continue for existing customers and can be implemented for those wishing to participate in POC EDI process.

Contested Case Handling

The adjudication of disputed Workers' Compensation Cases has been transferred to the Michigan Administrative Hearings System and is no longer a function of the Workers' Compensation Agency. The mediator positions have been eliminated.

After adjudication, cases are returned to the agency for post-judgment compliance enforcement by the Director.

Levels in the hearing process include:

1. Mediator (Pre-trial)
2. Magistrate
3. Appellate Commission
4. Court of Appeals
5. Supreme Court

Attorneys' Fees

WCA regulates attorneys' fees according to statute and administrative rules and they are taken out of the claimant's award.

Redemption Agreements

Redemption agreements are allowed. These agreements must be approved by a Magistrate and terminate indemnity and medical benefits. There is a 15 day appeal period before the redemption order is final.

Once redeemed and the appeal period passed, a claim can be reopened after a redemption agreement at the Circuit Court if there is evidence of fraud.

Medical Care and Evaluation

Fee Schedule

WCA has the authority to set medical and hospital fees through its Health Care Services Rules. All related materials regarding the rules and the fee rates can be found on the website:
http://www.michigan.gov/wca/0,4682,7-191-26922---,00.html

Treatment Guidelines

Michigan does not have specific treatment guidelines for workers' compensation.

Managed Care

WCA does authorize the use of managed care organizations.

Choice of Treating Physician

During the first 28 days starting when the care begins, the employer has the right to select the medical care providers. After that, the employee is free to change doctors if he/she wishes. In order to change, however, the employee must notify the employer of his/her desire to change and provide the name of the physician selected.

Rehabilitation

General Information

The workers' compensation law in Michigan provides for both vocational and physical rehabilitation. WCA approves vocational rehabilitation facilities and monitors them to ensure that policy guidelines are created and followed and that appropriate service is delivered.

Employees are entitled to re-training benefits for 52 weeks with the possibility of extension for an additional 52 weeks by approval of the WCA's director.

Rehabilitation plans focus on:

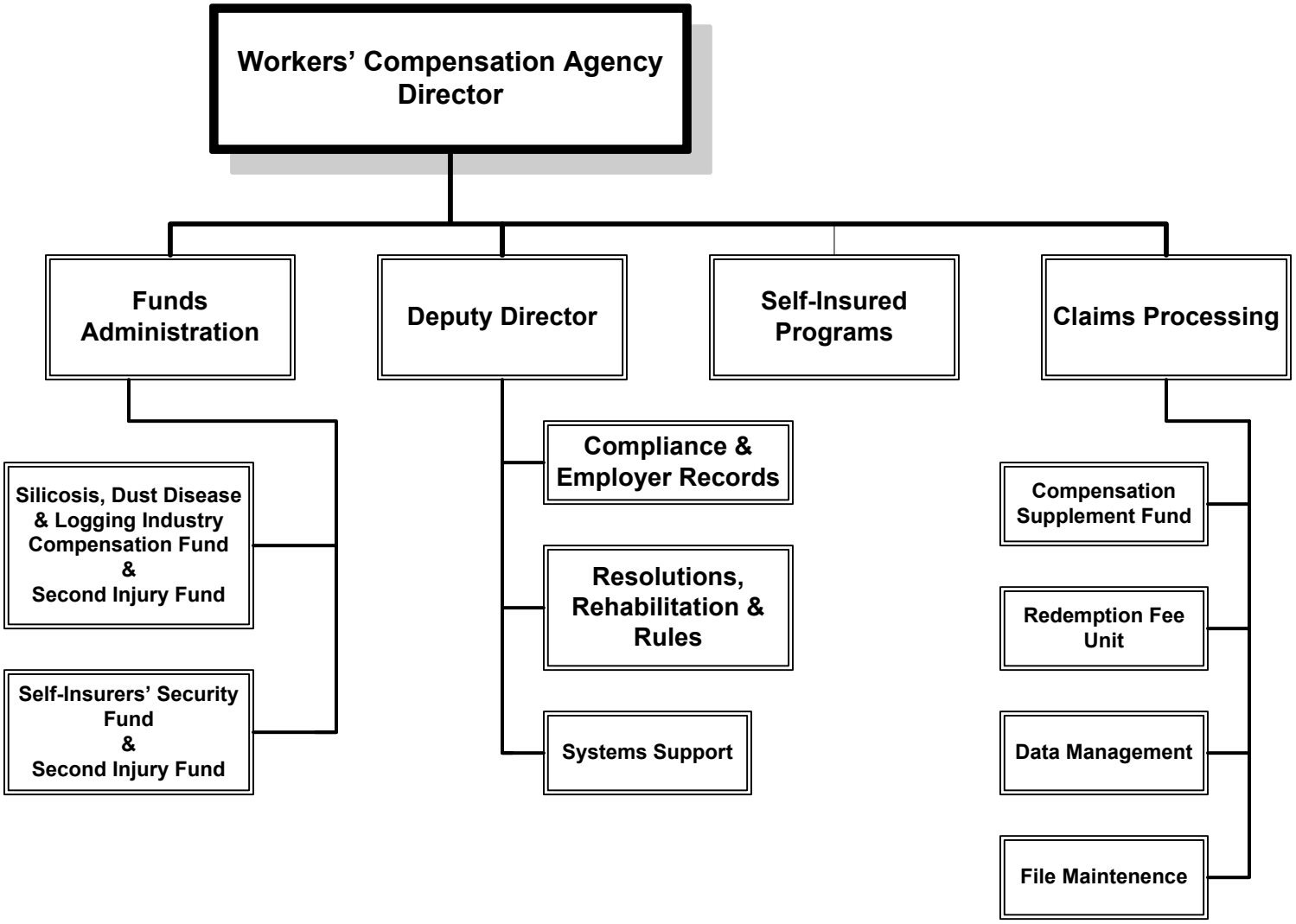
1) Return to work with the same employer

2) Return to work to a new employer and/or short term retraining; or

3) Self-employment

A worker undergoing rehabilitation receives continued temporary total disability benefits and any necessary expenses related to the rehabilitation program. Costs are paid by the insurer or employer. If a worker refuses to cooperate with a rehabilitation plan, benefits can be reduced or suspended by the WCA director following a hearing.

Organization Chart



Minnesota

Minnesota Workers' Compensation Division

443 Lafayette Road North

St. Paul, Minnesota 55155

(651) 284-5005 or (800) 342-5354

http://www.dli.mn.gov/WorkComp.asp

Agency

General Information

The Workers' Compensation Division (WCD) resides within the Minnesota Department of Labor and Industry. The responsibility for administration is vested in a single administrator, the Commissioner, who reports to the Governor of Minnesota.

Mission Statement

Ensure appropriate benefits are delivered to injured workers quickly, efficiently and at a reasonable cost to employers.

Legislative and Regulatory Links

Minnesota's Workers' Compensation Statutes 2012: https://www.revisor.mn.gov/statutes/?id=176

Minnesota Administrative Rules (Workers' Compensation begins in the 5000s): https://www.revisor.mn.gov/rules/?view=list

Budget and Financing

Agency Funding Source

The Special Compensation Fund is funded by assessments of insurers and self-insured employers. The total amount of the assessment must be allocated between self-insured employers and insured employers based on paid indemnity loses for the preceding calendar year. Self-insured assessments are based on paid indemnity loses. Insurers collect the assessment from their insured employers through a surcharge based on standard workers' compensation premium for each employer (Minnesota Statutes, section 176.129).

2012-2013 Operating Budget/Staff Size

WCD's operating budget is appropriated by the legislature and approved by the Governor.
Staff Size: 126.7 FTE
FY 2013 Operating Budget: $10,829,000

Funds

Second Injury Fund

The Second Injury Fund no longer exists for new injuries. For subsequent injuries that occurred before July 1, 1992, claim reimbursements to insurers and self-insured employers are:

- Administered by the Special Compensation Fund
- Financed by the Special Compensation Fund assessment

Number of penalties assessed in FY2012: 757 (for failure to insure)
Dollar amount of penalties assessed in FY2012: $1,582,484 (for failure to insure)

Insurance Requirements and Resources

General Information

Minnesota Workers' Compensation law states all employers are required to purchase workers' compensation insurance or become self-insured. This is often referred to as "mandatory coverage." Employers are generally defined as those that hire another to perform services. Employees are generally defined as people performing services for another, for hire, including minors, part-time workers and workers who are not citizens. There are limited exceptions to mandatory coverage listed in Minnesota Statutes 176.041. If an employer does not see exception(s) stated in the statute for every employee of theirs, the employer needs workers' compensation insurance.

Private Insurance

The Minnesota Department of Commerce has regulatory authority over workers' compensation insurance carriers and self-insurers. The Department of Commerce: issues licenses for insurers to write Minnesota worker's compensation policies, approves employer and employer group applications for workers' compensation self-insurance and group self-insurance, and disciplines and monitors carriers and self-insurers.

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, Minnesota 55101
Phone: 651-296-4026
Fax: 651-297-1959
http://mn.gov/commerce/

Self-Insurance

Individual Self-Insurance
(Minnesota Statutes, section 79A.03)

Subdivision 1.Procedure.

Each employer desiring to self-insure individually shall apply to the commissioner on forms available from the commissioner. The commissioner shall grant or deny the application within 60 days after a complete application is filed. The time limit may be extended for another 30 days upon 15 days' prior notice to the applicant. Any grant of authority to self-insure shall continue in effect until revoked by order of the commissioner or until such time as the employer becomes insured.

Subd. 2.Certified financial statement.

Each application for self-insurance shall be accompanied by a certified financial statement. Certified financial statements for a period ending more than six months prior to the date of the application must be accompanied by an affidavit, signed by a company officer under oath, stating that there has been no material lessening of the net worth nor other adverse changes in its financial condition since the end of the period. The commissioner may require additional financial information necessary to carry out the purpose of this chapter.

Subd. 3.Net worth.

Each individual self-insurer's net worth, as presented on its audited balance sheet filed with the Department of Commerce, shall equal at least ten percent of the entity's total assets and shall equal at least ten times the retention level selected with the Workers' Compensation Reinsurance Association.

Subd. 4.Assets, net worth, and liquidity.

(a) Each individual self-insurer shall have and maintain sufficient assets, net worth, and liquidity to promptly and completely meet all of its obligations that may arise under chapter 176 or this chapter. In determining whether a self-insurer meets this requirement, the commissioner shall consider the self-insurer's current ratio; its long-term and short-term debt to equity ratios; its net worth; financial characteristics of the particular industry in which the self-insurer is involved; any recent changes in the management and ownership of the self-insurer; any excess insurance purchased by the self-insurer from a licensed company or an authorized surplus line carrier, other than excess insurance from the Workers' Compensation Reinsurance Association; any other financial data submitted to the commissioner by the self-insurer; and the self-insurer's workers' compensation experience for the last four years. Notwithstanding any other provision of this chapter, the commissioner may deny an application for self-insurance authority or terminate existing self-insurance authority if the applicant or self-insurer does not have sufficient assets, net worth, and liquidity to promptly and completely meet all of its self-insurance obligations.

(b) An individual self-insurer must have had positive net income as shown on audited income statements filed with the Department of Commerce during three of the last five years and cumulatively over the five-year period. If the self-insurer has been in existence less than five years, it must have had cumulative net income during the period of existence and in the most recent year.

(c) An individual self-insurer must have had cash generated from operations as shown on the audited statements of cash flows filed with the Department of Commerce during three of the last five years and cumulatively over the five-year period. If the self-insurer has been in existence less than five years, it shall have had cumulative cash generated from operations during the period of existence and in the most recent year.

(d) No entity shall be admitted as an individual self-insurer, or be allowed to continue its self-insurance authority, if the audit report for the most recent year includes an explanatory paragraph stating that the auditor has concluded that there is substantial doubt about the entity's ability to continue as a going concern.

Group Self-Insurance

(Minnesota Statutes, section 79.03)

Subd. 6. Applications for group self-insurance.

(a) Two or more employers may apply to the commissioner for the authority to self-insure as a group, using forms available from the commissioner. This initial application shall be accompanied by a copy of the bylaws or plan of operation adopted by the group. Such bylaws or plan of operation shall conform to the conditions prescribed by law or rule. The commissioner shall approve or disapprove the bylaws within 60 days unless a question as to the legality of a specific bylaw or plan provision has been referred to the Attorney General's Office. The commissioner shall make a determination as to the application within 15 days after receipt of the requested response from the Attorney General's Office.

(b) After the initial application and the bylaws or plan of operation have been approved by the commissioner or at the time of the initial application, the group shall submit the names of employers that will be members of the group; an indemnity agreement providing for joint and several liability for all group members for any and all workers' compensation claims incurred by any member of the group, as set forth in Minnesota Rules, part 2780.9920, signed by an officer of each member; and an accounting review performed by a certified public accountant. A certified financial audit may be filed in lieu of an accounting review.

(c) When a group has obtained its authority to self-insure, additional applicants who wish to join the group must apply for approval by submitting, at least 45 days before joining the group: (1) an application; (2) an indemnity agreement providing for joint and several liability as set forth in Minnesota Rules, part 2780.9920, signed by an officer of the applicant; and (3) a certified financial audit performed by a certified public accountant. An accounting review performed by a certified public accountant may be filed in lieu of a certified audit.

New diminutive applicants to the group, as defined in section 79A.01, subdivision 11, applying for membership in groups in existence longer than one year, who have a combined equity of all group members in excess of 15 times the last retention limit selected by the group with the Workers' Compensation Reinsurance Association, and have posted 125 percent of the group's total estimated future liability, must submit the items in this paragraph at least ten days before joining the group.

If the cumulative total of premium added to the group by diminutive new members is greater than 50 percent in a fiscal year of the group, all subsequent new members' applications must be submitted at least 45 days before joining the group.

In all cases of new membership, evidence that cash premiums equal to not less than 20 percent of the current year's modified premium of each applicant have been paid into a common claims fund, maintained by the group in a designated depository, must be filed with the department at least ten days before joining the group.

Penalties for not Insuring

Minnesota Statutes, section 176.181 gives the commissioner of the Department of Labor and Industry the authority to enforce the mandatory coverage laws. Minnesota Statutes 176.184 is one of the provisions detailing the commissioner's powers of enforcement. These include the ability to enter and inspect a business and its records, take depositions, issue subpoenas and order the production of documents to determine if insurance coverage as required by law exists. If the inquiry reveals inadequate or nonexistent coverage, the commissioner's representative will continue the investigation and determine what action, if any, is appropriate.

Penalties for failure to insure include up to $1,000 per employee per week during which the employer was not in compliance, and liability for benefits paid by the special compensation fund to the employer's injured employee, plus a 65% penalty of all compensation benefits paid.

Reporting Requirements

First Report of Injury

It is mandatory to file a first report of injury with the WCD for all work-related fatalities and all injuries resulting in more than three calendar days or partial days of work disability or permanent partial disability. Fatalities or serious injuries must be reported within 48 hours from notice or knowledge. Non-fatal, non-serious injuries that require a first report need to be reported to the insurer by the employer within ten days and filed with the Department of Labor and Industry within 14 days of the first day of the disability or the date the employer was aware of the disability, whichever is later.

Additional Reports/Claims Processing and Monitoring

Other reports to file (as appropriate):

- Notice of Insurer's Primary Liability Determination
- Notice of Benefit Payment
- Notice of Intention to Discontinue Benefits
- Health Care Provider's Report
- Interim Status Report
- Disability Status Report

The WCD monitors initial payment or liability determination, periodic payments, last payment, payment of PPD benefits, promptness of payment.

If a claimant's permanent partial disability rating, as determined by a doctor, is challenged, the rating can be determined by the compensation judge or the appellate court (using the PPD Schedule in Minnesota Rules, Chapter 5223)

EDI Standards

The Minnesota Department of Labor and Industry (DLI) is working toward mandating the electronic filing of FROI forms via electronic data interchange (EDI) or an eFROI Web portal. Through the elimination of paper handling by the reporting entity and the department, DLI hopes to increase efficiency and facilitate the timely reporting of injuries to DLI. The information here is intended to provide advance notification to allow adequate time for reporting entities to prepare for an anticipated implementation date of Jan. 1, 2014.

There will be two options available for electronic filing.

1. EDI: Entities submitting many FROI forms each year may prefer EDI, which will be a transmission of FROI form data from the reporting entity's computer system to DLI's computer system. Submitted EDI FROI form data will populate an electronic version of the FROI form in DLI's database.

2. eFROI Web portal: Entities submitting few FROI forms each year may prefer the eFROI Web portal, which will allow an individual, on behalf of a reporting entity, to log onto a Web portal and enter FROI form data. The entered data will populate an electronic version of the FROI form in DLI's database.

To allow sufficient time to prepare for implementation, DLI has halted testing for any new EDI trading partners from Sept. 10, 2012 through May 1, 2013.

Contested Case Handling

Minnesota Statutes, section 176.261 requires the department to "... make efforts to settle problems of employees and employers by contacting third parties, including attorneys, insurers and health care providers, on behalf of employers and employees and using the department's persuasion to settle issues quickly and cooperatively." Before a formal hearing, various of alternative dispute resolution processes, including administrative conferences and mediation, can be utilized.

Levels in the hearing process include:

1. Formal hearing on record (Office of Administrative Hearings)
2. Workers' Compensation Court of Appeals
3. Minnesota Supreme Court

	Notes or Comments on Scope	Number in FY2012
Formal Hearing (Office of Administrative Hearings)	Held when a claim petition is filed to establish disputed liability for an injury or to request disputed monetary benefits. A formal hearing is also held when a party disagrees with a decision following an administrative conference on a disputed medical, rehabilitation or discontinuance dispute.	676 (includes de novo hearings, excludes attorney fee hearings)
Workers' Compensation Court of Appeals	Hears all appeals from decisions after a formal hearing. Also hears petitions to vacate orders or settlement awards.	147 (number of cases appealed from Office of Administrative Hearings; most have decisions, some are settled)
Minnesota Supreme Court	Hears all appeals from the Workers' Compensation Court of Appeals. May issue a summary affirmance instead of a full opinion.	10 in CY2012

Attorneys' Fees

Claimant's attorney fees are paid out of the claimant's award (except for those paid by the employer or insurer when there are insufficient monetary benefits awarded from which the contingent attorney fees can be paid, such as medical and rehabilitation disputes and disputes between insurers about liability). For current injuries, attorneys' fees are generally awarded on a contingent basis according to a statutory formula or awarded hourly.

Compromise and Release Agreements

"Stipulations for Settlement" are reviewed and awarded by a workers' compensation judge or WCD mediator. A settlement is conclusively presumed fair and reasonable and in conformity with the workers' compensation law if all parties are represented by attorneys and the settlement does not close out future medical or rehabilitation benefits. Settlements closing out medical or rehabilitation benefits are allowed only if the compensation judge or mediator determines that the settlement is reasonable, fair, and in conformity with the workers' compensation law.

Medical Care and Evaluation

Fee Schedule

WCD has the authority to set medical and hospital maximum fees. The workers' compensation fee schedule is based on the CMS relative value fee schedule. There are four conversion factors. There is also a pharmacy fee schedule containing formulas for reimbursement of drugs. The fee schedules and other payment rules are at https://www.revisor.mn.gov/rules/?id=5221

Treatment Guidelines

Minnesota has state specific medical treatment parameters for workers' compensation that cover back, neck, upper extremities, reflex sympathetic dystrophy of upper and lower extremities, inpatient hospitalization, surgical parameters, chronic management, medical imaging and medication.

Treatment parameters can be downloaded at: http://www.dli.mn.gov/Wc/TpMain.asp

Managed Care

An employer must tell an employee if they are covered by a certified managed care plan. Some employers or insurers have contracted with a managed care plan or network of doctors who are not certified by the department. Injured employees are not required to receive treatment from a doctor in a plan or network that is not certified.

There are three managed care plans certified under Minnesota Rules 5218.0100 to provide managed care for services for an injury or condition covered under Minnesota Statues Chapter 176, Workers' Compensation: Genex, Corvel, and HealthPartners. Information about certified managed care is at http://www.dli.mn.gov/WC/CertMgdCare.asp

Choice of Treating Physician

The employee selects an initial treating physician unless the employer and insurer have agreed to provide treatment through a certified managed care organization. The employee may change physicians without approval once within 60 days after initiation of medical treatment.

Rehabilitation

General Information

In Minnesota, the workers' compensation law provides for vocational rehabilitation service for injured workers. Any rehabilitation provider must be registered with the WCD. QRCs are required to be objective in the delivery of rehabilitation services. They are professionals who have knowledge of medical factors, local labor markets and statutes concerning rehabilitation within Minnesota's workers' compensation law.

The WCD's responsibilities related to rehabilitation include:

- Enforcement of compliance with rehabilitation rules and reporting requirements
- Review and approval of retraining plans;
- Investigation of complaints about rehabilitation providers;
- Registration of vocational rehabilitation providers;
- Training of vocational rehabilitation providers
- Informing of vocational rehabilitation laws to all parties;
- Promulgations of rules related to vocational rehabilitation and registration of providers

A claimant who does not make a good faith effort to cooperate with the vocational rehabilitation plan might receive a Notice of Intention to Discontinue Workers' Compensation Benefits to suspend benefits during the period of non-compliance.

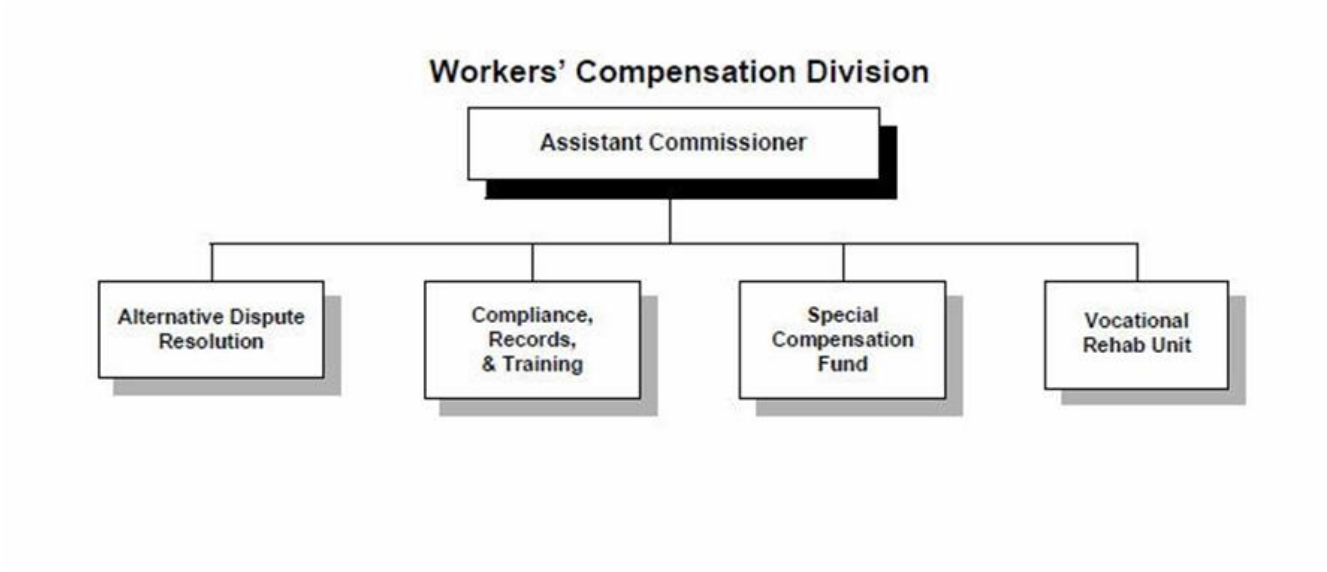
Vocational Rehabilitation Unit

The Department of Labor and Industry's Vocational Rehabilitation Unit (VRU) provides vocational rehabilitation services to injured workers whose claims have been denied by the employer/insurer. The legislative rationale was labeled "early (vocational rehabilitation) intervention" to provide needed vocational assistance to injured workers prior to, rather than after, a determination of liability by the courts.

These services are provided or coordinated by vocational rehabilitation counselors who are registered as qualified rehabilitation consultants (QRCs). Injured workers have the right to choose a QRC, to take an active part in developing their own written rehabilitation plan and to comment on or rate the services provided by VRU.

Although all injured workers are eligible, the Vocational Rehabilitation unit primarily serves claims where liability is denied by the insurer. The unit has 13 QRCs in eight regional locations throughout Minnesota.

Workers' Compensation Division Organization Chart



Mississippi

Mississippi Workers' Compensation Commission

P.O. Box 5300

Jackson, Mississippi

(601) 987-4200 or (866) 473-6922

http://www.mwcc.state.ms.us

Agency

General Information

The Mississippi Workers' Compensation Commission (WCC) is an independent State agency responsible for the administration of the workers' compensation statute. Administration is vested in three commission members.

MISS. CODE ANN. § 71-3-85 (1) (1972) creates the Workers' Compensation Commission, consisting of three members who shall devote their entire time to the duties of the office. The Governor appoints commission members for six-year terms with the advice and consent of the state Senate. Section 71-3-85 states that the commission's chairman shall be the administrative head of the commission and shall have the final authority in all matters relating to assignment of cases for hearing and trial and the administrative work of the commission and its employees.

The Mississippi Workers' Compensation Commission has the following primary responsibilities.

- Rulemaking—The commissioners act as a body in the promulgation of rules and regulations and in adopting and approving the forms that govern the practice and procedure before the commission.
- Adjudication—The commissioners hear and determine workers' compensation cases or claims that come before the commission. The commission has full power and authority to determine all questions relating to the payment of claims for compensation. This power is similar to that of a court of record. The commissioners, acting as a body, sit in review of the decisions of administrative judges when a party has requested an appeal or review of that decision. Once the commission reaches an agreement on a reviewed claim, the commissioner who has been assigned primary responsibility for that case is responsible for preparing an appropriate order to be issued by the commission.
- Self-Insurance—The commission regulates the practice of self-insurance by those employers or groups of employers that self-insure their liability for workers' compensation.
- Medical cost containment—The commission monitors medical fees, develops and maintains fee schedules, works with medical providers and payers to control medical costs, and provides dispute resolution mechanisms for disputes concerning medical fees, charges, and costs.

Mission Statement

The mission of the Mississippi Workers' Compensation Commission (hereafter the "Commission," "Agency" or "MWCC") is to administer and enforce the Workers' Compensation Law in an efficient and equitable manner through the performance of administrative and quasi-judicial functions, including the promulgation of such rules, regulations, guidelines and forms and may be necessary to further this mission; to aid and promote the prevention of occupational injury and illness; and, in the event of such injury or illness, to secure, monitor, and compel, if necessary, the provision of statutorily mandated benefits to those lawfully entitled in furtherance of their rehabilitation and restoration to health and vocational opportunity.

Legislative and Regulatory Links

Mississippi Workers' Compensation Laws and Rules of the Commission: http://www.mwcc.state.ms.us/LAW-CLMS/_law-clms.asp

Budget and Financing

Agency Funding Source

Each carrier and self-insured employer pays a $250 fee. In addition, they pay a pro-rated share of the total gross claims, including indemnity and medical payments, in the preceding year (Mississippi Statute 71-3-99 (b))

2012-2013 Operating Budget/Staff Size

Staff Size: WCC has 61 authorized positions for FY 2013.

Senate Bill 2979

AN ACT MAKING AN APPROPRIATION OF SPECIAL FUNDS TO DEFRAY THE EXPENSES OF THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION FOR FISCAL YEAR 2013. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following sum, or so much thereof as may be necessary, is hereby appropriated out of any money in the State Treasury to the credit of the Mississippi Workers' Compensation Commission, for the purpose of defraying the expenses incurred by said commission for the fiscal year beginning July 1, 2012, and ending June 30, 2013 [is] $ 5,524,269.00.

Funds

Second Injury Fund

The Commission is responsible for maintaining a second injury fund. If an employee who has previously lost, or lost the use of an arm, hand, leg, foot or eye, becomes totally incapacitated through the loss, or loss of use of, another member or organ while working for an employer covered by the Law, such employer is liable only for the compensation payable for disability related to the second injury. The employee is paid the remainder of compensation that would be due for permanent total incapacity out of the second injury fund. The second injury fund is maintained through payments made to the Commission in cases of compensable death. Such payments are deposited with the State Treasurer for the benefit of the second injury fund. If an employee's death is compensable, the injury causing death occurred prior to July 1, 1984, and there are surviving dependents, an amount of $150. 00 is payable to the second injury fund. If an employee's death is compensable and the injury causing death occurred July 1, 1984 or thereafter and there are surviving dependents, an amount of $300.00 is payable to the second injury fund. If there are no dependents, then there shall be paid to the Commission the sum of $500.00.

Insurance Requirements and Resources

General Information

The Mississippi Workers' Compensation Law is applicable to all employers who have in service five (5) or more workers regularly employed in the same business or in or about the same establishment under any contract of hire, express or implied. An employer may be a person, firm or private corporations, but all non-profit charitable, fraternal, cultural or religious corporations or associations are excluded. Several categories of workers are specifically exempted from the Mississippi Workers' Compensation Law as well: domestic servants, farmers and farm labor, transportation and maritime employees covered under federal compensation laws, independent contractors and vendors.

Private Insurance

The Mississippi Department of Insurance has regulatory authority over workers' compensation insurance carriers.

Mississippi Insurance Department
P.O. Box 79
Jackson, Mississippi 39205
(601) 359-3569
Statewide Toll Free: (800) 562-2957
http://www.mid.ms.gov/

Self-Insurance

The Mississippi Workers' Compensation Law provides that an employer may be granted an exemption from insuring liability for workers' compensation through the commercial insurance market. An employer may insure its own liability by application to and Order of the Commission. The principal requirement is that the applicant demonstrates the financial ability to pay its claims. Commission approval of the applicant may be conditioned on the applicant's provision of sufficient security to insure payment of all medical and indemnity claims.

By legislative act, effective July 1, 1988, group self-insurance was authorized in Mississippi. Each group acts as a "risk pool," where employers with common interests pay "premium" to the pool in return for workers' compensation coverage.

Penalties for not Insuring

In Mississippi, penalties for not insuring under the workers' compensation statute can include: a criminal fine up to $1,000, up to one year imprisonment, and/or a civil penalty not to exceed $10,000.

Reporting Requirements

First Report of Injury

It is mandatory to file a first report of injury with the WCC for injuries that involve six or more lost workdays, fatalities, and injuries causing permanent disability or serious head/facial disfigurement. The report must be filed within ten days after notice of death, within ten days after five-day waiting period is satisfied, or within ten days after discovery of permanent disability or disfigurement.

Additional Reports/Claims Processing and Monitoring

Other reports to file (as appropriate):
- Notice of First Payment
- Notice of Suspension of Payment
- Supplemental Payment Notice

* Above reports must be filed concurrently with occurrence.

- Final Payment Notice must be filed with the WCC within 30 days after final payment.

WCC monitors the payment of claims. Claim denial must be filed 14 days after notice of injury. Frivolous denials of claims may be punished by assessment of costs, attorneys' fees, and a fine of up to $10,000.

Administrative law judges, or, on appeal, the Commission as a whole, makes final administrative decisions for determining a claimant's disability rating based on the following factors:
- Impairment rating of the attending physician; and
- Employee's loss of wage earning capability.

EDI Standards

Mississippi currently requires use of the IAIABC's Claims Release 3.0 FROI for reporting.

Contested Case Handling

Levels in the hearing process include:

1. Hearing before an administrative law judge (ALJ)
2. Appeal to the Commission members as a body
3. Appeal to the Mississippi Supreme Court

	Notes or Comments on Scope	*Number in FY2012*
Hearing before an ALJ	Live with testimony, exhibits	1120
Appeal to the Commission	On the record, de novo	98
Appeal to the Mississippi Supreme Court	On the record, deference to Commission findings.	42

Attorneys' Fees

WCC regulates attorneys' fees. Fees are limited to 25% of the total award. The fee is deducted from the award unless a contract between the attorney and client provides otherwise.

Compromise and Release Agreements

Compromise and release (C&R) agreements are allowed when they are approved by the WCC. The agreement may terminate both indemnity and medical benefits, depending on its terms. A claim may be reopened after a C&R agreement for the following reasons (subject to a one year statute of limitations):
- Mistake in determination of fact
- Change in condition
- Fraud

Medical Care and Evaluation

Fee Schedule

WCC sets fees for medical services using a medical fee schedule. This fee schedule induces hospital based services.

Frequently Asked Questions on Mississippi Medical Fee Schedules: http://www.mwcc.state.ms.us/FAQ/_2010medfaq.asp

Treatment Guidelines

Mississippi does not have workers' compensation specific treatment guidelines.

Managed Care

Managed care organization may be offered by the employer but it is not required, and employee has choice of physician.

Choice of Treating Physician

The employee selects the initial treating physician. A change in physician requires prior approval of the insurer or WCC.

Rehabilitation

General Information

The Law provides for rehabilitation services for injured employees in order that they may return to gainful employment. An injured employee engaged in a rehabilitation program is entitled to receive additional compensation necessary for his maintenance; however such additional compensation shall not exceed $25.00 per week for more than 52 weeks.

The Commission has established within the agency a rehabilitation unit which works conjunction with rehabilitation providers to insure the availability of sufficient rehabilitation services to workers' compensation recipients who can potentially benefit from such services.

Missouri

Missouri Division of Workers' Compensation

P.O. Box 58
Jefferson City, Missouri
(573) 751-4231 or (800) 775-2667
http://www.labor.mo.gov/DWC/

Agency

General Information

The Missouri Division of Workers' Compensation (DWC) is part of the State Department of Labor and Industrial Relations (DOLIR). The Missouri Division of Workers' Compensation administers the programs providing services to all stake holders including workers who have been injured on the job or been exposed to occupational disease arising out of and in the course of employment. The Division makes sure that an injured worker receives benefits that he/she is entitled to under the Missouri Workers' Compensation law. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured workers entitlement to benefits allowed by Missouri law. The Division has eight offices throughout Missouri with the main office being in Jefferson City.

Reported Statistics (2012 Annual Report):

FY 2012- Number of Workplace Injuries, Illnesses, or Fatalities Reported= 105,306

FY 2012- Number of Workers' Compensation Claims Reported= 13,424

Mission Statement

Missouri Department of Labor mission statement: "To promote industry and labor and protect the rights and safety of Missouri's workforce."

Legislative and Regulatory Links

Missouri Code of State Regulations- Division of Workers' Compensation: http://www.sos.mo.gov/adrules/csr/current/8csr/8csr.asp#8-50

Missouri Revised Statutes: http://www.moga.mo.gov/STATUTES/C287.HTM

Budget and Financing

Agency Funding Source

The funding for the DWC to administer the Workers' Compensation Law comes from a tax and surcharge on employers workers' compensation net deposits, net premiums or net assessments, and net premium equivalents for self-insured employers. The Workers' Compensation Administrative Tax and Surcharge is capped at two percent per Missouri Statute 287.690.

2012-2013 Operating Budget/Staff Size

The Governor's FY 2013 recommended budget for DWC is $9,100,537.

Staff Size: The Division currently has 138 full time employees with 12 vacant positions

Funds

Second Injury Fund

The Second Injury Fund (SIF) compensates injured workers when a current work-related injury combines with a prior disability to create an increased combined disability. The SIF is funded by a surcharge on employers' workers' compensation premiums and equivalent premiums for self-insured employers. The Missouri State Treasurer is the "custodian" of the SIF. The Missouri Attorney General's Office defends the claims made against the SIF and obtains the Treasurer's authority to settle cases for the SIF. The Second Injury Fund Unit is responsible for the billing and collection of the Second Injury Fund Surcharge from insurance carriers writing workers' compensation premiums in Missouri and from self-insurers or group trusts authorized to self-insure in Missouri.

An injured worker must have a permanent, pre-existing disability to trigger liability of the SIF. The prior disability must be "of such seriousness as to constitute a hindrance or obstacle to employment". In order for an employee to recover from the SIF, certain minimum thresholds must be met.

The SIF also is responsible for paying medical bills of injured workers when the employer fails to insure its workers' compensation liability. In addition, if the employee is killed, burial expenses and death benefits in the form of weekly payments to the surviving spouse or dependents of the employee are paid from the SIF if the employer is uninsured.

The SIF also provides benefits to injured workers who are undergoing physical rehabilitation. To qualify for these benefits, the employee must be seriously injured and be receiving therapy at a facility certified by the Division. If the injured worker qualifies, he/she will receive $40 per week for up to 20 weeks for rehabilitation.

The last benefit from the SIF is second job wage loss benefit. The benefit applies to injuries that occurred after August 28, 1998. The employee must be injured on the job with the first employer. If the employee is unable to work at a second job as a result of the injury these benefits may be claimed from the SIF.

SIF is financed by a surcharge against employers set at a percentage that will generate 110% of the previous year's expenditures. The surcharge cannot exceed 3%.

In 2012, $35,473,348.76 in permanent total (PTD) benefits (lifetime benefits) was paid to 1,185 recipients. This is only an 18.6 percent increase from the PTD benefits paid in 2011 ($29.9 million). In 2012, there were 106 additional new injured employees receiving benefits from the Second Injury Fund annually; this is an increase of 43.2% from, 2011.

Insurance Requirements and Resources

General Information

Every employer that has five or more employees must insure its workers' compensation obligations with an insurance carrier that is authorized to write such insurance in the state of Missouri by the Department of Insurance, Financial Institutions and Professional Registration, or meet the Division of Workers' Compensation requirements to self-insure its liabilities. Construction industry employers that erect, alter, demolish or repair improvements are required to carry workers' compensation insurance if they have one or more employees.

The statutory definition of “employee” includes both full and part-time employees, and includes every person in the service of an employer under any contract of hire, express or implied, oral or written, or under any appointment or election, including executive officers of a corporation.

Sole proprietors and partners are not themselves covered unless they elect to be covered. On the other hand, close family member-employees and members of limited liability companies are presumed to be covered unless they opt out.

The Workers Compensation Act does exempt a very small and very specific group of employees, which includes farm laborers, domestic servants, certain real estate agents and direct sellers, and commercial motor-carrier owner-operators.

Private Insurance

The State Insurance Department has regulatory authority over workers’ compensation insurance carriers.

Missouri Department of Insurance, Financial Institutions and Professional Registration
PO Box 690
Jefferson City, Missouri 65102
(573) 751-4126
http://insurance.mo.gov/

Self-Insurance

As an alternative to purchasing an insurance policy, employers and groups of employers may apply to the Division of Workers’ Compensation to self-insure their workers’ compensation obligations. Application can be made through the Division’s Insurance Unit. The Insurance Unit functions as the chief underwriter, regulator and auditor for the self-insurance program. There are two types of self-insurance individual and group trusts. An employer wishing to self-insure must have the financial capability to self-insure. The inability of an employer to meet financial obligations of work-related injuries will directly impact the entire financial stability of the company. A potential advantage of self-insuring is reduced costs.

Individual Self-Insured Employers (2012): 289
Group Trusts (2012): 21
Employees Covered: 409,809

Individual Self-Insurance

Self-insurance on an individual basis allows for a large employer to retain the risk of its workers’ compensation liability. The employer is financially liable for the administration and payment of all workers’ compensation benefits to its injured workers. There is no insurance company that assumes the responsibility of paying benefits to the employer’s injured employees. An employer who believes it can safely absorb this financial risk can apply to the Division of Workers’ Compensation for self-insurance authority. The Division can grant approval to an employer to operate as a self-insured employer if it meets the requirements set forth in the regulations. Self-insurance involves administration, safety, record keeping, appropriate funding of losses, and filing the necessary reports with the Division as indicated in 8 CSR 50-3.010, Rules Governing Self-Insurance.

The Division of Workers' Compensation has the regulatory authority over employers who self-insure their workers' compensation liability. Self-insured employers must abide by the Rules Governing Self-Insurance found at 8 CSR 50-3.010, which detail the requirements for being self-insured. In addition, self-insured employers must comply with the statutory requirements set forth in Chapter 287, Revised Statutes of Missouri. Self-insured employers are required to pay the workers' compensation tax and Second Injury Fund surcharge, as required of all Missouri employers.

Group Self-Insurance

A self-insurance group trust is a method by which small - to medium - sized employers can pool their workers' compensation liability with other employers.

The group trust is the joint and several assumption of risk by a group of employers usually within the same industry or members of the same association. Employers spread out their workers' compensation risk among all the members of the group trust. Each member pays a premium to the group trust. All losses and expenses for the group trust are paid from the collected premiums. If the losses and expenses exceed the collected premium, then each member will be required to make additional contributions. However, each member may receive a surplus distribution if the losses and expenses for the group trust are less than the collected premium.

The success and proper functioning of a self-insurance group trust comes from its members' commitment to reducing work place accidents and the efficient administration of its claims and general operations.

The Division of Workers' Compensation has the regulatory authority over the group trust and the employers who participate in the group trust. The group trust and its members must abide by the Rules Governing Self-Insurance found at 8 CSR 50-3.010 and the statutory requirements set forth in Chapter 287, Revised Statutes of Missouri. Members of the group trust are required to pay the workers' compensation tax and second injury fund surcharge as required of all Missouri employers.

Religious Exception Program

The Religious Exception Program receives, reviews and responds to all questions related to granting a waiver or exception to an employer and employees of an employer who are members of a recognized religious sect or division, defined in 26 U.S.C. 1402(g) by reason of which they are conscientiously opposed to acceptance of benefits of any public or private insurance which makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or provides services for, medical bills, including the benefits of any insurance system established under the Federal Social Security Act, 42 U.S.C. 301 to 42 U.S.C. 1397jj. The Division has developed forms to be used by an applicant applying for the religious exception. An exception granted to an employee shall continue to be valid until such employee rescinds the prior rejection of coverage or the employee or sect ceases to meet the requirements of Section 287.804.1 RSMo.

Penalties for Noncompliance and Fraud

Noncompliance

Any employer who knowingly fails to insure his liability is guilty of a class A misdemeanor and is liable to the state of Missouri for a penalty up to three times the annual premium the employer would have paid had they been insured or up to fifty thousand dollars, whichever amount is greater. A subsequent violation is a class D felony.

Fraud

Fraud can be committed by employees, employers, lawyers, insurers, or physicians and convictions range from a class A misdemeanor up to a class C felony.

*Penalties Received**			
	Fraud	Noncompliance	Total Received
2010	$7,936.38	$574,741.19	$582,677.57
2011**	$123,397.78	$470,256.83	$593,654.61
2012**	$13,822.16	$453,186.77	$467,008.93

* Penalties received include those imposed in previous years. Many penalties are paid in monthly installments over several years.

** Amounts for 2012 have not been finalized because totals are likely to increase as penalties collected late in the year are reported to DWC

http://labor.mo.gov/DWC/Forms/DWC2012AnnualReport.pdf

Reporting Requirements

First Report of Injury

Every injury or occupational disease reported to an employer must be reported to the Division except those for immediate first aid with no further medical treatment required, no lost time from work or Claim for Compensation being filed. The injury must be reported to the Division within 30 days of the employer or insurer having knowledge of the injury. The employer must report all injuries to its insurance carrier or third party administrator within five days of the date of injury or date the injury was reported to the employer by the employee. The Division received such First Reports of Injury (FROIs) through Electronic Data Interchange (EDI).

Additional Reports/Claims Processing and Monitoring

In addition to filing an employer's first report, follow-up reports on medical treatment, and the amount of compensation paid must also be filed. The DWC monitors the initial payment and last payment of a workers' compensation claim. In addition, medical records must be filed with DWC in order to terminate temporary total disability benefits.

DWC makes the final administrative decision for determining a claimant's permanent partial disability rating. Factors used to determine a claimant's PPD rating include:

- Impairment rating of attending physician;
- Employee's loss of wage earning capability;
- Criteria as set forth by the courts; and
- Employee factors such as age, education, training, etc.

EDI Standards

There are three cost effective ways listed below to electronically file First Reports of Injury. In January 2009 the Division mandated the use of EDI Claims Release 1.0 for electronic filing of the First Report of Injury. A large volume filer may want to use the first two options, and a low volume filer may find that the Web-based option is more cost effective for their needs.

The Division uses the International Association of Industrial Accident Boards and Commissions (IAIABC) EDI Claims Release 1.0 format for the First Report of Injury which is a standard format used by other states, insurance companies, third party administrators and self-insured employers who are authorized by the Division to file electronically. A signed Trading Partner Agreement needs to be on file with the Division prior to utilizing any of the three options. These options provide flexibility and allow the reporting entity to choose the option that is cost effective, efficient, and streamlines the reporting process. The Division sends an acknowledgment to the reporting entity informing them that the reports were accepted and an injury number was assigned to the case. The Division also notifies the reporting entity if the report submitted requires additional data fields to be completed or needs data corrected before the report is considered properly filed with the Division.

Contested Case Handling

Dispute Management Unit

The Dispute Management Unit is responsible for providing information and attempting to resolve disputes between the injured worker and the employer/insurer (parties to the case) prior to a case proceeding to formal litigation. The Dispute Management Program is an alternative dispute resolution process to mediate disputes that arise soon after a workplace injury occurs. The Division has one mediator who assists parties in resolving medical treatment and lost wage disputes. This is a voluntary process and both parties must agree to mediate. When one of the parties does not agree to mediate, the party originally requesting mediation services is advised that he or she may take further steps if the problem persists, including requesting a docket setting with an Administrative Law Judge. The unit does not provide voluntary mediation services if a formal Claim for Compensation has been filed with the Division as the filing of a Claim initiates a contested case proceeding where an Administrative Law Judge has the authority to determine the issues in dispute.

Docketing and Adjudication

The Division offers various docket settings, such as voluntary settlement conference; prehearing; mediation; hardship hearing; hearing upon final award; and notice to show cause or dismissal setting.

A “conference” is a proceeding before an administrative law judge held in cases where no claim for compensation has been filed. A conference is an opportunity for the injured worker to meet with the lawyer for the employer/insurer, discuss the case, and attempt to resolve the case by settlement, if appropriate.

A pre-hearing is a proceeding before an administrative law judge to discuss issues in a case in which a Claim for Compensation has been filed; a pre-hearing may be requested when the parties want to present a settlement agreement for approval’ or disputes or other issues arise that must be resolved in order for the case to proceed; or the parties have a good faith belief that a brief meeting with an administrative law judge will help in moving the case more expeditiously to settlement or final hearing.

A mediation is a setting in which the parties and their lawyers, if represented, meet with an administrative law judge to discuss issues in a confidential manner, identify areas of agreement and facilitate a compromise settlement of a claim to avoid proceeding to a hearing.

A hardship hearing is an evidentiary hearing held before an administrative law judge when the employee alleges that he/she is not at maximum medical improvement, is in need of medical treatment or entitled to temporary total disability benefits, and the employer is not providing such treatment or benefits. A hardship hearing is a hearing in which the employee has already filed a Claim for Compensation and is requesting the issuance of a temporary or partial award. A temporary or partial award addresses issues of medical treatment and payment of temporary disability benefits. If a party requests the issuance of a final award and makes it an issue at the hearing and the evidence presented so merits, a final award may be issued.

A final hearing may be requested when the employee has reached maximum medical improvement or the case is otherwise ready for final resolution. This is an evidentiary hearing on the record, and a verbatim record will be made for the reviewing tribunal. A Claim for Compensation myst be filed by the employee before a case can be set for an evidentiary hearing. The administrative law judge may set the case for evidentiary hearing, or determine that the request for hearing is premature. The determination by the administrative law judge shall be recorded as a minute entry.

Application for Review to the Labor and Industrial Relations Commission

Once an employee has gone through the hearing process and an administrative law judge has issued an award, the parties to the case have the right to appeal the decision by filing an Application for Review with the Labor and Industrial Relations Commission (Commission) within 20 days of the date of the award. Written application must contain information as to the case and award that the party wishes reviewed and state the reasons for making the application for a review. The Commission is a three-member panel that reviews the awards of administrative law judges in workers' compensation cases. The Commission will ask the court reporter to make a complete transcript of the trial proceedings. The Commission will require that legal briefs be filed. If the Commission agrees completely with the judge's award, it may adopt the judge's award as its own. If the Commission disagrees with the judge's decision, in whole or in part, the Commission will issue a new award. Cases in which a settlement agreement or stipulation for compromise settlement was approved by an administrative law judge cannot be appealed to the Commission.

Missouri Court of Appeals

A second appeal may be requested by any party after a final award by the Commission. This is done by filing a timely Notice of Appeal to the Missouri Court of Appeals. The Court of Appeals does NOT hold a new trial. The Court of Appeals will review the transcript of the trial proceedings before the administrative law judge. The Court of Appeals can only change or reverse the Commission's award based upon legal issues. The Court of Appeals must accept the Commission's findings of fact.

Missouri Supreme Court

There is a possibility of a third appeal in some cases. The Missouri Supreme Court may accept a case for a third appeal, but this is very rare and only happens in cases involving significant legal issues.

The Division does not track the stats regarding Court of Appeals cases and Supreme Court cases, and our formal hearing types are broken out by type.

Attorneys' Fees

DWC has the authority to regulate attorneys' fees. The claimant's Attorneys' fees are paid out of the claimant's award.

Stipulation for Compromise Settlement Agreements

Stipulation for Compromise Settlement Agreements between the parties must be approved by an ALJ in order to be valid. An ALJ will approve a settlement agreement pursuant to §287.390 RSMo as valid and enforceable as long as:

- The settlement is not the result of undue influence or fraud;
- The employee fully understands his or her rights and benefits;
- The employee voluntarily agrees to accept the terms of the agreement; and
- The settlement is in accordance with the rights of the parties.

All stipulations for compromise settlement submitted for approval must be accompanied by copies of all available medical rating reports, surgical notes, and radiological reports, or progress notes showing a diagnosis, or statement from the employer/insurer's attorney indicating that the injury is of such a minor nature that no medical report is necessary.

Medical Care and Evaluation

Fee Schedule

Missouri does not have a medical fee schedule. §287.140.3 RSMo. states "All fees and charges under this chapter shall be fair and reasonable…..A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private insurance carrier…"

Treatment Guidelines

Missouri does not have treatment guidelines for workers' compensation.

Managed Care

Managed care organizations are authorized through and regulated by the Department of Insurance.

Choice of Treating Physician

The employer (or the insurer, on behalf of the employer) has the right to choose the healthcare provider or treating physician. However, the employee has the right to select a treating physician at the employee's own expense.

Medical Fee Dispute Program

A medical fee dispute ("MFD") is a proceeding filed by a health care provider when there is a dispute about the payment of bill(s) for medical treatment. There are two types of medical fee disputes: "Reasonableness", when the bill has been discounted and partially paid (also known as an application for payment of additional reimbursement of medical fees), and "Direct Pay", when treatment has been authorized but no payments have been made on the bill. The functions undertaken by the Medical Fee Dispute Program include processing the applications for direct payment and applications for payment of additional reimbursement of medical fees filed by a health care provider; processing answers filed by the employer or insurer; setting the reasonableness

disputes for an evidentiary hearing; and responding to all queries and telephone calls for assistance. If the total amount of reimbursement sought is less than one thousand dollars and a request for administrative ruling is filed by a party, the matter is referred to the dispute management unit. If the total amount of reimbursement sought is more than one thousand dollars a health care provider may file an application for evidentiary hearing with the Division and the case will be heard by an Administrative Law Judge. All requests for awards on undisputed facts in direct pay cases are reviewed and decided by an administrative law judge.

Rehabilitation

General Information

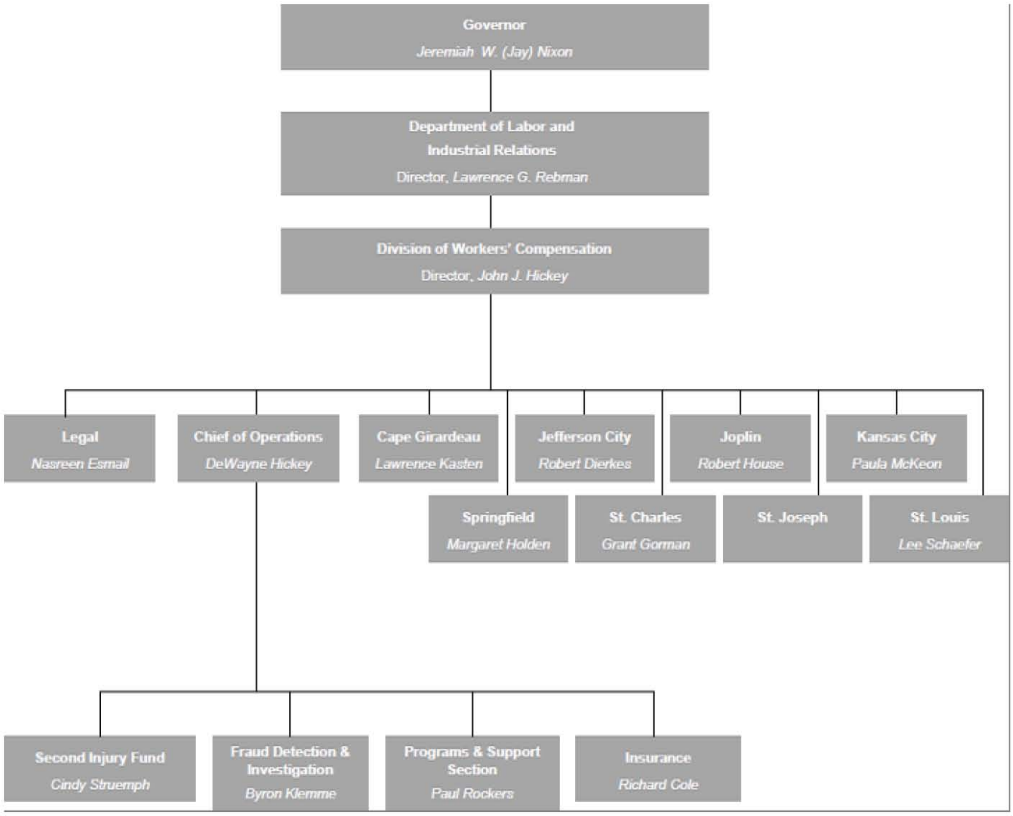
The Division of Workers' Compensation (Division) administers a program employers may use to provide vocational rehabilitation to severely injured worker. The employee must have sustained a workplace injury of sufficient severity as indicated in Section 287.148 RSMo. The employee may receive vocational rehabilitation services, if authorized by the employer, which are reasonably necessary to restore the employee to suitable and gainful employment.

The Division has the responsibility to ensure that qualified practitioners and facilities are available and have the capability of providing the appropriate rehabilitation services for the injuries sustained. The Division also has the responsibility of reviewing the written plan of care to ensure that the employee is restored to suitable and gainful employment.

Section 287.143-287.149 RSMo governs vocational rehabilitation.

Missouri Division of Workers' Compensation

Organizational Chart



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Montana

Montana Employment Relations Division

Beck Building

1805 Prospect Avenue

P.O. Box 8011

Helena, Montana 59604

http://erd.dli.mt.gov/

Agency

General Information

Montana's Employment Relations Division (ERD), in the Department of Labor & Industry, provides a wide variety of service and regulation related to the employer – employee relationship. This includes issues involving workers' compensation coverage and claims, human rights disputes, workplace safety and health, wage and hour disputes, prevailing wage issues, and public sector collective bargaining.

ERD provides education and technical assistance to employers to assist them in better understanding and complying with state labor laws. ERD works with both employers and employees to resolve disputes that do arise in the employment relationship through informal investigations and mediation.

Mission Statement

The mission of the Employment Relations Division is to uphold public policy as it relates to the employment relationship and illegal discrimination.

Vision Statement

Employment Relations Division Staff:

- Work together to maintain a relationship of open communication, mutual appreciation and respect
- Provide the highest level of customer satisfaction by listening and responding to the needs of our customers
- Are receptive to change
- Celebrate quality service and work, by individuals and units
- Have the power to act and take initiative to action in pursuit of our mission and vision
- Support innovation, risk-taking and open-mindedness
- Value and respect each other's individuality, skills and professional contributions

Legislative and Regulatory Links

Montana Code (Annotated 2011): http://leg.mt.gov/bills/mca_toc/39_71.htm

Montana Administrative Rules: http://www.mtrules.org/gateway/ChapterHome.asp?Chapter=24.29

Budget and Financing

Agency Funding Source

The primary funding source for ERD is an administrative assessment paid by employers who have workers' compensation coverage. Self-insured employers pay an assessment of up to 3% on the total benefits paid in the previous year. Insurers collect a premium surcharge from all policyholders that represent an assessment of up to 3% of the paid losses in the preceding calendar year. (Montana Statute 39-71-201, MCA). Some units, such as the Independent Contractor Central Unit (ICCU) and Uninsured Employers Fund (UEF), are self-funded.

Staff Size: 130
Biennium 2012-2013 Operating Budget: $20,981,576
http://leg.mt.gov/content/Publications/fiscal/BA_2013/section_a/labor_industry.pdf

Funds

Subsequent Injury Fund

The Subsequent Injury Fund (SIF) in Montana is administered by the Regulations and Claims Assistance Bureaus of ERD. SIF is financed by a direct assessment to self-insured employers and a policyholder premium surcharge to other employers in the state. A worker must qualify for certification by submitting an application to ERD. When a SIF certified worker obtains a subsequent injury, the Fund will pay, subject to statutory requirements, medical and wage loss benefits after the employer's insurer has paid for the first 104 weeks of medical and wage loss benefits.

Number of Certified Individuals in FY12: 4,812
Dollars paid in FY12: $713,114

Uninsured Employers' Fund

The Uninsured Employers' Fund (UEF) is administered by the Regulations Bureau of ERD. UEF is financed through fines and penalties on employers who fail to carry the proper workers' compensation coverage. If funds are available, UEF pays injured worker's wage loss and medical benefits according to provisions of the statute.

Dollars paid in indemnity and medical benefits in FY12: $775,626

Insurance Requirements and Resources

General Information

An employer who has an employee in service under any appointment or contract of hire, expressed or implied, oral or written, must elect to be bound by the provisions of compensation Plan 1 (self-insured), Plan 2 (private insurance companies), or Plan 3 (Montana State Fund). Some exemptions apply.

Private Insurance

Montana's Commissioner of Securities and Insurance has regulatory authority over workers' compensation carriers.

Montana Commissioner of Securities and Insurance
Commissioner of Securities and Insurance
840 Helena Avenue
Helena, Montana 59601

Self-Insurance (39-71-2101, MCA)

Montana's Department of Labor and Industry has regulatory authority over individual and group self-insurers.

The Department determines whether an employer has the requisite financial ability to pay workers' compensation indemnity and medical benefits and, if so, grants the employer permission to self-insure their workers' compensation liabilities.

An applicant for self-insurance is required to submit an application along with audited financial statements, or reviewed statements if audits are not normally prepared. The financial statements are reviewed and financial ratios are computed and compared to other businesses in the same industry to determine the strength of the business and its ability to make workers' compensation payments when due.

Qualifications for a self-insurer include, but are not limited to:

- Furnish satisfactory proof of financial solvency and ability to pay claims;
- Post a security deposit of at least $250,000; and
- Have been in business for three years or more.

Penalties for not Insuring (39-71-504, MCA)

The UEF is self-funded. Two forms of revenue are collected from uninsured employers:

1. Penalties - UEF levies and collects penalties for the time that the employer was legally required to have a workers' compensation policy until they are in compliance. Penalties can be double the insurance premium that would have been paid by the employer, or $200, whichever is greater. Penalties levied by UEF are based on the cost of the policy that should have been in place during the uninsured period, based on the company's industry code.
2. Recoupment of benefits paid - UEF collects from uninsured employers all medical and indemnity benefits paid by UEF on behalf of injured employees. UEF has the statutory authority to charge late fees and interest and can file liens on real property while trying to collect the debt owed.

Number of assessed penalties in FY12 – 845
Dollar amount of penalties assessed - $5,020,347
Dollar amount of penalties collected - $2,193,687

Reporting Requirements

Injury Reporting Requirements

An employee must report all on-the-job injuries or occupational diseases to their supervisor, insurer or employer as soon as possible. They must give notice within 30 days after the occurrence of the accident or one year from the date they knew or should have known their condition was from an occupational disease. The notice must include the time and place where the accident occurred and the nature of the injury. It is recommended the employee report minor injuries to their employer whether or not they receive medical treatment.

An employee must submit a signed First Report of Injury (FROI) within 12 months from the date of the accident or occupational disease. They can submit this form to their employer, the workers' compensation insurer or the Department of Labor and Industry.

Upon receipt of the signed FROI, the insurer has 30 days to accept or deny the claim.

Other Reports/Claims Processing and Monitoring

Insurers must report all injuries to the department. After filing the FROI, no further reporting is necessary for medical only claims. A Subsequent Report of Injury (SROI) is required for all indemnity claims, every six months from the date of injury, while benefits are being paid. A final SROI is due when no further medical or indemnity payments are expected. Additional reporting includes other statutorily required documentation, any documentation requested by ERD, and all required documentation for processing of settlements.

TTD benefits are payable until the worker reaches maximum medical improvement or returns to work.

The PPD award is determined statutorily using the factors below. However, appealed cases, considered a benefit issue, are directed to non-binding mediation in the Workers' Compensation Claims Assistance Bureau:

- Impairment rating by the attending physician;
- Employee's age and education;
- Wage loss;
- Physical restrictions;
- Use of the Sixth Edition of the AMA Guides to the Evaluation of Permanent Impairment

Electronic Data Interchange (EDI) Standards

Montana currently mandates the use of the IAIABC Claims Release 1.0 standard for FROI and SROI reporting and the IAIABC Proof of Coverage (POC) Release 2.1 standard.

Contested Case Handling

Levels in the hearing process include:

1. Mandatory Mediation
2. Workers' Compensation Court, overseen by a workers' compensation judge
3. Montana Supreme Court (overseen by 7 justices)

	Notes or Comments on Scope	*Number in FY2012*
Mandatory Mediation		1,375 petitions received
Workers' Compensation Court		198 new cases; 47 published decisions
Montana Supreme Court		7 decided cases (CY2012)

Attorneys' Fees

ERD must approve attorneys' fee agreements. In most cases, fees are paid from the award.

Compromise and Release Agreements

Compromise and Release agreements are allowed when approved by the Department of Labor and Industry. These agreements may terminate future indemnity benefits. Medical benefits may also terminate by settlement negotiation. The claim may be reopened after an agreement on finding of mutual mistake of fact or law.

Medical Care and Evaluation

Fee Schedules

The Department sets the medical reimbursement rates to be paid to medical providers for treatment of workers' compensation claimants.

The Facility Fee Schedule and Professional Fee Schedules are posted on the Department's website at the following links:

http://erd.dli.mt.gov/workers-comp-claims-assistance/medical-regulations/montana-facility-fee-schedule.html

http://mtwcfeeschedule.ingenix.com/overview.aspx

Medical Fee Schedules (39-71-704, MCA)

The Facility Fee Schedule reimburses facilities based on Diagnosis Related Groups (DRG) methodology for inpatient and for outpatient, Ambulatory Payment Classifications (APC) methodology. Using data provided by inpatient hospitals and outpatient services and surgery centers, ERD develops a reimbursement base rate for the facility fee schedule which is then multiplied by the relative weight to obtain the current allowable reimbursement rate. The APC methodology is basically the same. However, there are some reimbursements based on Current Procedural Terminology (CPT) codes in which ERD uses data from outpatient hospital and surgical centers to develop a base rate conversion factor, which is then multiplied by the relative value to obtain the allowable reimbursement for a procedure.

The Non-Facility Fee Schedule (name will be changed after July 1, 2013, to Professional Fee Schedule) reimbursement is based on Resource-Based Relative Value Scale (RBRVS). It incorporates the relative values produced by the Centers for Medicare and Medicaid Services for the physician fee schedule into relative values. Over 75% of non-Medicare payers use RBRVS to establish fees or maximum allowables for professional services. ERD uses the average conversion factor plus 10% of the top health insurers in Montana who use RBRVS as a methodology for reimbursement. The conversion factor is then multiplied by the relative value to obtain the allowable reimbursement for a procedure.

Treatment Guidelines (39-71-704(3), MCA)

The treating physician is responsible for the management and coordination of medical care and must treat the employee within the recommendations of Montana's Utilization and Treatment Guidelines. An insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department, unless the provider obtains prior authorization from the insurer. If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for payment of the medical treatment or services.

http://erd.dli.mt.gov/utilization-a-treatment-guidelines-project.html

Independent Medical Review (39-71-704(3), MCA)

The department was given the authority to establish by rule an Independent Medical Review (IMR) process (24.29.1594 ARM) for treatment or services denied by an insurer prior to mediation. The IMR carried out by the Medical Director is an informal alternative dispute resolution process. The Medical Director, during the course of an IMR, reviews the injured worker's medical records and other information relevant to the denial and issues a recommendation. If the insurer does not authorize treatment after issuance of the Medical Director's

recommendation, the interested party may file for mediation with the department pursuant to 39-71-2401 MCA.

Managed Care (39-71-1103 – 39-71-1105, MCA)

Managed Care Organizations are permitted in Montana and are regulated in ERD by the Workers' Compensation Regulations Bureau.

Choice of Treating Physician (39-71-1101, MCA)

An employee may choose the treating physician for initial treatment. Any time after acceptance of liability by an insurer, the insurer may designate a different treating physician, or approve the employee's choice of the treating physician.

Rehabilitation (39-71-1006, MCA)

General Information

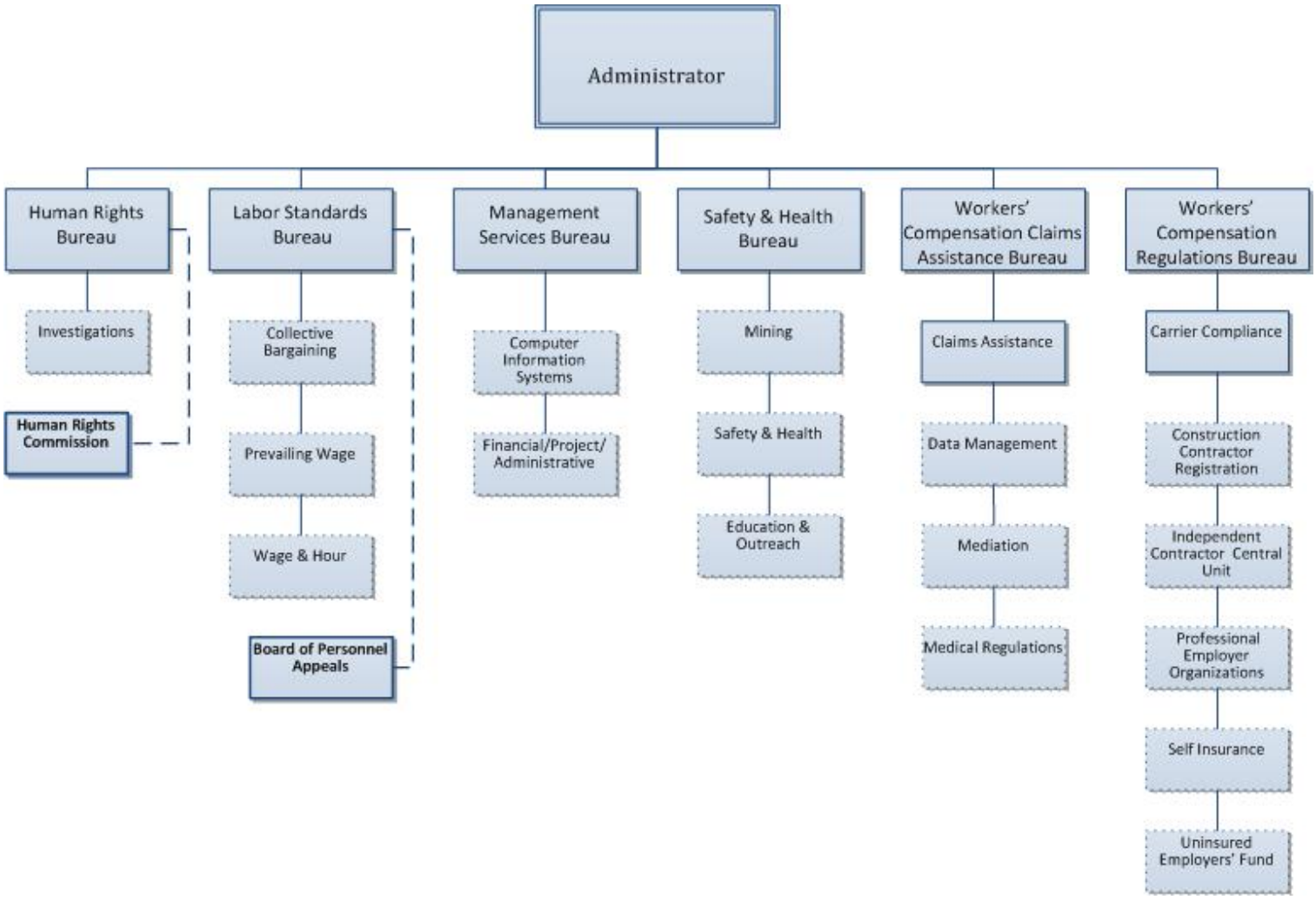
Vocational rehabilitation benefits are provided if:

- The worker meets the definition of a "disabled worker" and has an actual wage loss as a result of the injury or the worker has a whole person impairment rating of 15% or greater and has no actual wage loss;
- A rehabilitation provider certifies that the injured worker has reasonable vocational goals and reemployment opportunity and will have a reasonable reduction in the worker's actual wage with rehabilitation; and
- A rehabilitation plan is agreed upon by the worker and the insurer and a written copy of the plan is provided to the worker.

Benefits are terminated by the insurer if the claimant refuses to cooperate with rehabilitation. A worker who is undergoing rehabilitation under a rehabilitation plan may receive, in addition to TTD benefits, auxiliary rehabilitation benefits to cover travel and relocation expenses, employment searches, and on-the job training.

Rehabilitation costs are paid by insurers. Benefits may be available for up to 104 weeks. The goal is to return the injured worker to the work force with as little cost as possible to the employer.

Workers' Compensation Division Organization Chart



Nebraska

Nebraska Workers' Compensation Court

P.O. Box 98908

Lincoln, Nebraska 68509

(402) 471-6468 or

(800) 599-5155

http://www.wcc.ne.gov/

Agency

General Information

The Nebraska Workers' Compensation Court (Court) is a statutorily created court under the judicial branch and has responsibility for administration and enforcement of the Nebraska Workers' Compensation Act.

For administrative purposes, the judges and staff of the Court are organized into two operating divisions and seven operating sections. The adjudication division, under the direction of the presiding judge, includes the judges and the Office of the Clerk of the Court. The administration division, under the direction of the court administrator, includes the remaining six sections (Business and Human Resources, Legal, Coverage and Claims, Vocational Rehabilitation, Public Information, Information Technology). The presiding judge is charged with overall responsibility for the functioning of the Court, and the court administrator serves as the chief administrative officer for the Court.

Mission Statement

The mission of the Nebraska Workers' Compensation Court is to administer and enforce all provisions of the Nebraska Workers' Compensation Act, except those provisions that are committed to the courts of appellate jurisdiction or as otherwise provided by law.

Legislative and Regulatory Links

Nebraska Workers' Compensation Act (and other Labor Statutes) http://uniweb.legislature.ne.gov/laws/browse-chapters.php?chapter=48

Nebraska Rules of Procedure (Workers' Compensation Court): http://www.wcc.ne.gov/publications/rules.pdf

Budget and Financing

Agency Funding Source

The Compensation Court Cash Fund was established to pay expenses related to the workers' compensation act and the Workers' Compensation Court. Self-insured employers pay 1 1/4% of their prospective loss costs for like employment. Every insurer pays 1% of their gross premiums received in the previous calendar year (Nebraska Statute Sections 48-1,113 and 1,114).

Operating Budget and Staff

Staff Size: 54.1

FY 2012-2013 Operating Budget: The appropriation for fiscal year 2013 (July 1, 2012 to June 30, 2013) is $5,962,052.

Funds

Workers' Compensation Trust Fund

The Workers' Compensation Trust Fund was established July 1, 2000 as part of LB 1221 from the 2000 session of the Nebraska Legislature. The purpose of the fund is to make second injury benefit payments in accordance with Section 48-128 and vocational rehabilitation benefit payments in accordance with Section

48-162.01. Prior to July 1, 2000 second injury benefits were paid from the Second Injury Fund and vocational rehabilitation benefits were paid from the Vocational Rehabilitation Fund. These two funds were eliminated with the creation of the Workers' Compensation Trust Fund on July 1, 2000. The Workers' Compensation Trust Fund is financed by assessments against workers' compensation insurers, risk management pools, and self-insured employers. Assessments are made whenever the fund is projected to go below the statutory minimum level.

Insurance Requirements and Resources

General Information

The Nebraska Workers' Compensation Act applies to the State of Nebraska, to every governmental agency created by it, and to every employer in the state employing one or more employees in the regular trade, business, profession, or vocation of the employer. Thus, virtually all employees are covered by the workers' compensation law including employees of private industry, state and local government, part-time employees, minors, and employees of charitable organizations.

There are a few exceptions:

1. Federal employees, railroad employees, most volunteers, and independent contractors are not covered under the Nebraska Workers' Compensation Act.
2. Household domestic servants and some employees of agricultural operations are covered under the Nebraska Workers' Compensation Act only if the employer elects to provide worker's compensation insurance for them.
3. Self-employed individuals, sole proprietors, partners, and limited liability company members who are actually engaged in the business on a substantially full-time basis may elect to be covered under the Nebraska Workers' Compensation Act. To elect coverage such a person must file a written election with the insurer from whom workers' compensation insurance coverage is obtained.
4. Executive officers of Nebraska corporations who own 25 percent or more of the corporation's common stock are not considered employees of the corporation under the Nebraska Workers' Compensation Act unless they elect to be covered. To elect coverage, a corporate officer must file such election in writing with the workers' compensation insurer and the corporate secretary (not with the Court).
5. Executive officers of Nebraska nonprofit corporations who receive annual compensation of $1,000.00 or less from the corporation are not considered employees of the corporation under the Nebraska Workers' Compensation Act unless they elect to be covered. To elect coverage such officers must file a written election with the workers' compensation insurer and the corporate secretary (not with the Court).

Private Insurance

The Nebraska Department of Insurance has regulatory authority over workers' compensation insurers and inter-governmental risk management groups.

Nebraska Department of Insurance
PO Box 82089
Lincoln, Nebraska 68501
(402) 471-2201
http://www.doi.ne.gov/

Self-Insurance

The Court has regulatory authority over individual self-insurers and inter-governmental risk management groups.

A. The following factors will be among those used in analyzing an application and determining whether an employer can be granted approval to self-insure (NWCC Rule 72):

1. standard financial ratio analysis and comparison to similar industry statistical data;
2. historical operating results;
3. evaluation of financial trends;
4. organizational structure and management background;
5. contingent liabilities;
6. pending litigation;
7. general and specific industry economic conditions;
8. number of employees;
9. current and historical loss experience, reserves, and modification factor;
10. safety program;
11. nature of business;
12. claim administration procedures, and;
13. proposed retention and limits for excess insurance.
14. claims record regarding delinquent payment of indemnity and medical expenses, as defined by section 48-125.

B. The Court will approve employers to self-insure who meet the requirements of Rule 71,A and can provide:

1. satisfactory proof of financial strength and liquidity to meet all obligations under the Nebraska Workers' Compensation Act;
2. a fully executed parental guarantee if the employer is a subsidiary;
3. acceptable arrangements for claim administration and injury and payment reporting;
4. security in accordance with Rule 73;
5. excess insurance in accordance with Rule 74;
6. evidence of a safety committee and an effective written injury prevention program in accordance with section 48-443, and;
7. evidence of compliance with any other requirements under the Act and these rules.

C. After reviewing the application and all supporting documentation and other information the Court will send written notice of approval, denial, or requirements for further consideration. If the Court has additional requirements, the employer will have 30 days to comply. Upon receipt

of a written request the Court, at its discretion, may grant the employer additional time to comply. If all requirements are not met within the time prescribed, the application shall be considered withdrawn.

D. A certificate of approval to self-insure will be provided upon approval. The term of approval will be included on the certificate. Sections 48-145, and 48-443, 48-444, 48-445, 48-446, R.R.S. 2010.

Penalties for not Insuring

If an employer fails to secure workers' compensation coverage, any one or more of the following penalties may be applied:

1. A civil fine not to exceed $1,000.00 for each violation. Each day of continued failure to secure coverage constitutes a separate violation.

2. Imprisonment for not more than one year, a $1,000.00 fine, or both.
3. Enjoinder from doing business in Nebraska until compliance is secured.

Also, an injured employee may sue the employer for damages in district court and the employer will lose its common law defenses.

Reporting Requirements

First Report of Injury

The employer should notify its workers' compensation insurer of the injury or occupational disease and either the employer or the insurer should file a First Report of Alleged Occupational Injury or Illness with the Court within 10 days of the date of the notice of injury. The injured employee is not responsible for filing this report.

Other Reports/Claims Processing and Monitoring

In addition to the employer's first report of injury, an employer must file a subsequent report (SROI) electronically with the Court. This SROI reports indemnity, medical/hospital, and miscellaneous payments.

A judge, after a hearing, makes the final decision regarding a claimant's permanent partial disability rating when the rating is disputed. Factors used to determine the disability rating include:

- Impairment rating of the attending physician;
- Employee's loss of wage earning capability
- Criteria as set forth by the appellate courts;
- Employee factors such as age, education, training, etc; and
- Current AMA Guide to Permanent Impairment

EDI Standards

Nebraska currently mandates the use of the IAIABC Claims Release 1.0 standard for FROI and SROI reporting and the IAIABC Proof of Coverage (POC) Release 2.1 standard.

Contested Case Handling

Levels in the hearing process include:

1. First Hearing - heard by a single judge of the Court
2. *Review Hearing - heard by a three-judge Review Panel of the Court
3. Court of Appeals and/or Supreme Court - heard by higher appellate courts

*Appeals to the Review Panel have been eliminated for 1) cases filed with the compensation court on or after August 27, 2011, and 2) cases pending before the compensation court on August 27, 2011 in which a hearing on the merits has not been held. Appeals from an order, award, or judgment of the compensation court in any such case now proceed in accordance with the procedures regulating appeals in actions at law from the district courts, except as otherwise provided in Neb.Rev.Stat. §§ 48-182 and 48-185.

Conversely, appeals from any case pending before the compensation court on August 27, 2011 in which a hearing on the merits has been held will continue to be in accordance with the three-judge Review Panel procedure

	Notes or Comments on Scope	Number in FY2012
First Hearing	Includes petitions filed or reopened in the fiscal year.	1,397
Review Hearing	Includes appeals filed in the fiscal year. Appeals to the Review Hearing stage are being phased out in favor of direct appeal to the Court of Appeals or Supreme Court.	26
Court of Appeals/Supreme Court	Includes appeals filed in the fiscal year.	71

Attorneys' Fees

Attorneys' fees are awarded by the Court when benefits are not paid within 30 days and the employee receives an award, unless there is a reasonable controversy, or at the Review Hearing if the plaintiff has the award increased or if the defendant fails to obtain a reduction in the award. Fees are set if the attorney desires a lien or is representing a State of Nebraska employee. If attorney fees are awarded by the Court, the fees are paid by the employer in addition to the award; otherwise the fees are usually paid out of the claimant's award.

Settlement Agreements

A lump sum settlement must be reviewed and approved by the Court in the following circumstances: 1) employee is not represented by counsel, or 2) employee is a Medicare beneficiary or Medicare-eligible, or 3) medical expenses were paid by Medicaid and will not be reimbursed as part of the settlement, or 4) medical expenses have been incurred and will not be fully paid as part of the settlement, or 5) the settlement involves payment of benefits to dependents of the employee (Nebraska Statute Section 48-139). A court approved settlement terminates indemnity benefits and medical benefits, although medical benefits may be left open at the request of the parties. A claim may be reopened after a court approved settlement only upon proof of fraud.

Medical Care and Evaluation

Fee Schedule

The Court is charged with establishing schedules of fees for medical, surgical, and hospital services, except that fee schedules for inpatient hospital services are established by statute.
https://www.wcc.ne.gov/apps/IPUBA0008Afrm.aspx

Treatment Guidelines

Nebraska does not currently have workers' compensation specific treatment guidelines.

Managed Care

Managed care plans must be certified by the Court to provide treatment to injured workers.

Choice of Treating Physician

The employee has the right to select a physician who has maintained the medical records of the employee (or an immediate family member) when the employer notifies the employee of this right. If the employee does not have or does not choose such a physician, then the employer may select the physician. If the employer does not give proper notice to the employee regarding the right of selection, then the restrictions on choosing and changing physicians do not apply and the employee has the right to select any physician. The employee also may select a physician to perform a major surgical operation or in cases involving dismemberment. "Physician" means any person licensed to practice medicine and surgery, osteopathic medicine, chiropractic, podiatry, or dentistry in the State of Nebraska or in the state in which the physician is practicing.

Rehabilitation

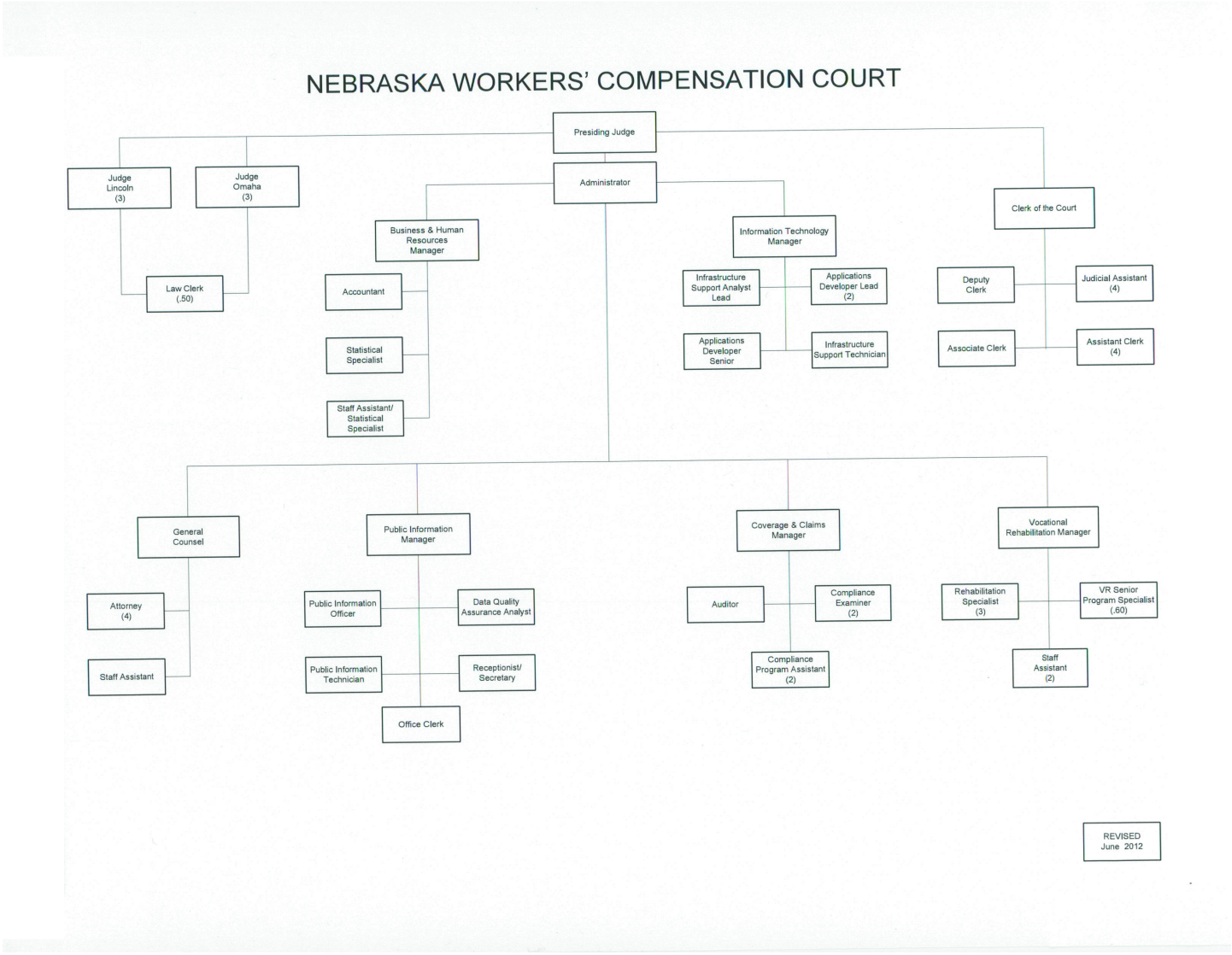
General Information

A manager, three vocational rehabilitation specialists, one senior program specialist, and two support staff are responsible for duties associated with vocational rehabilitation services to which an employee may be entitled under the Nebraska Workers' Compensation Act. The goal of vocational rehabilitation is to return an injured worker to suitable, gainful employment after an injury covered under the Act. A wide variety of services is available under the Act, from coordinating return to the pre-injury job with the employer to a period of formal training. The duties of the section can be divided into three broad categories: certifying vocational rehabilitation counselors and job placement specialists, appointing counselors when parties cannot agree, and reviewing, approving, and monitoring vocational rehabilitation plans.

Vocational rehabilitation services under the Act can only be provided by private counselors who have been certified by the Court. Rules 39–41 contain the requirements for certification. At the end of FY 2012 (June 30, 2012), there were 104 private vocational rehabilitation counselors and 108 job placement specialists certified by the Court. There are 38 certified private vocational rehabilitation counselors located in Nebraska.

When an injured worker claims entitlement to vocational rehabilitation services, the employee and the employer (or the employer's workers' compensation insurer) must try to agree on a vocational rehabilitation counselor to evaluate the employee and provide needed services. If they cannot agree, one of them can ask the Court to appoint a counselor. If notice of agreement to a counselor or a request for appointment of a counselor is filed with the Court, a vocational rehabilitation case is established.

Workers' Compensation Division Organization Chart



Nevada

Nevada Division of Industrial Relations

400 West King Street, Suite 400

Carson City, Nevada 89703

(775) 684-7260

http://dirweb.state.nv.us/

Agency

General Information

The Nevada Division of Industrial Relations promotes and enforces safety in the workplace. Should an injury occur, the Division ensures the timely and appropriate delivery of benefits.

Within the Division of Industrial Relations is the Workers' Compensation Section (WCS). WCS offices ensure compliance with Nevada's workers' compensation statutes and regulations pertaining to insurers, third-party administrators (TPAs), employers, and health care providers. Each has three sections providing this oversight: the Employer Compliance Unit, the Insurer/TPA Compliance Unit, and the Medical Unit. The WCS district offices are located in Carson City and Henderson.

Mission Statement

The Workers' Compensation Section (WCS) mission is to impartially serve the interests of Nevada Employers and Employees by providing assistance, information, and a fair and consistent regulatory structure by:

- Ensuring the timely and accurate delivery of workers' compensation benefits
- Ensuring employer compliance with mandatory coverage provisions

Legislative and Regulatory Links

Nevada Revised Statutes and Administrative Code: http://dirweb.state.nv.us/wcs/wcsdist.htm (see "Nevada Law" on left hand menu).

Budget and Financing

Agency Funding Source

The Fund for Workers' Compensation and Safety covers expenses relation to the Division of Industrial Relations, Fraud Control Unit and personnel in the Office for Consumer Health Assistance and Legislative Counsel. Private carriers pay an assessment based on their share of the total expected annual premiums to be received. Self-insured employers pay an assessment based on their share of expected annual claim expenses. Associations of self-insured public or private employers pay an assessment based on their share of expected annual claim expenses (Nevada 61A.425).

2012-2013 Operating Budget/Staff Size

The Governor proposes a biennial budget for DIR, which is reviewed, and sometimes modified, by the Nevada Legislature.

Funds

Subsequent Injury Accounts

Prior to 1999, Nevada has four Subsequent Injury Funds which were combined to create Subsequent Injury Accounts (SIA).

The primary purpose of the Subsequent Injury Account(s) is to encourage employers to hire workers who have suffered a permanent physical impairment. The impairment can be congenital or caused by a previous accident, illness or work-related injury/occupational disease. The costs of the subsequent injury are paid from a designated "subsequent injury account" which is supported by assessments received from workers' compensation insurers rather than having the current insurer pay the entire cost of a qualifying claim.

There are currently three separate subsequent injury accounts. Both the Self-insured Employers Account and the Associations of Self-insured Public or Private Employers Account has their own review board. They each have five board members who are appointed by the Governor. The Administrator of the Division of Industrial Relations (DIR) administers the account for private carriers.

To qualify for SIA, the employee must have a "Permanent impairment from any cause or origin" that supports a rating of permanent impairment of at least 6% according the AMA Guides to Evaluation of Permanent Impairment" and a "subsequent disability…which entitles him to compensation for disability that is substantially greater by reason of the combined effects of the pre-existing impairment and subsequent injury than which would have resulted from the subsequent injury alone." The employer must have written knowledge of the permanent impairment at the time of hire or retain the employee in employment after obtaining knowledge of the impairment. Notice of the claim must be submitted within 100 weeks after the injury or death.

Uninsured Employers' Claim Account

The Uninsured Employers' Claim Account (UECA) provides workers' compensation benefits to employees whose employers did not have industrial insurance at the time of their injuries. The account is administered by the DIR and is financed through assessments against insurers and self-insured employers. The uninsured employer is liable for money paid from the fund to provide benefits and compensation to the injured employee (NRS 616C.220).

Insurance Requirements and Resources

General Information

Unless excluded by statute, it is mandatory for an employer who has one or more employees to provide workers' compensation insurance coverage. Some employees are excluded by NRS 616A.110 due to unique criteria. Employment exempt from workers' compensation insurance coverage requirements includes:

- Employment related to those interstate commerce entities that are not subject to the legislative power of the state of Nevada.
- Employment covered by private disability and death benefit plans which comprehend compensation payments of equal or greater amounts than those provided in NRS 616 and which have been in effect for one year prior to July 1, 1947;
- Employees who are brought into Nevada on a temporary basis and who are insured in another state if extraterritorial coverage provisions are in effect with the other state. Exception: the construction trades.
- Casual employment (employment lasting not more than 20 days and having a total labor cost of less than $500) is exempt if employment is not in the course of trade, business, profession or occupation of the employer.

CONSTRUCTION TRADES ARE REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE.

Employers may purchase insurance from a private carrier licensed in Nevada or be certified by the Division of Insurance (DOI) as a self-insured employer or a member of an association of self-insured public or private employers. Private carriers currently utilize competitive premium rates which allow them to deviate on the 3 expense portion of the premiums.

Private Insurance

In July of 1999, private insurance companies were allowed to sell workers compensation in Nevada. Employers that are unable to obtain workers' compensation coverage from a private carrier may purchase insurance from a company that handles the "Assigned risk" pool (no state fund).

Individual Self-Insurance

Self-insured employers have been authorized since the early 1980s in Nevada. Since July 1995, group self-insurance has been authorized. To qualify as self-insured, an employer must obtain a certification from the Commissioner of Insurance (DOI) that it has sufficient administrative and financial resources to make certain prompt payment of compensation due under the Nevada workers' compensation statutes.

This includes:

- Having proof of financial ability to pay claims
- Depositing with the Commissioner money, securities, or a surety bond of not less than $100,000
- Submitting evidence of excess insurance to provide for protection against catastrophic losses

The Commissioner has the authority to decertify a self-insured employer fined by the DIR for non-compliance or negligence or for failing to continue to meet the minimum requirements for certification.

Group Self-Insurance

Associations of self-insured public and private employers are authorized pursuant to NRS 616B.350. They must meet the qualifications set forth in statute and obtain certification from the Commissioner. The Commissioner may withdraw the certification for failure to continue to meet statutory qualifications. All associations may be assessed for failure of any insolvent association to provide compensation.

Penalties for not Insuring

The Division of Industrial Relations, Workers' Compensation Section (WCS) is responsible for ensuring that all employers are in compliance with the law. Employers who do not provide workers' compensation will be charged with an administrative fine up to $15,000; appropriate premium penalties; may be ordered to close business until insurance has been obtained; and will be held financially responsible for all costs arising from a work-related injury. In addition, the uninsured employer may be subject to a criminal penalty for claims resulting in substantial bodily harm or death. (NRS 616D.200 & NAC 616D.345)

Reporting Requirements

First Report of Injury

Employers are required to record all on-the-job injuries. For minor injuries (no medical treatment required) an employee must completed the "notice of injury" form for the employer to retain. Injuries that require medical expenses and lost time must be reported to the insurer using an "Employer's Report of Industrial Injury or Occupational Disease" form. In employer who fails to report a claim to the insurer is to be fined up to $1,000 for each incident. The employee must report an accident and injury to the employer immediately (7 days after the accident is maximum).

EDI Standards

Nevada reports via paper and does not use EDI.

Contested Case Handling

The general, Nevada workers' compensation appeals process provides a two-tiered procedure.

Levels in the hearing process include:

1. Hearing before the Hearings Division Hearing Officer (aggrieved injured worker or employer has 72 days to request a hearing after an insurer's written determination).

   Hearing Officers conduct informal dispute resolution hearings in Workers Compensation and Victims of Crime cases. The hearings are informal and are intended to allow a person who disagrees with a written decision to bring the matter to an independent hearing officer for review and possible settlement or reversal.
   The Hearing Officer will review the evidence submitted by the parties and listen to any position statements by the parties present in person or by telephone. The burden of showing the decision appealed was wrong is on the person who filed the appeal to the Hearing Officer.
   The Hearing Officer can affirm or reverse the decision being appealed. The Hearing Officer can also send the matter back for further review or reconsideration.
2. Hearing before an Appeals Officer (aggrieved party after a Hearing Officer's decision has 30 days to appeal to the Appeals Officer).

   Appeals Officers conduct appeals of Hearing Officer decisions, as well as direct appeals in a wide variety of administrative law matters. In addition to hearing appeals from Hearing Officer decisions, the Appeals Officers hear State Purchasing bid disputes, Medicaid appeals, Department of Business and Industry, Division of Industrial Insurance Regulation appeals, and Financial Institution hearings, Purchasing Division bid award appeals, Department of Education teacher certification appeals, and other administrative law matters.
   A person who disagrees with a Hearing Officer decision has 30 days to appeal the Hearing Officer decision to the Appeals Officer.
   Appeals Officer hearings are "on the record" and are digitally recorded for purposes of providing transcripts of the proceeding in case of further appeals.
   Appeals Officers will review the Hearing Officer decision, but they will conduct an entirely separate hearing, and the parties must separately submit the evidence they want the Appeals Officer to consider. The Appeals Officer does not consider the evidence submitted to the Hearing Officer unless it is submitted again, or unless a written request is made to admit the evidence previously submitted to the Hearing Officer.
   The Appeals Officer can Affirm, Reverse, or Remand the Hearing Officer Decision or enter other orders allowed by law.

Appeals that are requested after hearings before a Hearing Officer and Appeals Officer go to judicial review in district court, after that, the Nevada Supreme Court.

Attorneys' Fees

Injured workers may be represented by private counsel or seek assistance and advice from the Nevada Attorney for Injured Workers, many represent themselves. Insurers and third party administrators often rely on claims examiners/adjusters or hearing advocates rather than attorneys.

Medical Care and Evaluation

Fee Schedule

2012 Medical Fee Schedule: http://dirweb.state.nv.us/WCS/mfs/2012mfs.pdf

Treatment Guidelines

Nevada uses the ACOEM Occupational Medicine Practice Guidelines (most current edition).
More Information: http://www.leg.state.nv.us/nac/NAC-616C.html#NAC616CSec123

Managed Care

Managed care organizations are allowed in Nevada. The employee should ask their employer or insurer for the list of authorized providers for the insurer they have chosen.

Choice of Treating Physician

The injured employee must go to an authorized medical provider who is a member of the Panel of Treating Physicians and Chiropractors. Insurers may use a managed care organization (MCO), preferred provider organization (PPO), health maintenance organization (HMO) or the insurance company's internal managed care unit.

Rehabilitation

When an injured workers is unable to return to the type of work they did prior to the injury, cannot work in a modified position, or has no existing marketable skills (according to assessments by a certified vocational counselor), the worker may qualify for vocational rehabilitation benefits. Vocational rehabilitation benefits may include job placement assistance, on-the-job training, or formal education. The insurer may also grant lump sum rehabilitation benefits pursuant to NRS 616C.595. If an injured worker lives out of state, the insurer may grant lump sum rehabilitation benefits, not to exceed $20,000. If an injured worker accepts lump sum benefits, they lose their right to receive vocational rehabilitation services under his claim or form any other state agency.

New Hampshire

New Hampshire Division of Workers' Compensation

95 Pleasant Street

Concord, New Hampshire 03301

(603) 271-3176

http://www.nh.gov/labor/about-us/index.htm

Agency

General Information

The New Hampshire Workers' Compensation Division (WCD) is part of the New Hampshire Department of Labor. The head of WCD is the Director of Workers' Compensation, who reports to the Commissioner of Labor.

The WCD's responsibilities include:

- Injury reporting and records retention
- Examining and monitoring of injury reports and forms
- Timely filing and reporting
- Assessment of penalties for late payments and late reporting
- Education of workers, employers, medical providers, rehabilitation providers, claims adjusters, and attorneys
- Licensing or certification of claims, rehabilitation, TPAs, and self-insurers
- Research
- Preparing statutory reports to the governor and legislature
- Employer compliance with coverage requirements
- Formal and informal dispute resolution

Mission Statement (Department of Labor)

To serve and protect the interests and dignity of the New Hampshire workforce.

Vision Statement (Department of Labor)

Our vision is to be recognized as:

- Being a proactive and accessible resource to employees & employers
- Ensuring fair and consistent labor practices
- Utilizing progressive technologies
- Having efficient and responsive processes
- Treating all individuals with respect and courtesy
- Being competent and professional

Legislative and Regulatory Links

New Hampshire Workers' Compensation Laws and Rules: http://www.nh.gov/labor/laws/index.htm

Budget and Financing

Agency Funding Source

Every insurer and self-insured employer pays a pro-rata share of the cost of administering the workers' compensation act. The pro rata share is based on the total workers' compensation benefits paid by all insurers and self-insured employers in the preceding calendar year (New Hampshire 2810A:59).

2012-2013 Operating Budget/Staff Size

WCD's operating budget is appropriated by the legislature and approved by the Governor.

Staff Size FY 2013: 72
FY 2013 Governor's recommended operating budget: $7,536,264

Funds

Second Injury Fund

New Hampshire's Second Injury Fund gives employers an opportunity to limit their compensation costs in the event that an impaired employee sustains a workers' compensation injury which leaves him/her more disabled than the same injury would leave a non-impaired worker. The worker's original impairment can be of any type or cause - work related or not - as long as it is a permanent impairment and is serious enough to pose an obstacle to the worker in obtaining employment.

The intent of the Second Injury Fund is to equalize the compensation costs that the employer and his insurance company must pay for impaired and non-impaired workers alike, thereby removing a potential barrier to the employment of impaired workers.

At the time of hire - or as soon after hire as the information becomes known to you make note in writing of your knowledge of the employee's impairment. In the event of a Second Injury Fund claim in the future, this written record will need to be produced as evidence that you knew of the worker's impairment prior to the subsequent injury. The written record can take any form you wish (e.g. pre-placement physical examination report, a memorandum to the personnel file, interview notes signed and dated by the interviewer, or a letter from a rehabilitation counselor who knew the worker) as long as:

- the information is recorded in writing
- the record clearly identifies the employer, employee and the date that the record was created
- the record presents information about the worker's impairment and the limitations caused by the impairment

This is the only step that the employer needs to take. In the event that the impaired worker becomes seriously disabled from a workers' compensation injury in the future, the insurance company will initiate the process of applying to the Second Injury Fund and, as part of this, will ask the employer for a copy of this record. If the record is not available, the case will not be eligible for reimbursement from the Fund.

Insurance Requirements and Resources

General Information

Under the New Hampshire Workers' Compensation Law RSA 281-A:5, every employer who has any employees, full or part-time, is required to cover these employees with workers' compensation insurance written by a carrier. It does not matter if they are related, such as daughter, son, husband, etc. It also does not matter if the business is a "Non-Profit" organization.

Sole-proprietors, partners and self-employed persons are not required to carry workers' compensation on themselves but may elect to be covered, per RSA 281-A:3. Sole proprietors or partners operating as Sub-Contractors, without employees, under a General Contractor may be required to carry workers' compensation coverage by the General Contractor.

RSA 281-A:2,VIII explains that if a corporation or limited liability company (LLC) has 3 or less executive officers or LLC members and no other employees, coverage is not mandatory but may be elected pursuant to RSA 281-A:3. Once there is a 4th executive officer or LLC member, workers' compensation insurance must be obtained. Once coverage is in place or any employees regardless of the number of officers or LLC members, all persons, including all officers or LLC members, are considered employees and would automatically be covered. Up to three executive officers or LLC members may then elect to be excluded per RSA 281-A:18-a. Professional Associations are to be treated the same as corporations and LLC's.

Private Insurance

The New Hampshire Insurance Department has regulatory authority over insurance carriers and monitors their performance.

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301
http://www.nh.gov/insurance/

Self-Insurance

RSA 281-A:5-a provides for any private employer, or any homogeneous group of employers who qualify, to self-insure their workers' compensation.

New Hampshire regulation requires that the full sum of the self-insured retained risk be guaranteed; various types of guarantees are permitted, with the most common being a surety bond. Additionally, self-insurers must purchase excess insurance coverage which attaches at a point that leaves no gap between the sum of the guaranteed retained risk and the excess coverage. Also, please bear in mind that self-insured groups must be "Homogeneous" as defined in New Hampshire Administrative Rules Chapter LAB 404.01 Workers' Compensation Self-Insurance.

Penalties for not Insuring

Uninsured employers are subject to a $2,500 civil penalty, and $100 per employee for each day of non-compliance. Non-insured employers are found via injury reports, termination of coverage notices, and wage/hour inspections.

Reporting Requirements

First Report of Injury

"Every employer or self-insurer shall record in sufficient detail and shall report or cause to be reported to the commissioner any injury sustained by an employee in the course of employment as soon as possible, but no later than (5) days after the employer learns of the occurrence of such an injury." If an employer fails to file a First Report of Injury, the employer may be subject to a fine of up to $2,500.00.

Additional Reports/Claims Processing and Monitoring

Notice of first and last compensation payments must be reported to WCD. First payment is due within 21 days from the date the first report of injury was received. WCD has the right to deny permission to stop payment.

Other required reports/forms

- Memo of payments
- Denials
- PI award information

WCD makes the final administrative decision for determining a claimant's PPD rating. Factors used to determine the claimant's PPD rating include:

- Impairment rating of attending physician;
- Use *of AMA Guide to Permanent Impairment*; and
- Use of Statutory rating guide.

EDI Standards

Beginning July 1, 2006 the New Hampshire, Department of Labor began accepting Injury Reports (NH Form 8WC) via Electronic Data Interchange (EDI). The New Hampshire Legislation mandated the reporting of workers claims via EDI. Most are currently reporting claims via EDI today; the few exceptions are those who report a very small quantity of reports in a year. The department will be providing a Web submission method in the near future to allow these low volume employers the ability to report workers claims electronically.

In August of 2008 the New Hampshire, Department of Labor signed an agreement with NCCI, to begin to accept the New Hampshire Form 6WC (Proof of Coverage) filings via EDI. As NCCI currently provides a service for the collection and reporting of proof of coverage information in several states, the New Hampshire, Department of Labor has designated NCCI as its agent to collect, store and report POC Information. We are working on the development of this system with NCCI and expect to complete testing in February/March 2009. You must continue to submit your proof of coverage filings via paper until you are contacted by the department, NCCI or both, to notify you of the switch from paper filings to electronic filings.

More information on EDI in New Hampshire: http://www.nh.gov/labor/workers-comp/electronic-data/index.htm

Contested Case Handling

Levels in the hearing process include:

1. Disputed cases are heard at the Department of Labor (DOL) by a hearing officer who is an employee of the DOL.
2. Appeal of the DOL's decision is to the Compensation Appeals Board and is a de novo hearing.
3. Appeal of the decision of the Compensation Appeals Board is to the New Hampshire Supreme Court.

Attorneys' Fees

WCD regulates attorneys' fee. Fees are based on actual hours worked on the case for appeal. Attorney's fees are paid out of the claimant's award on DOL level-max 20%. Attorney fees on contested medical bills are paid by the carrier if the claimant prevails at the DOL hearing.

Compromise and Release Agreements

Compromise and release (C&R) agreements are allowed if they are approved by WCD. Medical benefits are not terminated by C&R agreements.

Medical Care and Evaluation

Fee Schedule

Medical and hospital fees are not regulated by WCD. Disputed fees are handled through the hearing process.

Treatment Guidelines

New Hampshire has treatment protocols for managed care programs. MCOs must be approved by WCD. Managed care requirements are defined in RSA 281-A:60 and further defined in NH Labor Rule 701. See: http://www.gencourt.state.nh.us/rules/state_agencies/lab700.html

Managed Care

Use of managed care organizations is allowed.

To see a list of MCOs approved in New Hampshire visit: http://www.nh.gov/labor/workers-comp/managed-care.htm

Choice of Treating Physician

The claimant has free choice of physician during the duration of the disability, unless the employer has contracted with an approved managed care network. The claimant may change their physician without approval if the employer is not with a managed care organization.

Rehabilitation

General Information

RSA 281-A:25

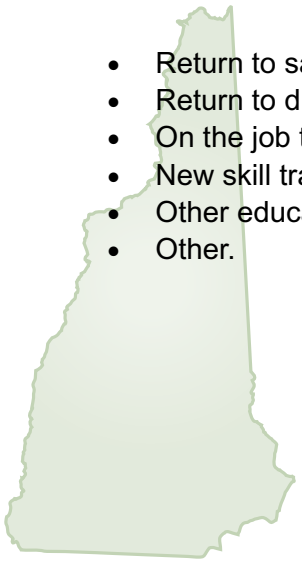
The New Hampshire Workers' Compensation Law provides for Vocational Rehabilitation services to injured workers who are unable to return to the kind of work for which they have training or experience.

Vocational Rehabilitation is the provision of services that shall restore the employee to, or as close as possible to, his or her prior earning capacity as measured by the employee's average weekly wage. Although Vocational Rehabilitation services are provided in a variety of settings, Workers' Compensation Vocational Rehabilitation is provided by private rehabilitation companies, which are staffed by Certified Vocational Rehabilitation Providers. The services they provide are regulated and monitored by the Department of Labor to ensure compliance with the law.

There are a variety of services offered by Vocational Rehabilitation. Examples of these would be vocational counseling, vocational testing, job seeking skills training, job development services, and vocational exploration. Vocational Rehabilitation services vary according to your physical capacities, as established by a physician, your average weekly wage, your prior training, work experience, education, age, and the level of the hierarchy selected.

Vocational Rehabilitation is provided in a hierarchy of services, in other words, in a very specific order. The hierarchy of services is as follows:

- Return to same job, same employer;
- Return to same job modified, same employer;
- Return to different job, same employer;
- Return to same job, different employer;



- Return to same job modified, different employer;
- Return to different job, different employer;
- On the job training;
- New skill training or retraining;
- Other educational/academic program; and
- Other.

New Jersey

New Jersey Division of Workers' Compensation

PO Box 381

Trenton, New Jersey 08625

(609) 292-2515

http://lwd.dol.state.nj.us/labor/wc/wc_index.html

Agency

General Information

The New Jersey Division of Workers' Compensation is part of the New Jersey Department of Labor and Workforce Development

The Division of Workers' Compensation (DWC) is responsible for the administration of the NJ Workers' Compensation Law, N.J.S.A. 34:15-1 et seq., and the disposition of disputes raised under it. It does so by:

- Ensuring that injured workers receive fair and timely workers' compensation benefits from their employers and their insurance carriers
- Enforcing the law that requires employers to secure the necessary insurance coverage from commercial carriers or through self-insurance programs.
- Providing temporary disability benefits and medical expenses to workers suffering from compensable injuries while working for uninsured employers
- Providing benefit payments to workers who are already partially disabled who subsequently experience a work related injury which together, render them totally disabled.

Mission Statement

A partnership among government, industry and labor, the NJ Division of Workers' Compensation seeks to establish an equitable balance between the needs of injured workers and the needs of employers.

With a commitment to the highest standards of professionalism, our mission is to ensure that proper benefits are paid to workers who are injured on the job in addition to enforcing the law requiring employers to obtain insurance coverage for their employees.

Legislative and Regulatory Links

New Jersey Workers' Compensation Law: http://lwd.dol.state.nj.us/labor/forms_pdfs/wc/pdf/wc_law.pdf

New Jersey Workers' Compensation Rules: http://lwd.dol.state.nj.us/labor/forms_pdfs/wc/pdf/rules.pdf

Budget and Financing

Agency Funding Source

New Jersey has an annual assessment on insurers and self-insured employers.

2012-2013 Operating Budget/Staff Size

Staff Size FY 2013: 152
FY 2013 Governor's recommended operating budget: $12,289,000

Funds

Second Injury Fund

The Second Injury Fund is administered by the administrator of the Office of Special Compensation Funds (located within the Division of Workers' Compensation). The Second Injury Fund was created in 1923 for the purpose of making benefit payments to workers already partially disabled who subsequently experience a work related injury which together, renders them totally disabled. The concept behind the Second Injury Fund was to encourage employers to hire disabled workers by limiting, in the case of further injury, their liability for compensation payments to amounts only applicable to the latest injury. Payments from the SIF commence at the conclusion of the payment of benefits from the employer or the insurance carrier and continue until the death of the beneficiary or gainful employment.

Uninsured Employers' Fund

The Uninsured Employers' Fund is also administered by the administrator of the Office of Special Compensation Funds. The UEF provides temporary disability benefits and medical expenses to disabled workers where the compensable injury arose from employment with an uninsured employer. The UEF is financed by assessments on carriers and self-insurers based on the amount of compensation paid during the preceding calendar year, and recovery of monies owed by uninsured employers for benefits paid from the fund and penalties assessed.

Insurance Requirements and Resources

General Information

New Jersey law requires that all New Jersey employers, not covered by Federal programs, have workers' compensation coverage or be approved for self-insurance. Even out-of-state employers may need workers' compensation coverage if a contract of employment is entered into in New Jersey or if work is performed in New Jersey.

Private Insurance

Employers in New Jersey can obtain a workers' compensation insurance policy written by a mutual or stock carrier authorized to write insurance in New Jersey. Premiums for such insurance are based on the classification(s) of the work being performed by employees, the claims experience of the employer and the payroll of the employer.

The Department of Banking and Insurance has regulatory authority over insurance carriers and self-insured employers and monitors their performance.

NJ Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, New Jersey 08625
Phone: (609) 292-7272
http://www.state.nj.us/dobi/index.html

Self-Insurance

Employers in New Jersey can also opt to apply for self-insurance.

To qualify as a self-insurer in New Jersey, and employer:

- Must meet financial qualifications to demonstrate ability to pay compensation; and
- May be required to maintain a separate account or reserve fund, obtain a surety bond, or obtain reinsurance (if a subsidiary, may be required to submit guarantee that the parent corporation will discharge compensation liability).

Penalties for not Insuring

The consequences for failure to provide workers' compensation coverage can be very significant, even without a work-related injury. Specifically, the law provides that failing to insure is a disorderly persons offense and, if determined to be willful, a crime of the fourth degree. Moreover, penalties for such failure can be assessed up to $5,000 for the first ten days and up to $5,000 for each additional ten-day period of failure to insure thereafter. In the case of a corporation, liability for failure to insure can extend to the corporate officers individually. Penalties assessed for failure to insure are not dischargeable in bankruptcy.

Where a work-related injury or death has occurred, the employer, including individual corporate officers, partners or members of an LLC, is directly liable for medical expenses, temporary disability and permanent disability or dependency benefits. In addition to awards for medical expenses and other benefits, New Jersey law also provides for civil penalties against the employer and its officers where failure to insure is determined. Awards and penalties arising from these claims can become liens against the uninsured employer and its officers, which are generally enforceable in the New Jersey Superior Court against any assets belonging to the uninsured employer and its officers.

Reporting Requirements

First Report of Injury

A First Report of Injury is required to be electronically filed for injuries where medical treatment beyond first aid was provided or a death occurred.

Additional Reports/Claims Processing and Monitoring

A Subsequent Report is required to be electronically filed within 26 weeks after the injured worker returns to work or reaches maximum medical improvement.

EDI Standards

On January 5, 2002, P.L. 2001 Chapter 326 (Senate Bill 246/Assembly Bill 1976) was passed requiring insurance carriers, third party administrators, self-administered self-insured employers and statutory non-insured employers including the State, counties, municipalities and school boards to file accident reports with the State in an electronic format compatible with national Electronic Data Interchange (EDI) standards.

This law, which went into effect July 5, 2002, applies to all work-related accidents with a date of injury of July 5, 2002 and later. The law amended the following sections of the law: NJSA 34:15-96 and NJSA 34:15-98 .

Currently, New Jersey mandates the use of the IAIABC's Claims Release 3 FROI and SROI.

Contested Case Handling

Levels in the hearing process include:

1. Formal and informal hearing before the Judge of Compensation.
2. Court of Appeals: Appellate Division of Superior Court
3. New Jersey Supreme Court

	Notes or Comments on Scope	Number in FY2012
Hearing with Judge of Compensation		34,155
Court of Appeals		20
New Jersey Supreme Court		1

Attorneys' Fees

Attorneys' fees are limited to 20 percent of the total award. Fees may be assessed in whole or in part against the carrier or self-insurer.

Compromise and Release Agreements

Compromise and release agreements are allowed if approved by a compensation judge. An agreement fore-closes any rights to future benefits for the claimant and anyone claiming through the claimant.

Medical Care and Evaluation

Fee Schedule

New Jersey has no fee schedule. Medical expenses are reimbursed at a reasonable rate based upon the fees normally received in the community in which the services are performed.

The Division of Workers' Compensation has the authority to set medical fees over $50, including hospital charges.

Treatment Guidelines

New Jersey does not have specific guidelines for workers' compensation.

Managed Care

Most insurance carriers utilize managed care networks.

Choice of Treating Physician

The employer has the right to choose the treating physician. If the employer refuses to provide medical treat-ment, the injured worker is free to choose the treating physician. However, in the case of an emergency, an injured worker may obtain medical or hospital treatment without specific authorization from the employer, but the employer should be notified as soon as possible concerning the treatment being received.

Rehabilitation

General Information

Employees who are found to be permanently totally disabled are referred to vocational rehabilitation after 450 weeks.

A claimant who refuses rehabilitation may forfeit all rights to permanent total disability benefits.

New Mexico

New Mexico Workers' Compensation Administration

2410 Centre Avenue SE

P.O. Box 27198

Albuquerque, New Mexico 87125

(505) 841-6000

http://www.workerscomp.state.nm.us/ /

Agency

General Information

The New Mexico Workers' Compensation Administration (WCA) is an agency in the executive branch of the New Mexico State Government. Responsibility for administration of workers' compensation is vested in a single administrator, the Director, appointed by the Governor.

Functions of the WCA include:

- Enforcement of workers' compensation insurance coverage
- Mediation and adjudication of contested claims
- Providing information to workers, employers, insurance carriers, health care providers, and others concerning their rights and obligations
- Certification and auditing of self-insured employers and groups
- Safety consultation with and education of employer and workers (implementation of an extra-hazardous program)
- Collection and analysis of statistical data on compensable injuries and illnesses (examine and monitor injury reports, forms, and late payments)
- Investigation and prosecution of violations of the New Mexico Workers' Compensation Act and WCA rules.
- Administration of programs to contain medical costs
- Publication and dissemination of booklets and reports on New Mexico's workers' compensation system
- Investigation of criminal fraud in the workers' compensation system
- Compile annual reports to legislative and executive government
- Provide uninsured employer benefits to workers injured while working for an employer not covered by workers' compensation insurance and prosecute employers for not having insurance

Mission Statement

"Our mission is to assure the timely delivery of benefits to injured workers at a reasonable cost to employers."

Legislative and Regulatory Links

New Mexico Workers' Compensation Rules and Statutes: http://www.workerscomp.state.nm.us/rules.php

Budget and Financing

Agency Funding Source

The Workers' Compensation Administration Fund is funded by assessments from employers and employees. Each employer is assessed a quarterly fee of $2.30 per covered employee. Additionally, each employee has $2.00 deducted from his paycheck each quarter.

2012-2013 Operating Budget/Staff Size

Staff Size FY 2013: 120
FY 2013 Governor's recommended operating budget: $11,614,300, actual legislative budget: $11,622,300

Funds

Second Injury Fund

(repealed, effective July 1, 1999)

Uninsured Employers' Fund

The UEF is administered by WCA and provides indemnity and medical benefits to workers whose employers fail to have the required insurance coverage as stated by the New Mexico Workers' Compensation Act. The UEF may try to recoup the cost of the injured workers' benefits from the uninsured employers. The UEF is funded by the contributions of employers through the WCA Assessment.

Insurance Requirements and Resources

General Information

All employers who employ three or more workers are required by law to have workers' compensation coverage, except:

- All employers engaged in activities required to be licensed under the Construction Industries Licensing Act must have coverage, regardless of the number of employees;
- Coverage is not required for household servants;
- Coverage is not required for real estate salespersons;
- Coverage is not required for farm and ranch laborers.

New Mexico is a private insurance state. Coverage is purchased from private insurance carriers or authorized self-insurance groups through insurance agents. A business may self-insure with the approval of the WCA. The WCA does not pay insurance benefits. The WCA provides regulatory, dispute resolution and informational services.

Private Insurance

The Superintendent of Insurance (SI) and the WCA share in regulatory authority over workers' compensation insurance carriers, third party administrators, and adjusters.

- SI issues licenses to adjusters and third party administrators (TPAs).
- SI sets rates.
- SI disciplines carriers for violations of the insurance code.

- SI and WCA monitor economic performance of carriers.
- WCA monitors adjuster, TPA, and carrier compliance with workers' compensation requirements.

Self-Insurance

WCA has regulatory authority over workers' compensation self-insurers.

- Issues certificates
- Monitors reserves and financial security requirements
- Monitors performance
- Oversees other regulatory performance

The qualifications for becoming self-insured are determined by the WCA Director and are set forth in the WCA rules.

View the self-insurance rules and regulations: http://www.workerscomp.state.nm.us/pdf/rules/rule8.pdf

Penalties for not Insuring

The WCA Director may levy fines and the district court may enjoin businesses that operate without workers' compensation insurance coverage.

Number of penalties assessed in FY2012: 17
Dollar amount of penalties assessed in FY2012: $8,500.00

Reporting Requirements

First Report of Injury

The filing of the employer's First Report of Injury or illness with the WCA is mandatory for fatalities and injuries or illnesses resulting in more than seven days of lost time. Notification is due within ten days of injury or onset of illness.

Additional Reports/Claims Processing and Monitoring

The Notice of Benefit Payment is due within ten days of the initial indemnity payment or within 90 days of a medical-only payment greater than $300.00, and within 30 days of a change in benefits or closing payment. On a controverted claim, the Notice of Benefit Payment is due within 50 days from the date of an order for payment of benefits.

The WCA Director may levy fines against noncompliant employers or claims administrators.

The WCA monitors the initial payment, last payment, and promptness of payment. Denials are not monitored by the WCA. If the worker is denied benefits, he or she has the choice to file a complaint within 1 year and 31 days of the denial.

The final administrative decision for determining a claimant's permanent partial disability rating is made by a Workers' Compensation Judge. Factors used to determine a disability rating include:

- Impairment rating from an attending health care provider or independent medical examiner using the

most current AMA Guides to the Evaluation of Permanent Impairment; and

- Employee factors such as age, education, training, and residual physical capacity.
- For non-disputed claims, PPD is based on a formula established in the statute containing employee factors such as age, education, training, and physical capacity.

EDI Standards

New Mexico law requires that every employer or employer's representative file a FROI with the WCA within the time frames and criteria outlined in NMSA 1978. §52-1-58. Under EDI processing, a claims administrator may electronically file a FROI with the WCA in lieu of a paper copy. Organizations filing by EDI become the agent of the employer and are under the same legal filing requirements as the employer. Once the claims administrator has entered into a written EDI filing agreement with the WCA, and has passed the testing requirements (which entails the filing of a Trading Partner Profile), the employer no longer files a paper copy of the FROI with the WCA

Contested Case Handling

Levels in the hearing process include:

1. Mediation conference with a WCA attorney/mediator
2. Adjudication with a Workers' Compensation Judge
3. Appellate review by the New Mexico Court of Appeals and Supreme Court

	Notes or Comments on Scope	*Number in 2012 (calendar)*
Mediation conference with a WCA attorney/ mediator		1937
Adjudication with WC Judge		118 trials held
Appellate Review		52

Attorneys' Fees

According to statutory and case law guidelines, a workers' compensation judge must approve attorneys' fees.

- Defense and plaintiff attorneys fees are limited to a maximum of $16,500, although new legislation increases fee cap to $22,500 starting in June 2013
- The law requires that the worker and employer each pay half of the worker's attorney fees if the worker prevails except in specified circumstances.

Compromise and Release Agreements

Lump sum claim settlements are governed by NMSA 1978 §§ 52-5-12, -14. Agreements must be approved by a workers' compensation judge. The agreements must be in writing, the worker must be fully informed and understand the terms, and the agreement must be fair and equitable and provide justice to the parties.

Medical Care and Evaluation

Fee Schedule

WCA's 2012 Health Care Providers' Fee Schedule: https://www.wcasubmit.org/fees/

Treatment Guidelines

New Mexico Rule 11-4-4 (http://www.workerscomp.state.nm.us/pdf/rules/rule4.pdf) was adopted in December of 2012, and treatment guidelines for workers' compensation will go into effect July 1, 2013. New Mexico will use the most current Official Disability Guidelines (ODG).

Managed Care

Managed care organizations such as PPOs and HMOs may provide treatment and are being used in New Mexico, subject to the schedules of maximum allowable payments.

Choice of Treating Physician

The employer may select or permit the worker to select the initial treating health care provider. The party who did not make the initial selection may make the second selection. Under new agency rules, if the decision of the employer is not communicated in writing to the worker, then the medical care received by the worker prior to written notification is not considered a choice of treating HCP by either party.

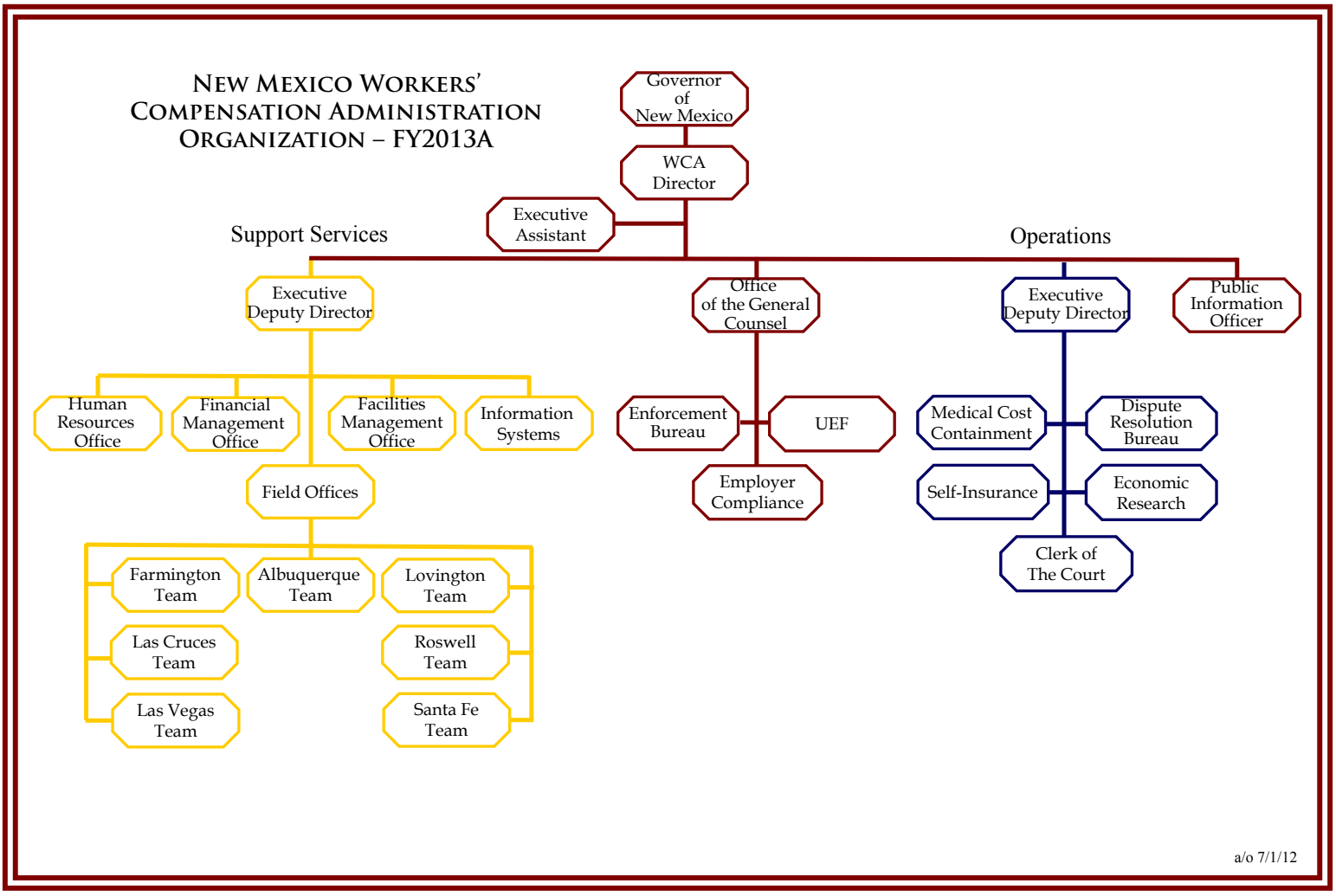
Rehabilitation

General Information

There is no mandatory vocational rehabilitation. Payment for vocational rehabilitation services is voluntary on the part of the insurer or employer (§52-1-50).Vocational rehabilitation professionals may not testify regarding the extent of an injured worker's disability.

Employers are required by statute to rehire injured workers who are able to return to work if the employer is hiring and the worker requests employment.

Workers' Compensation Division Organization Chart



New York

New York Workers' Compensation Board

328 State Street

Schenectady, NY 12305-2318

(518) 462-8880

Toll Free: (877) 632-4996

http://www.wcb.ny.gov/

Agency

General Information

The New York State Workers' Compensation Board (Board) is an autonomous agency under the umbrella of the State Department of Labor. The Board is composed of 13 commissioners, appointed by the governor and confirmed by the State Senate for terms of seven years. The head of the agency is the Chairman. The Executive Director oversees operations of the agency.

There are 10 district offices located in Albany, Binghamton, Brooklyn, Buffalo, Long Island, Manhattan, Peekskill, Queens, Rochester, and Syracuse.

The Board has responsibility for administering:

- Workers' Compensation
- Disability Benefits
- Volunteer Firefighters' Benefit
- Volunteer Ambulance Workers' Benefit
- Workers' Compensation Act for Civil Defense Volunteers

Mission Statement

The New York State Workers' Compensation Board protects the rights of employees and employers by ensuring the proper delivery of benefits to those who are injured or ill, and by promoting compliance with the law.

Legislative and Regulatory Links

New York Workers' Compensation Laws, Regulations, and Decisions: http://www.wcb.ny.gov/content/main/wclaws/newlaws.jsp

Budget and Financing

Agency Funding Source

The Board's operations are financed through an administrative assessment on employers (NY WCL 151). Prior to 2014, each class of payer (private insurer, New York State Insurance Fund, self-insured employer, and group self-insurance trust) was assessed based on its share of total compensation paid for the class in relation to all compensation paid in the previous year. The payer was authorized to charge employers a premium surcharge to cover the cost of the assessment.

The Business Relief Act of 2013 reformed how the Board administers assessments. The Board will determine a common assessment methodology and rate, which payers will collect from their shareholders and remit directly to the Board. This new assessment will include the costs of the Board's operations.

2012-2013 Operating Budget/Staff Size

Staff Size FY 2013: 1,287
FY 2013 Governor's recommended operating budget: $203,200,000

Second Injury Fund

Second Injury Fund (WCL 15(8)) [closed to new applications effective 1/1/10 and to claims with date of injury after 3/13/07].

The Second Injury Fund reimburses insurers and self-insured employers for all costs of claims that are accepted in the Second Injury Fund after 260 weeks of indemnity payments have been made. To be eligible for the Second Injury Fund, the injured employee must have had a pre-existing permanent physical impairment and the disability resulting from the subsequent injury (which is the subject of the claim) must be "materially and substantially greater" than that which would have stemmed from the second injury alone.

The Second Injury Fund (WCL 15(8)) was closed to new claims as a result of the 2007 Workers' Compensation Reform Act. No claim with a date of injury or disability after June 30, 2007, is eligible for Second Injury Fund relief. All applications and supporting evidence for Second Injury Fund must have been submitted by July 1, 2010. Claims that have been accepted by the Second Injury Fund continue to receive the benefit of subrogation until the claim has been finally settled or permanently closed.

Claimants with an accepted Second Injury Fund claim receive the same benefits as non-Second Injury Fund claims. The only difference is that the employer receives reimbursement from the Fund for the costs paid on the claim. The Second Injury Fund is funded by an assessment on employers based on the value of the prior year's reimbursements.

Fund for Reopened Cases (WCL 25-a) [Closing to new applications, effective 1/1/14]

Payment in certain old and re-opened claims may be made out of a special fund, the Fund for Reopened Cases, to relieve the employer and the insurance carrier of this obligation. Generally, under Section 25-a of the Workers' Compensation Law, eligibility for this relief occurs:

1. After a lapse of seven years from the date of the injury or death, where claim for compensation previously has been disallowed or the claim has been otherwise disposed of without an award of compensation; or
2. After a lapse of seven years from the date of the injury or death and also a lapse of three years from the date of the last payment of compensation.

If the claim is transferred to 25-a, the claim is managed by the Special Funds Conservation Committee and all subsequent payments are made by the 25-a fund.

The Business Relief Act of 2013 closes the 25-a Fund to any new applications on January 1, 2014. The carrier or self-insured employer must have applied for 25-a relief, for which the claim must qualify, on or before December 31, 2013.

Uninsured Employers' Fund

If an employee is hurt when there is no workers' compensation policy in effect and the employee files a workers' compensation claim, the injured worker will receive the medical and indemnity benefits through the Uninsured Employer's Fund (UEF). The Fund pays the benefits and administers the claim. The UEF charges the uninsured employer for the actual cost of medical care and compensation payments, in addition to penalties. If

a corporation has failed to secure workers' compensation coverage, the president, secretary and treasurer of a corporation are personally liable for the medical care, compensation payments, penalties and possible criminal prosecution. (WCL §26-a)

http://www.wcb.ny.gov/content/main/Employers/UEF.jsp

Insurance Requirements and Resources

General Information

Virtually all employers who employ individuals that work in New York State must provide workers' compensation coverage (WCL §§ 2, 3). Coverage options include insurance policies purchased from the New York State Insurance Fund or a private insurance company, individual self-insurance, or membership in a group self-insurance trust.

Out of state employers must maintain full statutory coverage (3A coverage) in New York if its employees are working in New York State. The WCB has articulated standards for what level of in-state activity triggers the requirement to maintain a 3A policy, and when coverage under 3C is sufficient. http://www.wcb.ny.gov/content/main/onthejob/CoverageSituations/outOfStateEmployers.jsp

Employers must post notice of coverage in their place(s) of business (WCL § 51). Employers must cover the following workers:

1. Workers in all employments conducted for-profit. Part-time employees, borrowed employees, leased employees, family members and volunteers working for a for-profit business must also be covered under the Workers› Compensation Law (WCL §3 Groups 1-14-a);
2. Employees of counties and municipalities engaged in work defined by the law as «hazardous» (WCL §3 Groups 15, 15-a and 17);
3. Public school teachers, excluding those employed by New York City, and public school aides, including New York City (WCL §3 Groups 20, 20-a and 22);
4. Employees of the State of New York, including some volunteer workers (WCL §3 Group 16);
5. Domestic workers employed forty or more hours per week by the same employer, including full-time sitters or companions, and live-in maids (WCL §3 Group 12) (see Domestic Workers)
6. Farm workers whose employer paid $1,200 or more for farm labor in the preceding calendar year (WCL §3 Group 14-b) (see Farms)
7. Any other worker determined by the Board to be an employee and not specifically excluded from coverage under the WCL (WCL §3 Groups 1-14-a and 18);
8. All corporate officers if the corporation has more than two officers and/or two stockholders (WCL §54 [6]) (see Corporate Officer Coverage Requirements);
9. Officers of one-or-two person corporations if there are other individuals in employment. These officers may choose to exclude themselves from coverage (WCL §54 [6]) (see Corporate Officer Coverage Requirements); and
10. Most workers compensated by a nonprofit organization (WCL §3 Group 18) (see Nonprofit Organizations).

Private Insurance

More than 370 companies currently write workers' compensation policies in New York. The New York Depart-

ment of Financial Services (DFS) has the following regulatory authority over all insurance carriers. The responsibilities of DFS include:

- Issuing licenses to adjusters
- Regulating insurance premium (loss cost) rates
- Monitoring the financial stability of all authorized carriers
- Initiating investigations into performance upon receipt of complaint
- Regulating performance through market conduct examinations
- Assessing penalties on non-compliance insurers

http://www.dfs.ny.gov/

Workers' compensation premium costs are regulated by the DFS. The DFS approves loss costs that are developed and filed by the New York Compensation Insurance Rating Board (NYCIRB) www.nycirb.org. The loss costs reflect the cost of medical benefits, indemnity benefits, and allocated loss adjustment expenses. Carrier's unallocated expenses, overhead, profit, and other considerations are incorporated into an individual loss cost multiplier, which each carrier files with the DFS. http://www.dfs.ny.gov/insurance/wc/lcm_approved.pdf. The NYCIRB collects financial and statistical information from carriers, which is used to develop actuarial estimates of the future loss costs.

The cost of a standard workers' compensation policy is determined based on the policyholders' payroll, occupational classifications, experience modification (if they have more than $5,000 in annual premium), and the carrier's loss cost multiplier. The DFS approves loss costs for each of more than 600 occupational classifications based on the statistical loss experience of claims for each occupational code. Manual premium is determined as follows:

(1) (for each occupational code) multiply the payroll by the loss cost rate,
(2) combine the product (step 1) for each occupational code,
(3) multiply the sum (step 2) by the policyholder's experience modification (if applicable), and
4) multiply the product (step 3) by the carrier's approved loss cost multiplier.

Additional discounts and adjustments may be applied to this standard premium. More information is available on CIRB's website, www.nycirb.org.

New York allows for a range of different policy programs, including large deductible policies, retrospective policies, merit rating adjustments, and the Construction Premium Adjustment Program (CPAP).

New York State Insurance Fund

The New York State Insurance Fund (NYSIF) is a state entity (WCL Article 6, §§76-100) created to provide workers' compensation coverage as the insurer of last resort. The NYSIF has flexibility in establishing insurance premiums for employers based on the insured's risk. The NYSIF shall establish premium rates "at the lowest possible rates consistent with the maintenance of a solvent fund and of reasonable reserves and surplus."

In 2012, the NYSIF's policies represented approximately 41% of total premium in the workers' compensation insurance market. Information on the New York State Insurance Fund can be found at www.nysif.com

Self-Insurance

The Board has regulatory authority over workers' compensation self-insured employers.

Individual Self-Insurance

Employers who wish to self-insure must submit an application with required document to the Board for review. Approval will become effective when all documentation is received by the Board and the security deposit has been received. The employer must:

- Furnish satisfactory proof to the Chair of the ability to pay the necessary compensation/
- Make a security deposit consisting of securities, security bond, cash, or letters of credits as the Chair deems necessary; and
- Obtain specific excess insurance for catastrophes.

Political subdivisions (cities, counties, towns, school districts, etc.) are entitled to self-insure by law and do not need WCB approval. They are not required to post a security deposit.

Group Self-Insurance

The New York State Legislature amended the Workers' Compensation Law on March 31, 2011 which enacted significant changes to the existing group self-insurance program. Governor Cuomo signed the bill into law on April 1, 2011 as Chapter 57 of the Laws of 2011.

The changes to the Law repeals the current provisions of the Law authorizing group self-insured trusts and replaces them with a new program that allows only the most financially stable group trusts to continue to offer coverage. Any existing group that met the new criteria had to reapply and qualify under these new provisions.

These changes became effective January 1, 2012.

Groups that met the minimum qualifications outlined under the new legislation were allowed to continue to offer coverage provided they met and continue to meet the new provisions of the Law, including security deposit posting requirements outlined therein.

Groups that did not meet the new criteria were terminated effective December 31, 2011 and their members had to provide alternate coverage for their employees.

The current program, called the Self-Insured Group (SIG) Program is limited to the groups that met the new provisions and chose to continue their program under the amended Law. In accordance with the amended Law, no new employer groups can be approved to self-insure.

Opportunities for membership in an existing SIG are further limited to the homogeneity requirements of the current Self-Insured Groups.

Penalties for not Insuring

Employers who do not maintain workers' compensation insurance, including those who knowingly misstate the payroll or occupational classification to avoid premium, are liable for penalties up to $2,000 per 10-day period of noncompliance. If an employee is injured during a period of non-coverage, the employer is also liable for the actual award (including both compensation and medical costs), plus any other penalties the Board assesses for noncompliance. In cases involving severely injured employees, the medical costs alone could be in the hundreds of thousands of dollars per injury.

Number of penalties (WCL § 52-5) assessed in FY2012: 44,586

Since 2007, the Board has been able to issue stop work orders if an employer fails to maintain proper workers' compensation coverage. In 2012, the Board issued 1,197 stop work orders.

Reporting Requirements

First Report of Injury

An employer's first report of an injury must be filed with the Board, within ten days of occurrence, for fatalities or accidents resulting in personal injury which has caused or will cause a loss of time from regular work duties of one day beyond the working day or shift on which the accident occurred, or which has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid.

Failure to file a first report of injury/disease or to keep record of injuries is a misdemeanor, punishable by a fine of not more than $1,000.

Additional Reports/Claims Processing and Monitoring

Claim administrators must report whether they are accepting or disputing liability in a claim within 10 days of receiving notice of the injury or 18 days of the disability, whichever is later. They must begin making payment, if they accept the claim and benefits are due, in the same time period. Late payments are subject to a 20% penalty payable to the claimant.

A claim administrator must also notify the Board within 16 days if it stops or modifies payments of temporary disability benefits.

Permanent Partial Disability Benefits

The final administrative decision determining whether a claimant has a permanent partial disability rating is made by the Workers' Compensation Law Judge either upon stipulation of the parties or after litigation. The claimant must first reach maximum medical improvement (MMI). There are two types of permanent partial disability benefits: schedule loss of use (SLU) and non-schedule loss (NSL).

Section 15 establishes a schedule of weeks of benefits for the complete loss of a body part, such as a finger, hand, arm, toe, foot or leg. An injured worker who has a permanent partial loss of use of a body part included in the schedule is eligible for a portion of the total weeks provided for the particular body part, based on the percentage impairment rating. For example, someone with a 25% loss of a leg (loss of an entire leg is worth 288 weeks) is entitled to 72 weeks of benefits (25% of 288 weeks). Any weeks of temporary disability benefits previously paid are deducted from the SLU award. SLU awards are paid at the total disability rate (2/3 of average weekly wage).

A permanent partial disability that is not amenable to a SLU (either because of the affected body part or because the injury involves a progressive and severe condition), is a NSL claim. NSL-PPD benefits are different than SLUs in several significant ways:

1. The determination of the benefit duration cap is based on a calculation of loss of wage earning capacity (see below) rather than medical impairment only.
2. The benefit rate is a partial rate (paid based on the percentage of loss of wage earning capacity) rather than at the total disability rate.
3. Periods of temporary benefits are not deducted from the award.

Duration caps, ranging from 250 to 525 weeks based on loss of wage earning capacity, were introduced for claims with a date of accident on or after March 13, 2007. Prior claims are eligible for lifetime NSL benefits. Permanent total disability claims have no duration limits and PPD-NSL claims with a rating of more than 80%

may be eligible for benefits beyond the duration cap under the safety net provision.

The method of determining loss of wage earning capacity (i.e. disability rating) in an NSL claim are set forth in the 2012 NYS Guidelines to Determine Permanent Medical Impairment and Loss of Wage Earning Capacity. They include:

- Medical impairment rating of attending health care provider and/or the employer's/carrier's medical consultant.
- Evaluation of functional ability, including ability to lift, bend, climb, etc.
- Employee factors such as age, education, training, English literacy, etc.

EDI Standards

eClaims is the New York State Workers' Compensation Board's implementation of an electronic claim reporting standard for reports of injury filings. The WCB has adopted a national standard for claims reporting from the International Association of Industrial Accident Boards and Commissions (IAIABC): Claims Electronic Data Interchange (EDI) Release 3.0. The standard uses Electronic Data Interchange, commonly known as EDI, so that data can be transmitted electronically between the WCB and its EDI Trading Partners quickly, efficiently, and cost-effectively. Formal testing and implementation of eClaims begins in June 2013 with trading partners being added in three phases through March 2014. More information on eClaims is available at http://www.wcb.ny.gov/content/ebiz/eclaims/eclaims_overview.jsp.

In 2001, the WCB adopted a national electronic standard for Proof of Coverage (POC) reporting. Use of the POC standard has resulted in more timely reporting of coverage and employer compliance.

Contested Case Handling

Levels in the hearing process include:

1. Decision rendered by the Workers' Compensation Law Judge
2. Review by three Board members
3. Full board or Appellate Division
4. Court of Appeals

Type of Decision	*Number in FY2012*
Administrative Determinations (issued by claim examiners to document claim events)	72,063
Proposed Decisions (decision based on the paper record without a hearing)	79,499
Decisions Rendered by WC Law Judge After Formal Hearing (includes Section 32 settlements)	178,829
Review and Decisions by Board Panel	10,224
Full Board	1,475
Appellate Division Decisions	87
Court of Appeals Decisions	3

Attorneys' Fees

Legal fees for claimant representatives are awarded by the Workers' Compensation Law Judge commensurate with the services rendered and considering the financial status of the claimant. Requests for fees greater than

$450 must be in writing. In 2012, $233,885,507 in legal fees were awarded to claimant representatives.

Compromise and Release Agreements

The claimant may enter into an agreement or release to waive his or her right to compensation and other benefits so long as the agreement is approved by the Board. Section 32 of the NYSWCL provides that parties may agree to settle any and all issues in a claim. Such settlements will be final and conclusive and once the Board approves the settlement the approval is not subject to review. Any party may request a disapproval within 10 days of the approval. Modification of the agreement is permitted if all parties agree to the modification and the Board approves.

Section 15(5-b) permits parties to enter in to a non-schedule adjustment. Such cases must be established, compensation has been paid for not less than three months, and continuance of disability and future earning capacity cannot be ascertained with reasonable certainty. Before approving such an agreement there must be an examination of the claimant, and the non-schedule adjustment must be fair and in the best interest of the claimant. The board may order all future compensation to be paid in one or more lump sums or periodically. Non-schedule adjustments are a closing of the claim unless there is evidence that there has been a change in condition or a change in the degree of disability of the claimant not found in the medical evidence and therefore not contemplated at the time of the non-schedule adjustment.

Medical Care and Evaluation

Fee Schedule

The workers' compensation system has the following fee schedules governing the cost of health care to injured workers:

- Ambulatory surgery fee schedule (facility payments for outpatient surgery provided in hospital or ambulatory surgery center): these fee schedules are based on the Product of Ambulatory Surgery (PAS) methodology employed by New York's Medicaid system prior to 2009. Facility specific schedules are available on the WCB's website.
- Inpatient fee schedule – facility payments for inpatient care is based on New York's Medicaid APR-DRG methodology, with minor modifications.
- Professional fee schedule (covers physicians, chiropractors, podiatrists, psychologists, occupational and physical therapists, etc.) is New York-specific and is available for purchase from Optum-Ingenix. There are four geographic regions with separate conversion factors for each region and service type.
- Pharmacy fee schedule is based on the Average Wholesale Price (AWP): For brand drugs, price is AWP-12% plus $4 dispensing fee. For generic drugs, prices is AWP – 20% plus $5 dispensing fee.
- Durable medical equipment fee schedule is based on Medicaid's fee schedule.
- Dentist fee schedule is New York specific and available on the WCB's website

http://www.wcb.ny.gov/content/main/hcpp/FeeSchedules.jsp

Treatment Guidelines

The Workers' Compensation Board has implemented a major change in how medical care is provided to injured workers. New Medical Treatment Guidelines are the mandatory standard of care for the back, neck, shoulder, and knee, effective for dates of service, on or after December 1, 2010. As of July 1, 2013, the Board maintains Medical Treatment Guidelines for five body parts: neck, shoulder, mid- and low-back, knee, and carpal tunnel syndrome. Guidelines for the treatment of non-acute (chronic) pain have been proposed and are expected to be adopted by early 2014.

A Medical Advisory Committee (MAC) composed of prominent physicians from a range of medical specialities and subspecialities meets regularly to develop new guidelines and update existing guidelines.
http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/MTGOverview.jsp

Managed Care

Preferred Provider Organization Program
Article 10-A of the WCL authorizes the insurance carriers and self-insured employers to contract with NYS Department of Health certified preferred provider organizations (PPOs) to provide services to diagnose, treat, and rehabilitate a claimant requiring medical treatment of an occupational disease or injury. Insurance carriers and self-insured employers may direct claimants to providers within an approved PPO for the first 30 days of the claim, after which a claimant may choose to treat with any WCB-authorized provider.

In order to be licensed as a PPO, an entity must apply to the Commissioner of Health and provide certain information including:

- The standards by which the health providers will be selected to participate
- The names and credentials of individuals and organizations which will provide services
- The manner in which services will be provided and procedures to be followed for ongoing quality assurance, utilization review, and dispute resolution

In addition, the PPO must provide at least five providers in each specialty and three hospitals from which the employee may seek treatment.

Alternative Dispute Resolution Program

Employers and employees in the construction industry may resolve workers' compensation claims under an Alternative Dispute Resolution (ADR) program which was established on a pilot basis by the Legislature in 1995. The program allows employers and union representative to negotiate, through the collective bargaining process, their own procedures for resolving claims outside the Workers' Compensation Board.

These arrangements typically use mediation and/or arbitration techniques, rendering Board hearing obsolete. Determinations made under ADR have the same force and effect as those of Board law judges.

Choice of Treating Physician

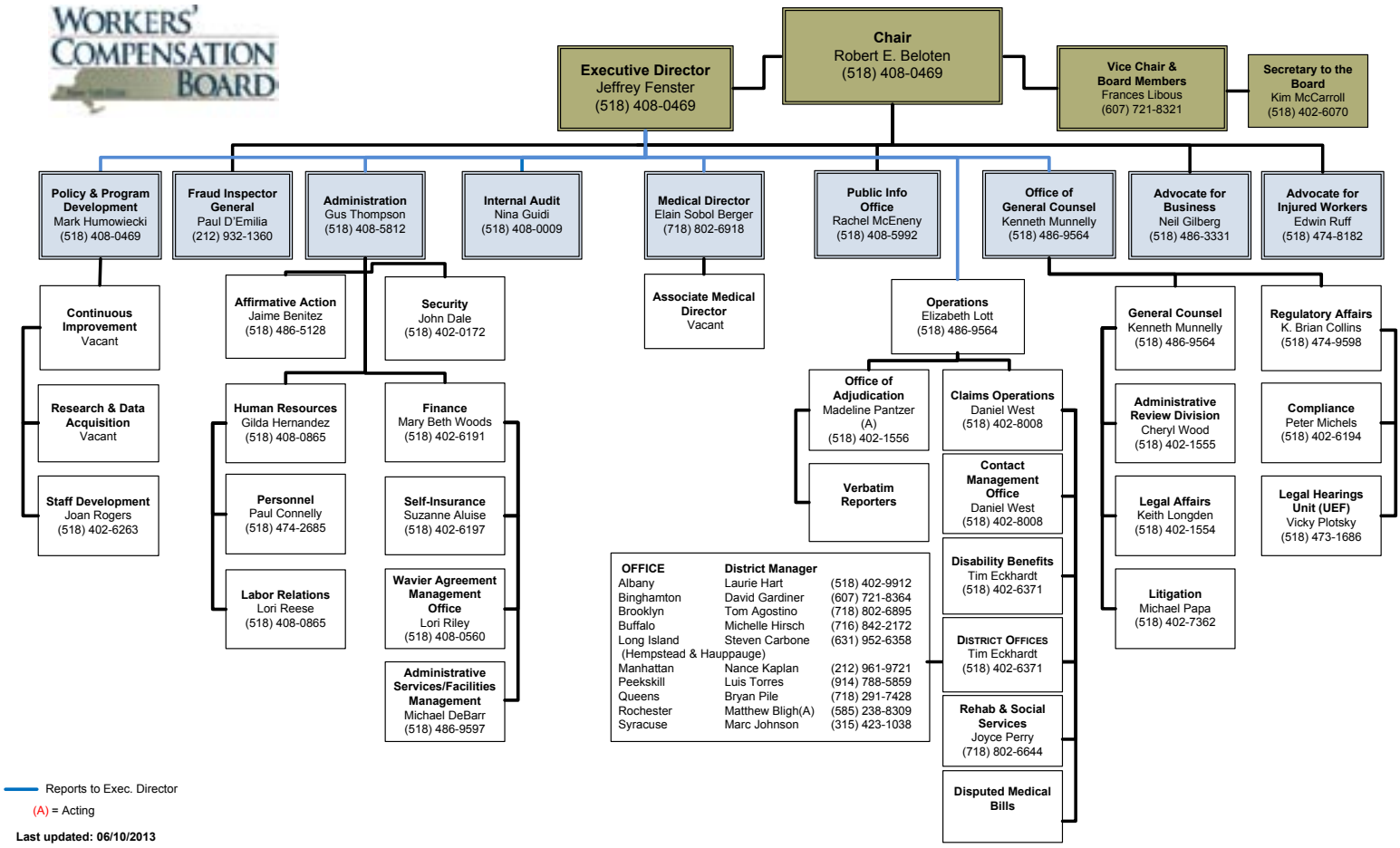
Providers within certain professions (physician, chiropractor, psychologist and podiatrist) must be authorized by the Chair of the WCB to treat injured workers. As a general rule, injured employees have the right to select or change providers for the treatment of their work related condition. An exception exists, however, when such treatment is provided in accordance with a preferred provider program, or alternative dispute resolution program.

Vocational Rehabilitation

General Information

Under the Workers' Compensation Law, vocational rehabilitation is voluntary on the part of the insurer and claimant. The Board does not provide direct rehabilitation services, but the Rehabilitation Bureau of the Board evaluates a claimant's need for rehabilitation services and arranges for these services when determined to be necessary to return to work. The criteria for determining a "successful" rehabilitation case is the return to gainful employment.

Workers' Compensation Division Organization Chart



North Carolina

North Carolina Industrial Commission

430 N. Salisbury Street

Raleigh, North Carolina 27603

(919) 807-2501 or (800) 688-8349

http://www.ic.nc.gov/

Agency

General Information

The North Carolina Industrial Commission (Commission) is an independent regulatory agency. The responsibility for administration of workers' compensation is vested in a six-member commission. The Commission does not have any branch offices, but the commission's initial hearing, rehabilitation services, and safety training are conducted in all 100 counties of the State. The Industrial Commission employees administer the Workers' Compensation Act, the Tort Claims Act, the Childhood Vaccine-Related Injury Act, the Law Enforcement Officers', Firemen's, Rescue Squad Workers', and Civil Air Patrol Members' Death Benefit Act, and the Act to Compensate Individuals Erroneously Convicted of Felonies. Our mission is to ensure all parties are treated fairly and equally in accordance with North Carolina State Law.

Mission Statement

The North Carolina Industrial Commission is an agency of the State of North Carolina created by the General Assembly in 1929 to administer the North Carolina Workers' Compensation Act. In 1949, the Industrial Commission was also given authority by the General Assembly to administer the Tort Claims Act.

Additionally, the Industrial Commission is charged with administering the Law Enforcement Officers', Firemen's, Rescue Squad Workers' and Civil Air Patrol Members' Death Benefits Act, the Childhood Vaccine-Related Injury Compensation Program and Compensation to Persons Erroneously Convicted of Felonies.

The North Carolina Industrial Commission strives to effectively and fairly administer the Workers' Compensation Act and Tort Claims Act for the State of North Carolina and its citizens in the following manner:

- Providing reliable, accurate and efficient claims servicing;
- Providing quick resolutions to disputed issues in an administrative forum;
- Reviewing status of insurance coverage for employers subject to the Workers' Compensation Act;
- Promoting active resolution of disputes through mediation;
- Resolving controversies by rendering impartial and well-reasoned decisions;
- Facilitating high quality, effective medical care and rehabilitation for injured workers in complex medical/legal situations;
- Providing education and training to employers to reduce accident potential in the workplace;
- Providing prompt, efficient medical bill review in accordance with the NCIC Medical Fees Schedule;
- Investigating potential criminal violations of the NC Workers' Compensation Act, insuring compliance and confidence in our state's workers' compensation system.

Legislative and Regulatory Links

North Carolina Workers' Compensation Act: http://www.ic.nc.gov/ncic/pages/statute.htm
North Carolina Commission Rules: http://www.ic.nc.gov/ncic/pages/abtrules.htm

Budget and Financing

Agency Funding Source

North Carolina has a general fund.

Operating Budget and Staff Size

For fiscal year 2012-2013, the Commission's budget was $12,091,426 and the approved FTE was 153.59

Funds

Second Injury/Subsequent Injury Fund

North Carolina's Second Injury fund pays benefits when total disability results from a combination of pre-existing condition and the new work injury if each one contributes at least 20% of the total resultant disability.

The administration of the fund falls under the responsibility of the Administrator of the Industrial Commission and the Fiscal Management Division of the North Carolina Department of Commerce.

The Fund will pay for uncompensated loss as determined by the Fund administrator, and depending upon availability of funds. The employer pays for medical and indemnity benefits as found liable. Awards made in total disability cases trigger payment by the Fund.

Insurance Requirements and Resources

General Information

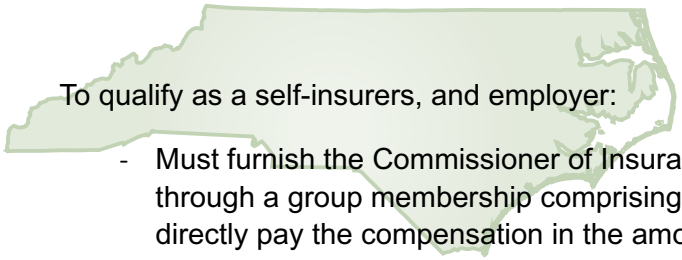
The North Carolina Workers' Compensation Act requires that all businesses which employ three or more employees, including those operating as corporations, sole proprietorships, limited liability companies and partnerships, obtain workers' compensation insurance or qualify as self-insured employers for purposes of paying workers' compensation benefits to their employees. The only exceptions to this requirement are (a) employees of certain railroads; (b) casual employees, i.e., individuals who do not perform "work pertaining to the regular course of defendant's business"; (c) domestic servants directly employed by the household; (d) farm laborers when fewer than 10 full-time, non-seasonal farm laborers are regularly employed by the same employer; (e) federal government employees in North Carolina; and (f) "sellers of agricultural products for the producers thereof on commission or for other compensation, paid by the producers, provided the product is prepared for sale by the producer."

Private Insurance

The North Carolina Department of Insurance has regulatory authority over workers' compensation insurance carriers.

Self-Insurance

The North Carolina Department of Insurance also has regulatory authority over self-insurers.



To qualify as a self-insurers, and employer:

- Must furnish the Commissioner of Insurance satisfactory proof of financial ability, either alone or through a group membership comprising of two or more employers who agree to pool their liabilities, to directly pay the compensation in the amount and manner and when due;
- May be required to deposit an acceptable security, indemnity, or bond to secure the payment of compensation liabilities as they are incurred; and
- Will be subject to rules promulgated by the Commissioner of Insurance.

All individual self-insurers and group self-insurers shall be and remain members of the Self- Insurance Guaranty Association as a condition of being licensed to self-insure in this State. The Association shall perform its functions under a Plan of Operation established or amended, or both, by the Board and approved by the Commissioner, and shall exercise its powers through the Board.

Penalties for Not Insuring

In North Carolina, if an insurer fails to carry workers' compensation insurance, they may:

1) Face stiff financial penalties;
2) Be charged with a misdemeanor;
3) Be charged with a felony; and
4) Be imprisoned.

Reporting Requirements

First Report of Injury

The filing of the employer's first report with the Commission is mandatory in cases for injuries/illnesses resulting in one or more lost workdays, for fatalities, and for medical expenses exceeding $2000.

Other Reports/Claims Processing and Monitoring

After filing a first report, the employer is also responsible for filing a form upon an employee's return to work and a form if a hearing is desired.

The Commission monitors initial and last payments of the claim. A penalty is assessed for lack of promptness of payment when a case is subject of an award by the Commission.

A form is required to be filed in order to terminate temporary total disability benefits, and an informal phone conference hearing will be held before termination of benefits.

In Cases in which there are contested issues but which are not on the hearing docket or calendared for hearing before a Deputy Commissioner, the Executive Secretary's Office monitors the issues raised by the parties and renders Administrative Decisions to address the issues.

EDI Standards

Currently North Carolina uses the IAIABC Claims Release 3.0 Standard and Medical Release 2.0 on a voluntary basis with plans to mandate that standards' use in the beginning of 2014.

Contested Case Handling

Appeals Process

Levels in the hearing process are as follows:

1. All contested cases are referred to mediation with one Deputy Commissioner.
2. Hearing before the Full Commission (composed of panels of three Commissioners)
3. Appeal to the State Court of Appeals
4. Appeal to the State Supreme Court

Attorneys' Fees

The Commission approves or regulates the attorneys' fees based on a contract between the attorney and client, the amount of time spent on the case, the degree of complexity, and the usual and customary fees in similar cases. Fees are usually paid out of the claimant's award, unless there is evidence of insurer/employer abuse.

Compromise and Release Agreements

Compromise Settlement Agreements (CSA) are allowed and must be approved by the Executive Secretary of the Commission. CSAs terminate indemnity and medical benefits, unless there is a reservation of rights. Claims can only be reopened after CSA in cases of fraud or undue duress.

Medical Care and Evaluation

Fee Schedule

The Commission has the authority to set medical fees for all medical services.

Most recent Medical Fee Schedule: http://www.ic.nc.gov/medfeeschdisclaimer.html

Treatment Guidelines

North Carolina currently does not have treatment guidelines for workers' compensation.

Managed Care

Legislation does permit carriers or employers to contract with managed care organizations.

Choice of Treating Physician

The carrier selects the worker's treating physician, but the workers may petition the Commission for change of physician.

Rehabilitation

General Information

The law provides for both vocational and physical rehabilitation in North Carolina.

Ongoing rehabilitation case management of injured workers covered by the Workers' Compensation Act is usually provided by Medical and Vocational Rehabilitation Professionals employed in private industry. The Industrial Commission's Medical Rehabilitation Nurse Consultants are available to assist with difficult cases temporarily, promoting ongoing case management within the private industry. The Nurse Consultants also perform specific rehabilitation activities as ordered by hearing officers within the Industrial Commission. The Industrial Commission's Medical Rehabilitation Nurses Section services are available to anyone who wishes to express concern regarding an injured worker's care or rehabilitation.

Physical rehabilitation is paid for by carriers, except for that provided by the Commission's six rehabilitation nurses who are employed within the Industrial Commission.

The criteria used to determine a "successful" rehabilitation case is the return to work, reaching maximum medical improvement, decrease in pain, restoring quality of life that is possible under the circumstances, and helping the family adjust.

North Dakota

North Dakota Workforce Safety and Insurance

1600 East Century Avenue, Suite 1

Bismarck, North Dakota 58503

(701) 328−3800 or 1−800−777−5033

http://www.workforcesafety.com/

Agency

General Information

Workforce Safety & Insurance (WSI) is an exclusive, employer financed, no-fault insurance state fund covering workplace injuries, illnesses, and death. WSI is the sole provider and administrator of the workers' compensation system in North Dakota.

WSI is responsible for administering the Workers' Compensation Act, which provides benefits to injured workers.

2012 Covered Workforce: 369,996

2012 Total Claims Filed: 24,647

2012 Total Indemnity Benefits Paid: $54.4 Million

2012 Total Medical Benefits Paid: $76.1 Million

Core Purpose and Business Definition

Our core purpose is to care for injured workers.

Our business definition is that we provide workers' compensation and safety services.

Our vision is a safe, secure and healthy North Dakota workforce.

Legislative and Regulatory Links

North Dakota Workers' Compensation Act: http://www.legis.nd.gov/cencode/t65.html

North Dakota Workers' Compensation Rules: http://www.legis.nd.gov/information/acdata/html/Title92.html

Budget and Financing

Agency Funding Source

WSI's source of operating funds is employer premiums (North Dakota Chapter 65-04: The Fund and Premium Payments Thereto).

Operating Budget and Staff Size

The biennial 2011-2013 total budget appropriation is $58,413,293 (including $466,258 for Century Center back-up generator). The approved FTE is 247.14.

Funds

Second Injury/Subsequent Injury Fund

The Second Injury Fund in North Dakota covers all subsequent injuries arising in the course of, or out of employment. The Fund is administered by WSI. There is not separate fund maintained for payment of second injury benefits. Employer is not required to have knowledge of the pre-existing condition.

Insurance Requirements and Resources

General Information

North Dakota is one of four "exclusive" state funds in the country (the other three are Ohio, Washington, and Wyoming). This means that all employers must purchase workers' compensation insurance from the state fund, rather than from private insurance companies. In the other 46 states and the District of Columbia, employers have the option to either buy workers' compensation insurance from private insurance companies and competitive state funds or to self-insure.

Private Insurance

Private insurance is not permitted in North Dakota.

Self-Insurance

Not permitted in North Dakota

Penalties for not Insuring

If you have employees and do not have a workers' compensation policy, North Dakota law provides for the assessment of premium and penalty charges. You may have to pay premiums retroactively to cover the time your employees were not insured. The state may also assess a penalty for your failure to obtain mandatory coverage. If an employee is injured while you are uninsured, he may sue you for the damages he suffered.

Reporting Requirements

First Report of Injury

WSI encourages workers and employers to immediately file a claim with WSI (within 24 hours of injury occurrence) as that allows for more effective management of the claim.

WORKER: Under North Dakota law, you must notify your employer of your injury within 7 days after an accident or when the general nature of the injury became apparent.

EMPLOYER: Under North Dakota law, an employer is required to file a First Report of Injury form with Workforce Safety & Insurance (WSI) within 7 days of receiving notice of an injury from a worker.

Other Reports/Claims Processing and Monitoring

In North Dakota, there is no statutory penalty for failure to promptly pay workers' compensation benefits. It is mandatory to send the injured workers a notice of intention to discontinue benefits prior to terminating disability benefits.

EDI Standards

Workforce Safety & Insurance (WSI) encourages providers to submit medical bills using Electronic Data Interchange (EDI) technology.

Contested Case Handling

Appeals Process

1. Administrative Hearing
2. District Court Appeal
3. Supreme Court Appeal

	Number in FY2012
Administrative Hearings Held	125
District Court of Appeals	20
Supreme Court Appeal	7

WSI claims defense is handled by contracted law firms across the State with attorneys representing WSI designated as Special Assistant Attorneys General. An administrative hearing is held before an Administrative Law Judge who renders a decision.

Attorneys' Fees

A worker is not required to seek assistance from Decision Review Office (DRO). However, attorneys' fees will only be paid by WSI, up to the caps provided in the North Dakota Administrative Code, if the worker first seeks DRO's assistance and subsequently prevails on further appeal of an order. In addition, WSI will pay an Attorneys' up to $500 in fees and $150 in costs to review an administrative order for a worker after completion of the DRO process.

Compromise and Release Agreements

Compromise and release agreement are allowed. C&R agreements may terminate indemnity, medical, PPI, and vocational rehabilitation benefits. WSI will pay an Attorneys' up to $500 in fees and $150 in costs to review a proposed compromise agreement for a worker if the worker does not have legal representation at the time of the agreement.

Medical Care and Evaluation

Fee Schedule

North Dakota Century Code authorizes Workforce Safety & Insurance (WSI) to establish medical and hospital fee schedules. The fee schedule is a list that establishes the recommended maximum level of reimbursement for medical services. A fee schedule usually has two components: a relative value scale and a monetary conversion factor. The fee schedule also establishes guidelines for payment of services. These guidelines may include limitations on the number of allowed treatments, restrictions on frequency of service, or requirements for treatment plans. WSI currently has the following fee schedules:

- Ambulance
- Ambulatory Surgical Center (ASC)
- Anesthesia

- Dental
- Durable Medical Equipment (DME)
- Evaluation & Management
- Home Health
- Hospital (Inpatient)
- Hospital (Outpatient)
- Medicine (includes Chiropractic)
- Pathology & Lab
- Physician Administered Drugs
- Radiology
- Physical & Occupational Therapy
- Surgery

To review the fee schedules, visit: http://www.workforcesafety.com/medical-providers/feeschedule/fee-scheduleagreement.asp

Treatment Guidelines

WSI utilizes the following evidence-based clinical guidelines from national and state authorities as outlined Administrative Rule 92-01-02-33 (5):

- Official Disability Guidelines (ODG)
- American College of Occupational and Environmental Medicine's Practice Guidelines
- Guide to Physical Therapy Practice
- Medical Disability Advisor
- Diagnosis and Treatment of Physicians and Therapist Upper Extremity Rehabilitation
- Treatment Guidelines of the American Society of Hand Therapists
- Other treatment and disability guidelines or standards it deems appropriate to administer claims.

Managed Care

Managed medical care organizations (PPOs and HMOs) are permitted, but not used.

Choice of Treating Physician

A Designated Medical Provider is a medical professional or a facility selected by the employer to treat work related injuries. All employers in North Dakota have the option of selecting a DMP.

Employers may choose a single provider, a group of providers, or any combination of provider specialties (including chiropractors).

A change in DMP is permitted with written authorization of WSI or upon referral by a treating physician. An employee must treat with the DMP for 30 days to avoid non-payment of benefits.

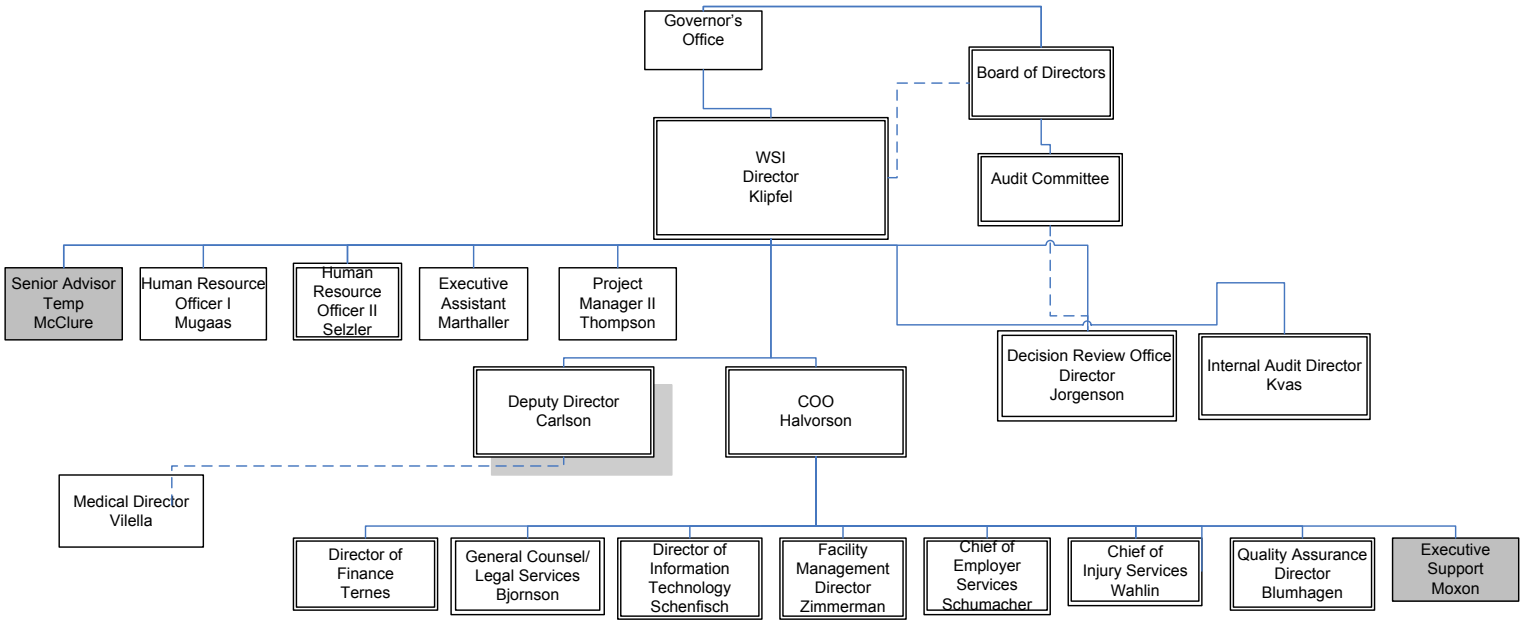
Rehabilitation

General Information

Vocational and physical rehabilitation is provided under the workers' compensation law and ranges from return to work with the original employer to retraining options.

WSI has a Return-to-Work Services Unit that oversees vocational rehabilitation services, medical case management services, and preferred worker programs for injured workers. Injured workers receive vocational rehabilitation benefits and appropriate allowances while undergoing a training program. Injured workers may receive partial disability benefits upon return to work, depending on post-training earning or earning capacity. An injured worker who refuses vocational rehabilitation will have wage loss benefits suspended or terminated. WSI pays for the cost of rehabilitation services and programs.

Workforce Safety & Insurance Executive Organization Chart



Ohio

Ohio Bureau of Workers' Compensation

30 W. Spring Street

Columbus, Ohio 43215

Toll-free: 1-800-OHIOBWC (1-800-644-6292)

http://www.ohiobwc.com/

Agency

General information

Workers' compensation in Ohio is a no-fault system that offers protection from costly lawsuits to employers and guaranteed benefits to injured workers. It is comprised of two parts.

- The Ohio Bureau of Workers' Compensation (BWC) is the administrative and insurance arm.
- The Industrial Commission of Ohio (IC) is the claims adjudicative branch.

Number of penalties assessed in FY2012: 127
Dollar amount of penalties assessed in FY2012: $29,665.61

The Ohio Revised Code governs both agencies.

Note: The above statistics pertain exclusively to special investigations' employer fraud investigations. These statistics do not include results independently secured by BWC's employer compliance department or the BWC underwriting & premium audit department.

Mission Statement

Industrial Commission of Ohio: "Serve injured workers and Ohio employers through expeditious and impartial resolution of issues arising from workers' compensation claims and through the establishment of adjudication policy."

Ohio Bureau of Workers' Compensation: "To protect Ohio's workers and employers through the prevention, care and management of workplace injuries and illnesses at fair rates"

Legislative and Regulatory Links

Ohio rules, statutes, executive orders and public hearings: https://www.ohiobwc.com/basics/guidedtour/generalinfo/ORCandOAC.asp

Budget and Financing

Agency Funding Source

Employer premiums and self-insurance assessments fund BWC (see Ohio Revised Code section 4123). The state legislature appropriates BWC's administrative operating budget; the governor must approve the budget.

2012-2013 Operating Budget/Staff Size

Staff size for fiscal year 2013: 1,911 employees (as of June 10, 2013)
Operating budget for fiscal year 2013: approximately $287 million

Funds

State Insurance Fund

BWC administers the State Insurance Fund (SIF). The SIF provides benefits to both public and private employers for:

- The payment of lost-time compensation;
- Medical services, examinations, nursing and hospital services;
- Rehabilitation;
- Death benefits and funeral expenses;
- Other benefits for losses sustained from job-related injury, disease or death.

Disabled Workers' Relief Fund (DWRF)

The Disabled Workers' Relief Fund (DWRF) is a special fund that supplements the benefits received by permanently and totally disabled injured workers whose benefits fall below the current cost of living. Prior to its establishment in 1953, benefits of permanently and totally disabled injured workers were fixed. Thus, these injured workers were adversely affected by continued inflation.

BWC adjusts the current cost of living annually based on the U.S. Department of Labor's Consumer Price Index. BWC refers to this adjusted cost of living amount as the DWRF entry level. The adjusted DWRF qualifying figure is effective Jan. 1 of each year. DWRF provides a subsidy payment to permanently and totally disabled injured workers receiving less than the DWRF entry level.

Public Works Relief Employees Fund (PWREF)

BWC administers the PWREF. The PWREF provides compensation to injured persons required to work for governmental units in exchange for relief assistance. The PWREF is financed by premiums assessed upon public employers having control of work relief employees, and investment income from the PWREF. Benefits are based upon the amount of work relief which would have been afforded the injured person for the calendar week in which the injury or death occurred.

Coal Workers' Pneumoconiosis Fund (CWPF)

The CWPF is administered by BWC and provides coverage to employees of mining operators who elect to subscribe to ensure payment of benefits required by Title IV of the Federal Coal Mine Safety Act of 1969, 83 Stat. 742, 30 U.S.C 801. The IC approves employers' election to subscribe. The CWPF is financed by premiums and other payments by subscribers upon the basis and at the intervals determined by BWC.

Marine Industry Fund (MIF)

The MIF is administered by the federal government, with jurisdiction for claims handling through the U.S. Department of Labor. The MIF provides insurance coverage to maritime employers who have difficulty obtaining liability coverage to pay compensation and medical benefits to injured maritime employees. Marine industry employers and investment income from the MIF finance this fund.

Self-Insuring Employers' Guaranty Fund (SIEGF)

BWC administers the SIEGF. The fund provides payment of compensation and benefits to employees of self-insured employers in order to cover any default in payments by self-insured employers. Self-insured employers' assessments and investment income from the SIEGF finance the fund. BWC bases assessments on self-insured employers' workers' compensation indemnity payments from the prior year. BWC bases the assessments of a new self-insured employer on a percentage of base-rated premiums.

Insurance Requirements and Resources

General Information
Ohio is a monopolistic state fund. It is the exclusive provider of workers' compensation insurance to employers in Ohio who are not granted self-insurance, the privilege of paying claims directly.

Private Insurance
Ohio does not have private workers' compensation insurance.

Self-Insurance
BWC has regulatory authority over workers' compensation self-insurers. BWC is responsible for monitoring performance and revoking self-insurance privileges.

To qualify as an individual self-insurer, an employer must demonstrate financial and administrative ability to meet its obligations.

Penalties for not insuring
BWC's special investigations department seeks out uninsured employers, and assesses penalties for non-complying employers.

Reporting Requirements

First Report of Injury
The filing of the employer's First Report of an Injury, Occupational Disease or Death (FROI) with BWC or the employer's managed care organization (MCO) is mandatory for all workplace injuries or occupational diseases regardless of length of disability. The FROI is due within a week of acquiring knowledge of the injury or disease. Failure to file a FROI is considered a misdemeanor of the fourth degree, and constitutes and additional day within the time period given to the claimant by the applicable statute of limitations for filing a claim, not to exceed two years.

Additional Reports/Claims Processing and Monitoring
Additional required reports?

BWC monitors the initial payment, periodic payments and last payment of a workers' compensation claim. BWC does not monitor the denial behavior of insurers unless complaints are made against self-insured employers. Complaints against self-insured employers are referred to BWC's Self-Insuring Employers Evaluation Board for investigation.

A penalty of 5 percent interest is paid to providers for any bills not paid within required times.

A hearing is necessary if there is a dispute regarding payment, or if medical reports from the employer, agency medical resource, or attending physician indicate anything other than temporary total disability.

The IC makes the final administrative decision for determining a claimant's permanent partial disability rating through a hearing process if an objection is filed as the result of a BWC tentative order. Permanent partial tentative orders are placed by BWC claim representatives.

Factors used in determining the disability rating include:

- Impairment rating of the attending physician
- Use of the AMA Guide to Physical Impairment

EDI Standards

Ohio does not use EDI

Contested Case Handling

Appeal process of BWC order regarding payment of a claim:

1. Workers of employer can appeal to the IC to request a hearing with District Hearing Officers.
2. Decisions of the District Hearing Officers may be appealed to an IC Staff Hearing Officer; decision of the Staff Hearing Officer may be appealed to the 3-member IC (the IC may refuse to hear such appeals).
3. Appeals beyond the IC level may be made to the appropriate state court.

FISCAL YEAR 2012 (non-C92)	*Notes or Comments on Scope*	*Number in FY2012*
Appeals from BWC	First level appeals that will be docketed at the DHO level	96,087
Appeal to District Hearing Officer order	Appeals will be docketed at SHO level	37,314
Appeal to the Staff Hearing Officer order	Appeals will be considered for docketing at COM level	23,945
Appeal to the State Court	.512 Appeals Only	5,111

Attorneys' Fees

The IC has the authority to regulate the amount of attorney's fees, but there is no set statutory fee percentage or rate. Attorneys appearing before the IC must be licensed. A union official may represent claimant if they do not receive fees directly.

Compromise and Release Agreements

Compromise and Release Agreements are allowed and must be reviewed by the IC. It terminates the employer liability for past and future medical and indemnity benefits.

Medical Care and Evaluation

Fee Schedule

BWC is statutorily required to establish and update on an annual basis reimbursement schedules for all medical services paid by the SIF. Ohio has fee schedules for medical providers, hospital (inpatient and outpatient), ambulatory, and vocational rehabilitation.

Please see: http://www.ohiobwc.com/provider/services/agreement.asp

Treatment Guidelines

Ohio uses the Official Disability Guidelines for workers' compensation.

Managed Care

BWC determines compensability and pays indemnity benefits. It contracts with MCOs to provide total management of the medical component of workers' compensation claims. MCOs provide effective case management of claims, including:

- Processing the FROI;
- Helping employers establish transitional/early return-to-work programs;
- Processing medical bills and making provider payments.

BWC monitors the performance of MCOs. For example, it measures the effectiveness of the MCOs' quality medical-management efforts using the Measurement of Disability (MoD) metric. BWC also measures the MCOs' FROI timing and FROI turnaround. BWC publishes most of these measures in its annual MCO Report Card, which is available on ohiobwc.com. BWC encourages employers to view this report before selecting an MCO. There are currently 17 BWC-certified MCOs.

Rehabilitation

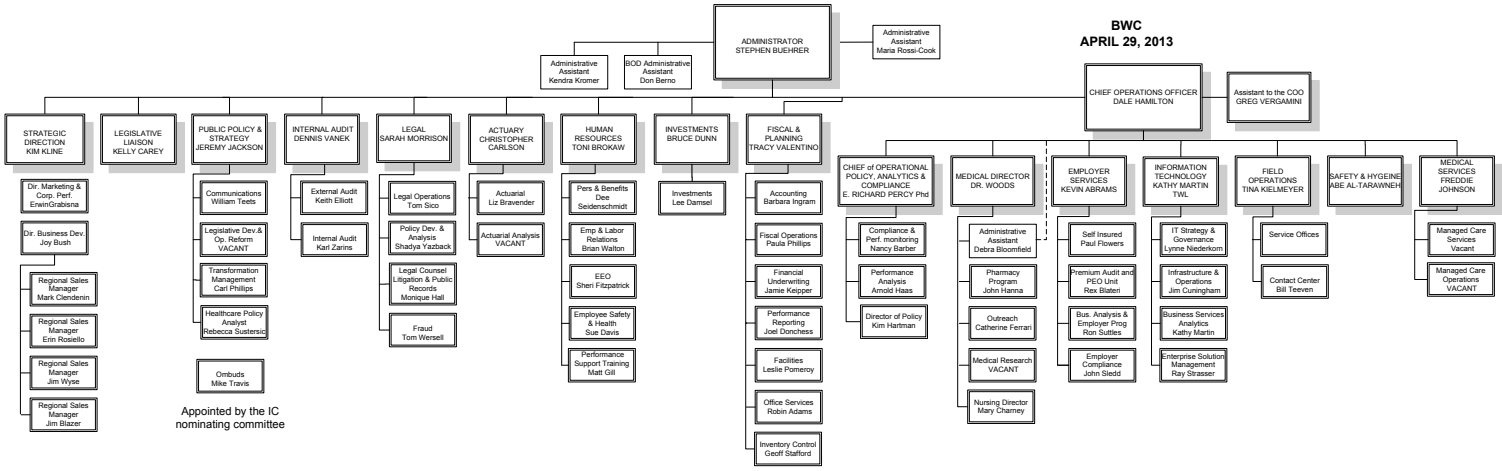
General Information

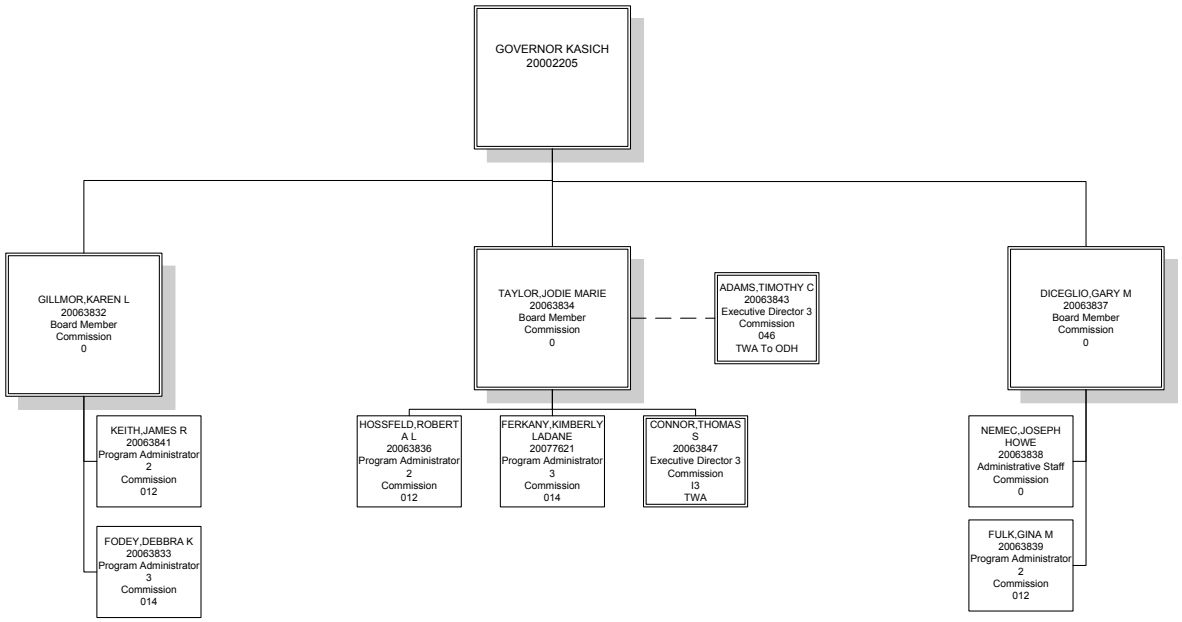
The goal of BWC's rehabilitation efforts is to ensure quality, cost effective rehabilitation services that minimize the emotional, physical, and financial impact to the injured worker and employer.

Vocational rehabilitation is assessed immediately following an accident and at various stages in the life of the claim. The thought is that rehabilitation in the early stages is more likely to secure timely RTW. A RTW plan is created on every lost-time claim; BWC vocational coordinators and MCO case management staff review and collaborate on claims from the very start to determine if vocational rehabilitation intervention could assist in an appropriate and safe that exceeds the optimal RTW. Rehabilitation services in lost-time claims are provided as part of a formal vocational rehabilitation plan.

Transitional work programs provide employers and injured workers with an opportunity to reduce the number of lost work days following an accident through workplace accommodation.

Workers' Compensation Division Organization Chart





AS OF JUNE 2013

ADMINISTRATION

Oklahoma

Oklahoma Workers' Compensation Court

1915 North Stiles Avenue

Oklahoma City, Oklahoma 73105

(405) 522-8600 or (800) 522-8210

http://www.owcc.state.ok.us/

Agency

General Information

The Workers' Compensation Court (WCC) is a State court of record. Responsibility for administration of workers' compensation is vested in a single administrator.

All of the administrative and judicial functions are provided by the WCC central office. Functions include:

- Injury reporting and records retention
- Examining and monitoring of injury reports and forms
- Timely filing and reporting
- Assessment of penalties
- Education of workers, employers, medical providers, rehabilitation providers, claims adjusters, and attorneys
- Licensing or certification of independent medical examiners, 3rd party administrators, and self-insurers
- Compiling statistics
- Preparing statutory reports to the governor and legislature
- Formal dispute resolution

Mission Statement

The Oklahoma Workers' Compensation Court applies the law as set out in the Oklahoma Workers' Compensation Code. Its responsibility is to provide fair and timely procedures for the resolution of disputes and identification of issues involving on-the-job injuries. To this end we dedicate ourselves to carry out this responsibility and to serve the public promptly, courteously and impartially.

Legislative and Regulatory Links

Oklahoma Workers' Compensation Code and Rules: http://www.owcc.state.ok.us/administrator_and_court_rules.htm

Budget and Financing

Agency Funding Source

WSI's source of operating funds is employer premium incomes (North Dakota Chapter 65-04: The Fund and Premium Payments Thereto).

Operating Budget and Staff Size

WCC's 2013 appropriated budget is $4,197,166.

The staff size of WCC is 2013 is 72.

Funds

Second Injury/Subsequent Injury Fund

Oklahoma's Multiple Injury Trust Fund went through a period of insolvency in the early 21st century. In 2005, a reform bill was passed by the Oklahoma legislature that re-funded the trust. New policies, procedures, and oversight protocols were put in place. The Fund is administered by CompSource Oklahoma. Employees found to be permanently totally disabled as a result of a combination of disability as defined by the statute and case law may now draw weekly benefits from the Multiple Injury Trust Fund until the age of 65 or for 15 years, whichever is longer.

Insurance Requirements and Resources

General Information

Generally, every employee hired in Oklahoma or who is injured in Oklahoma is covered by the workers' compensation laws of the state. Independent contractors are not employees and are therefore not covered. Other exceptions to coverage include persons covered for job-related injuries under the federal law; certain agricultural workers; licensed real estate brokers paid on a commission basis; certain persons providing services administered by the Oklahoma Department of Human Services; any person employed by an employer with 5 or fewer employees, all of whom are related by blood or marriage to the employer; any person employed by a tax-exempt youth sports league; sole proprietors, members of a partnership, certain persons who are a party to a franchise agreement, certain members of a limited liability company and certain stockholders of a corporation; any person that provides voluntary service who receives no wages for the services other than meals, drug or alcohol rehabilitation therapy, transportation, lodging or reimbursement for incidental expenses; owner-operators of a truck-tractor; and drive-away owner operators. All of these groups of people are exempt from the workers' compensation laws of the state by law.

Private Insurance

The Oklahoma Insurance Department has regulatory authority over workers' compensation insurance carries. They issue licenses, discipline carriers, monitor performance, and oversee other regulatory performance.

Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th, Suite 100
Oklahoma City, Oklahoma 73112
(405) 521-2828
www.ok.gov/oid/

Other Insurance Options

Employers in Oklahoma can also choose to insure through CompSource Oklahoma, an entity created by law which provides workers' compensation coverage for public and private Oklahoma employers.

Self-Insurance

Employers also may satisfy their workers' compensation obligations by insuring themselves as an own-risk employer or member of a group self-insurance association, if approved by the Workers' Compensation Court

Administrator.

The WCC's Insurance Division has regulatory authority over workers' compensation self-insurers.

The Administrator, pursuant to rules adopted by the Workers' Compensation Court or the Administrator for an individual self-insured or a group self-insurance association, shall require an employer that has:

(1) less than one hundred employees or less than One Million Dollars ($1,000,000.00) in net assets to:

(a) deposit with the Administrator securities, an irrevocable letter of credit or a surety bond payable to the state, in an amount determined by the Administrator which shall be at least an average of the yearly claims for the last three (3) years, or

(b) provide proof of excess coverage with such terms and conditions as is commensurate with their ability to pay the benefits required by the provisions of the Workers' Compensation Code, or

(2) one hundred or more employees and One Million Dollars ($1,000,000.00) or more in net assets to:

(a) secure a surety bond payable to the state, or an irrevocable letter of credit, in an amount determined by the Administrator which shall be at least an average of the yearly claims for the last three (3) years, or

(b) provide proof of excess coverage with such terms and conditions as is commensurate with their ability to pay the benefits required by the provisions of the Workers' Compensation Code.

Penalties for not Insuring

An employer required by law to secure workers' compensation coverage that fails to obtain such coverage, may be charged with a misdemeanor and subjected to a fine. In addition, after an employer is cited for 2 offenses of failing to obtain workers' compensation coverage, the Commissioner of Labor has the authority to order cessation of business activities until insurance is procured.

Reporting Requirements

First Report of Injury

The filing of employer's first reports with the WCC is mandatory for fatalities and any injury resulting in lost time beyond the shift, or which requires medical treatment away from the job site. The first report of injury is due within ten days or a reasonable time after notification. Failure to file the initial report may result in a fine of up to $1,000.

Other Reports/Claims Processing and Monitoring

The WCC is authorized to monitor the initial payment and the promptness of payments of a workers' compensation claim. A penalty may be assessed by WCC for lack of promptness.

Forms must be filed out in order to deny a claim, terminate temporary total disability benefits.

Permanent disability for work-related injuries is determined by judges of WCC based on medical opinions of permanent impairment stated within a reasonable degree of medical certainty. Factors which may be used in determining the disability rating include:

- Impairment rating of the attending physician
- Use of the *AMA Guides to the Evaluation of Permanent Impairment* if the impairment is to a non-schedule member, and
- Impairment rating of a court-appointed independent medical examiner.

EDI Standards

Pending request for funding by the Legislature

Contested Case Handling

Appeals Process

Levels in the hearing process:

1. Trial Judge, no jury
2. Court En Banc, 3-judge panel
3. State Supreme Court

	Notes or Comments on Scope	*Number in FY2012*
Hearing with a Trial Judge	PPD, TTD, Death, Denials	7,054
Hearing before a 3-Judge Panel (Court En Banc)		934
State Supreme Court		141

Attorneys' Fees

Attorneys' fees are established by statute. Ten percent of temporary total disability award and twenty percent of permanent disability and death award are the maximums allowed, on quantum meruit basis. The claimant's attorney fee is paid out of the claimant's award.

Compromise and Release Agreements

A Joint Petition Settlement is a full, final, and complete settlement of the claim and cannot be reopened. A Form 14 agreement is also a claim settlement. However, it can be reopened, under certain circumstances, upon a change in condition.

Medical Care and Evaluation

Fee Schedule

In Oklahoma, the Schedule of Medical and Hospital Fees establishes the maximum amount the WCC will authorize for payment. Regardless of the amount charged by the medical provider, the carrier will usually pay the bill in accordance with their own interpretation of the fee schedule.

Treatment Guidelines

Oklahoma uses ODG and State Specific treatment guidelines. State specific guidelines are used for use on Schedule II drugs (OTG-Drugs) and were implemented April 2, 2012. State specific guidelines are also used for the spine (OTG Spine, pending). ODG guidelines govern all treatment except as otherwise provided in the state specific guidelines.

For OTG-Drugs: http://www.owcc.state.ok.us/OTG-Drugs.pdf

Existing treatment guidelines for the spine until OTG-Spine becomes' operative or if disapproved: http://www.owcc.state.ok.us/Guidelines.htm

Managed Care

Managed medical care organizations (PPOs and HMOs) are permitted. Certified workplace medical plans (CWMPs) are organizations that provide managed care in workers' compensation in Oklahoma.

Choice of Treating Physician

The procedure for changing a treating physician is different depending upon whether or not the employee is covered by a certified workplace medical plan (CWMP). CWMPs are organizations that provide managed care in workers' compensation.

If the employee is not covered by a CWMP, the employee may apply to the WCC for one change of physician for any affected body part. No change of treating physician is allowed for a body part unless medical care for that body part was provided for 180 days before the application. No more than two changes of physician are allowed in a claim.

If the employee is covered by a CWMP, the employee may apply for a one-time change of physician to another appropriate physician within the network of the CWMP using the dispute resolution process set out in the CWMP. Once the dispute resolution process has been exhausted, the employee may petition the Court for a change of physician within the plan. If there is not a physician available within the plan that is qualified to treat the employee's injuries, a physician outside of the plan may be selected if the physician agrees to comply with all the rules, terms and conditions of the certified workplace medical plan.

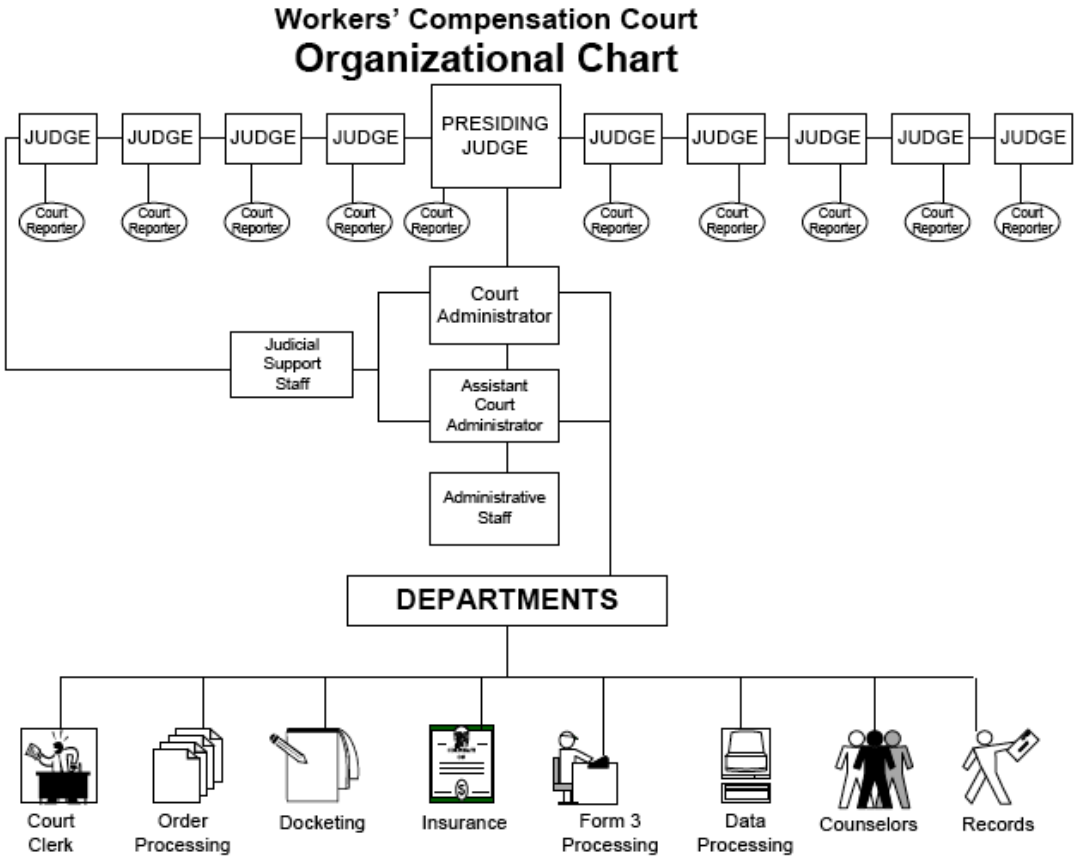
Rehabilitation

General Information

The workers' compensation law provides for both vocational and physical rehabilitation. In order to qualify for rehabilitation, a worker's injury must result in the worker not being able to perform the same occupational duties as before the injury. The restrictions on receiving rehabilitation are that is must be requested within 60 days of the PPD award. It cannot extend for more than 52 weeks, except by court order for additional 52-week period. When rehabilitation is provided voluntarily, the WCC's involvement is limited. If a trial is requested, a Judge has the authority to resolve any rehabilitation issues.

When a worker is undergoing rehabilitation, he/she is entitled to reasonable cost of board and lodging (when necessary), travel, tuition, books, and necessary equipment, in addition to any weekly benefits to which he/she is entitled. The insurer is responsible for paying the cost of rehabilitation.

Workers' Compensation Division Organization Chart



Oregon

Oregon Workers' Compensation Division

350 Winter Street NE

PO Box 14480

Salem, Oregon 97309

http://www.cbs.state.or.us/external/wcd/index.html

Agency

General Information

The Workers' Compensation Division (WCD) is the state agency that administers and regulates laws and rules that impact the participants in the Oregon workers' compensation system. WCD is located within the Oregon Department of Consumer and Business Services (DCBS). The Workers' Compensation Division has a total of five sections: Benefit Services, Compliance, Medical, Operations, and the Administrator's Office. WCD has programs that ensure timely and appropriate medical treatment and time-loss benefits to injured workers, while assisting in keeping costs and burdens low for Oregon employers. In addition, the division administers return-to-work programs that assist in helping injured workers return to their previous job or to find new employment.

Also, with DCBS is the Workers' Compensation Board (Board). The Board provides timely and impartial resolution of disputes appealed from its Hearings Division. The Board also approves claim disposition agreements, reviews disputes regarding the processing of "own motion" claims under ORS 656.278, and resolves disputes arising from third party settlements/judgments.

The Hearings Division ensures timely and impartial resolution of Oregon workers' compensation and Oregon Occupational Safety and Health Division (OR-OSHA) disputes.

Dispute resolution can be accomplished in a number of methods. Administrative Law Judges (ALJs) conduct contested case hearings which result in the issuance of an Opinion and Order, consistent with statutory requirements. Additionally, ALJs provide motion decisions, review and/or approve settlements between the parties. ALJs also provide mediation services.

The Administrative Services Division (ASD) is the operational center of the Board. It provides support to ensure that effective and efficient service is provided to the public. Services include docket, hearing notice production, interpreter services, litigation coding and record retention. ASD also handles the facilities, risk management, contracts and billing, mail processing, statistics, payroll, and personnel on behalf of WCB.

Mission Statement

Workers' Compensation Division: To continuously improve Oregon's workers' compensation system for workers and employers.

Workers' Compensation Board: Our mission here at the Workers' Compensation Board is to provide timely and impartial resolution of disputes arising under Oregon Workers' Compensation Law and the Oregon Safe Employment Act.

Legislative and Regulatory Links

Oregon Workers' Compensation Laws and Rules: http://www.cbs.state.or.us/external/wcd/policy/rules/oarors.html

Budget and Financing

Agency Funding Source

The Workers' Compensation Division, Workers' Compensation Board, most of Oregon-OSHA, part of the Insurance Division, and other parts of the Department of Consumer and Business Services are supported by an assessment levied against insurers. Employers pay a percentage based on their insurance premium. The premium assessment rate in 2011 was 6.4%.

Operating Budget and Staff Size
Need information for 2013

Funds

Second Injury/Subsequent Injury Fund
Oregon does not have a Second Injury Fund.

Workers' Benefit Fund
WCD administers the Worker Benefit Fund (WBF). The employer and worker each pay an assessment (2.8 cents/hour for FY 2012) into the fund. The assessment rate is reviewed annually by DCBS to ensure sufficient fund for anticipated expenditures.
The Workers' Benefit Fund covers the following continuing expenditures:

- Workers with Disabilities Program (ORS 656.628)
- Reemployment Assistance Program (ORS 656.622)
- Reopened Claims Program (ORS 656.625)
- Retroactive Program (ORS 656.506)
- Noncomplying Employer Payments (ORS 656.054 & .735)
- Supplemental Disability Benefit (ORS 656.210)
- Rehabilitation Payments (for pre-1986 Vocational Assistance Costs) (Oregon Laws 1985, Chapter 600, Section 15)
- Expenses of the Center for Research on Occupational and Environmental Toxicology (CROET) of the Oregon Health Sciences University (ORS 656.630)
- Payments due workers who have not received payment from an insurer in default (ORS 656.445)
- Expenses of the Bureau of Labor and Industries for activities related to investigation of alleged injured worker discrimination (ORS 656.605)

Insurance Requirements and Resources

General Information
Oregon employers with one or more subject workers must purchase a workers' compensation policy. In Oregon, there are about 30 exemptions with most of them found in Oregon law ORS 656.027.

Private Insurance
The Oregon Insurance Division has regulatory authority over certain workers' compensation insurance functions. The Insurance Division issues insurance company and agent licenses, approves rates and policy forms, monitors insurance company solvency including maintenance of the insurers' workers' compensation deposits; and in sometimes oversees regulatory performance, monitors performance, and may discipline workers' compensation insurers for non-compliance.

Oregon Insurance Division
350 Winter St. NE
PO Box 14480
Salem, Oregon 97309

Other Insurance Options

Employers who are denied coverage from a licensed insurance company may join the Oregon Workers' Compensation Plan, or assigned risk plan.

Self-Insurance

WCD certifies self-insured employers, monitors their performance, and may discipline self-insured employers for non-compliance.

In order to qualify as a certified self-insured employer, an employer must establish proof of adequate qualifies staff to process claims, meet financial requirements, obtain excess coverage, and provide surety bond, letter of credit, deposits, securities or other financial indemnification as approved by DCBS.

Penalties for Not Insuring

If an employer is found by WCD to be non-compliant, a fine is assessed. The penalty for the first offense is two times the amount of premium you should have paid for insurance, with a minimum of $1,000.

If an employer continues to employ without coverage, the penalty goes to $250 per day with no limit on the total fine. In addition, WCD will request a permanent court injunction to force the employer to stay in compliance. If the employer disobeys an injunction, they are in contempt of court and are subject to other types of sanctions, including jail time.

When WCD discovers you should have coverage but don't, it sends an order to you, stating the period of noncompliance and assessing a fine. The penalty for the first offense is two times the amount of premium you should have paid for insurance, with a minimum of $1,000.

Reporting Requirements

First Report of Injury

The first report of injury or "worker's and employer's report of occupational injury or disease/illness" must be filed for fatalities, denied claims, and disabling claims, i.e., claims with more than three lost workdays or workdays with reduced wages, if worker is hospitalized, or for claims which will likely result in permanent disability. The time limit for employer's filing of the first report is five days from the date employer knows about the claim.

Other Reports/Claims Processing and Monitoring

Additional reports that need to be filed with WCD are:

- First/Subsequent Reports
- Closure Summary
- Insurer Notice of Closure (inc. Worksheet)
- Vocational Closure Report and copies of certain worker notices
- Notices of claim/condition acceptance and denial.

WCD monitors the initial payment and the promptness of payment of a workers' compensation claim. Initial payment is due within 14 days of employer's knowledge.

WCD monitors the denial behavior of insurers.

Factors that are used to determine a disability rating include:

- Impairment measurements provided by the attending physician

- Employee's loss of wage earning capability
- Employee factors such as age, education, training, etc
- Use of the AMA Guide to Physical Impairment
- Use of WCD's disability rating standards
- Use of an independent medical arbiter

EDI Standards

On July 1, 2009, Oregon began transitioning from requiring that insurers file a guaranty contract to a policy-based proof of coverage system. Electronic Data Interchange (EDI) reporting of proof of coverage is now mandatory for all insurers providing coverage in the state. Oregon mandates the use of IAIABC's Proof of Coverage 2.1 Standard.

Effective Jan. 1, 2011, all insurers with 100 or more disabling claims per year in Oregon, as determined by the director based on an average accepted disabling claim volume for the previous three calendar years, are required to report paid medical bills to the division. The division uses Secure File Transfer Protocol (SFTP) for trading partners to submit medical EDI files. Oregon mandates the use of the IAIABC Medical 1.1 Standard.

Contested Case Handling

Appeals Process

The steps in the appeals process are as follows (WCD's Jurisdiction):

1. Administrative Review by WCD
2. Hearing by WCB Hearing Division
3. Review by the director or review by the Board
4. Judicial review by the court of appeals
5. Discretionary review by the Oregon Supreme Court

The steps in the appeals process are as follows (The Board's jurisdiction):

1. Hearings Division, Workers' Compensation Board Administrative Law Judge (ALJ)
2. Workers' Compensation Board Review of ALJ's decision/Board members
3. Judicial review of Board decision by the Court of Appeals
4. Discretionary review of Court of Appeals decision by the Oregon Supreme Court.

Attorneys' Fees

Attorney fees may be assessed against an insurer on matters allowed by statute if the claimant prevails or the lawyer is instrumental in obtaining a settlement prior to issuance of a hearing Judge's order. A request for hearing must be filed before attorney fees can be assessed.

Compromise and Release Agreements

Claim Disposition Agreements are allowed and must be approved by the Workers' Compensation Board. These agreements terminate indemnity benefits, and the claim cannot be reopened. Medical benefits cannot be compromised.

Medical Care and Evaluation

Treatment Guidelines

Oregon does not have specific workers' compensation treatment guidelines, but treatment guidelines are required for MCO certification in the state.

Managed Care

Managed care organizations are authorized to exist for the treatment of injured workers.

Choice of Treating Physician

Under Oregon law, no one may require a worker injured on the job to obtain treatment from a specific provider or type of provider. The law limits the length of time some health care providers may treat injured workers, or if they can authorize time off work. In Oregon, only a certified managed care organization (MCO) may restrict the choice of a health care provider or medical service provider, in addition to imposing specific treatment guidelines, protocols, or standards. Even within the MCO, the worker is free to choose his or her provider from a list of health care providers who are members of the certified MCO's panel. An employer whose workers' compensation claims are covered by an MCO is not permitted to direct an injured worker to a particular health care provider.

Rehabilitation

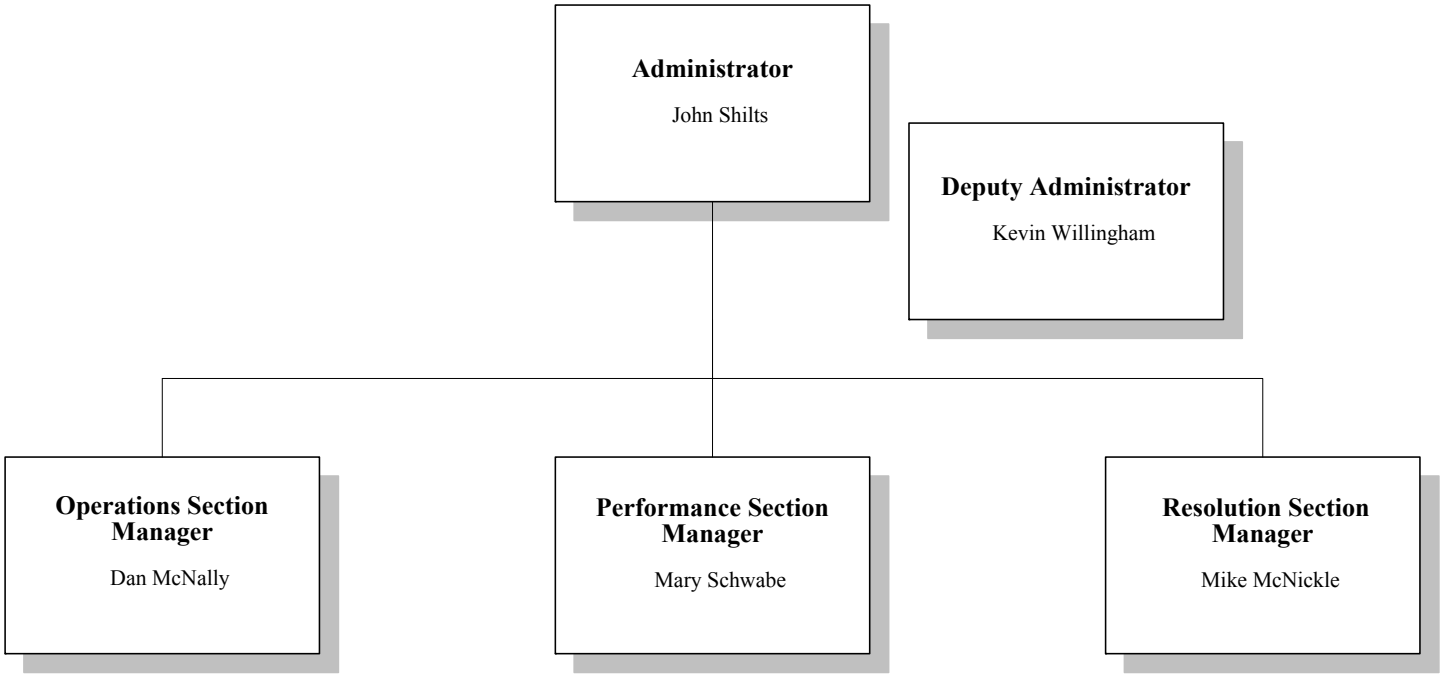
General Information

The law provides for both vocational and physical rehabilitation. The Rehabilitation Review Unit of the Reemployment and Dispute Resolutions Services Section monitors the insurer's requirement to provide vocational assistance, and resolves vocational assistance disputes, plan reviews, and consultations.

WCD certifies vocational rehabilitation professionals in the private sector.

Claimants who have a substantial handicap to employment are eligible for vocational assistance. "Substantial handicap to employment" means the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills, and abilities to be employees at 80% or more of their adjusted pre-injury weekly wage. A worker enrolled and actively engaged in an approved rehabilitation training plan is entitled to temporary total disability, adjusted for any earnings.

Workers' Compensation Division



- Policy development
- Rule, bulletin, and form coordination
- Hearing coordination
- Legal issue coordination
- EDI coordination
- IME
- Claim data collection
- Communications
- Web coordination
- Training and outreach

- Performance audit
- Payments and reimbursements
- Insurer/TPA registration
- Coverage investigation and enforcement
- Self-insurance
- Worker leasing licensing and enforcement
- Managed care

- Dispute resolution
- Sanctions
- Reconsideration
- Reclassifications
- Benefit consultation
- Employment incentives
- Employer-at-injury incentives
- Vocational assistance
- Lay representation in contested cases

Pennsylvania

Pennsylvania Bureau of Workers' Compensation

1171 South Cameron Street, Room 324

Harrisburg, Pennsylvania 17104

(717) 783-5421

http://www.portal.state.pa.us/portal/server.pt/community/workers%27_compensation/10386

Agency

General Information

The Bureau of Workers' Compensation (BWC) and the Workers' Compensation Office of Adjudication (WCOA) are part of the State Labor and Industry Department.

Functions of the BWC include: injury reporting and records retention, timely filing and reporting; educating workers, employers, medical providers, rehabilitation providers, claims adjusters, attorneys, and repricing companies; safety committee certification of employers; approving/disapproving self-insurance status of employers and administering self-insurance program; compiling statistics; preparing statutory reports to the Governor and legislature; and employer compliance with statutory coverage requirements.

The WCOA consists of 24 field offices located throughout Pennsylvania. Workers' compensation judges are finders of fact for all workers' compensation disputes in Pennsylvania. They conduct hearings and engage in alternative dispute resolution to resolve disputes. Hearings and mediations are conducted in field offices and in other locations as needed.

Mission Statement

The Pennsylvania workers' compensation program was established to reduce injuries and provide lost wages and medical benefits to Pennsylvania employees who become ill or injured through the course of their employment so they can heal and return to the workforce.

The BWC and the Office of Adjudication are responsible for carrying out the provisions of the act and related legislation, and for fulfilling the overall purpose of Pennsylvania's workers' compensation system. In carrying out the act's requirements, BWC and the Office of Adjudication have several primary roles:

1. Obtain, review and maintain records on certain loss-time work injuries and benefit documents.

2. Certify individual self-insured employers and self-insured employer pools, and determine their monetary security requirements.

3. Resolve disputes among the participants in the workers' compensation system.

4. Enforce the Workers' Compensation Act's provisions.

5. Promote the health and safety of employees in accordance with the 1993 and 1996 amendments to the act.

6. Enforce the Workers' Compensation Act's occupational disease provisions

Legislative and Regulatory Links

Pennsylvania Workers' Compensation Act: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=553004&mode=2

Budget and Financing

Agency Funding Source

The Workers' Compensation Office of Adjudication, (WCOA) the Workers' Compensation Appeal Board (WCAB) and the Bureau of Workers' Compensation's (BWC) operations are funded by the WC Administration Fund. Each insurer or self-insured employer is assessed based on the ratio each insurer or self-insured employer paid for compensation in relation to the total compensation paid in the preceding year (Pennsylvania Statute 77-443).

Operating Budget and Staff Size

FY 2012 Operating Budget: $81,896,000
Staff Size: 526 employees with WCOA, WCAB and BWC

Funds

Subsequent Injury Fund

The purpose of the Subsequent Injury Fund (SIF) is to compensate workers who experience certain losses (for example: arm, hand, leg, foot, eye) subsequent to a prior loss. The total amount of the fund equals the amount expended from the fund in the preceding year. Law requires the fund to have a minimum funding of $100,000.

The Workers' Compensation Administration Fund

This fund provides for the administrative operation of the Bureau of Workers' Compensation, the Workers' Compensation Office of Adjudication, and the Workers' Compensation Appeal Board.

Uninsured Employer Guaranty Fund

The Uninsured Employer Guaranty Fund (Fund) was established in 2006 to provide benefits to injured employees of uninsured employers. The injured workers must notify the Fund within 45 days after the injured worker knew that the employer was uninsured. Act 147 prohibits an injured worker from filing a claim petition against the Fund until at least 21 days after notice of a claim is made to the Fund.

The Supersedeas Fund

The Supersedeas Fund provides for the relief to employer/insurers for payments made during litigation of claims contesting whether compensation is payable. When an employer/insurer files a petition for termination, modification, or suspension of benefits, a supersedeas hearing can also be requested. At this hearing, the workers' compensation judge can deny the request or grant a temporary order of partial or total suspension of benefits. If the request is denied, but the final decision of the judge is that compensation was not payable, the employer/insurer can apply to be reimbursed from the Supersedeas Fund for "overpayments" made following the initial denial.

The Self-Insurance Guaranty Fund

The purpose of this fund is to make payment to any eligible claimant or dependent upon the default of the self-insurer liable to pay compensation or associated costs due under the Pennsylvania Workers' Compensation Act and the Pennsylvania Occupational Disease Act. This fund is used when the securities posted by defaulting companies are exhausted, but can only be used for injuries occurring after the 1993 amendment to the Workers' Compensation Act. With the passage of Act 53 of 2000, the General Assembly created a restricted account within the Guaranty Fund called the Prefund Account. The purpose of the Prefund Account is to provide the continuation of benefits to workers who were injured prior to 1993 and whose self-insured employers have gone bankrupt. The financing of the Prefund Account is a budget item of the Administration Fund.

Insurance Requirements and Resources

General Information

The requirement to insure workers' compensation liability is mandatory for any employer who:

- employs at least one employee who could be injured or develop a work-related disease in this state, or
- could be injured outside the state if the employment is principally localized in Pennsylvania, or
- could be injured outside the state, while under a contract of hire made in Pennsylvania, if the employment is not principally localized in any state, if the employment is principally localized in a state whose workers' compensation laws do not apply, or the employment is outside the United States and Canada

UNLESS all employees are excluded from the provisions of Pennsylvania's workers' compensation laws.

In Pennsylvania, an employer may be excluded from the requirement to insure its workers' compensation liability only if ALL workers employed by it fall into one or more of the following categories:

- federal workers
- longshoremen
- railroad workers
- casual workers whose employment is casual in character AND not in the regular course of the business of the employer
- persons who work out of their own homes or other premises not under the control or management of the enterprise AND make up, clean, wash, alter, ornament, finish, repair, or adapt articles or materials for sale that are given to them
- agricultural laborers earning under $1200 per person per calendar year AND no one agricultural laborer works 30 days or more per calendar year, unless the agricultural labor is provided by the employer's spouse or child(ren) under the age of eighteen and they have not sought inclusion under Pennsylvania's workers' compensation laws by filing an express written contract of hire with the Department
- domestic workers who have not elected with the Department of Labor and Industry to come under the provisions of the Workers' Compensation Act
- sole proprietor or general partners

- have been granted exemption due to their religious beliefs by the Department of Labor and Industry
- executive officers who have been granted exclusion by the Department of Labor and Industry
- licensed real estate salespersons or associate real estate brokers affiliated with a licensed real estate broker or a licensed insurance agent affiliated with a licensed insurance agency, under a written agreement, remunerated on a commission-only basis and qualifying as independent contractors for State tax purposes or for Federal tax purposes under the Internal Revenue Code of 1986.

Private Insurance

The State Insurance department has regulatory authority over workers' compensation carriers and is responsible for issuing licenses, setting rates, disciplining carriers, and monitoring performance.

Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120
(877) 881-6388
www.insurance.pa.gov

Self-Insurance

BWC has regulatory authority over workers' compensation self-insurers and is responsible for issuing certification, monitoring performance, and handles default situations involving the administration of the Self-Insurance Guaranty Fund.

To be authorized by the Department of Labor and Industry's Bureau of Workers' Compensation to self-insure under the Workers' Compensation Act (Act), an employer must first demonstrate that it has the financial ability to guarantee the payment of all benefits it may incur under the Act while it is approved as a self-insurer and that it has an adequate accident and illness prevention program. See question below for further explanation on financial ability. Additionally, an approved self-insurer must post security, such as a bond or letter of credit, covering its liability; must purchase excess insurance to protect it and its workers from losses resulting from a large claim or a catastrophic situation; and, must arrange for the proper adjusting and administration of its potential claims, either through in-house resources or the retention of an authorized claims services company.

State Workers' Insurance Fund (SWIF)

SWIF is a state agency and is required to provide coverage to all businesses who request coverage from it, especially those having difficulty obtaining coverage from private sector insurers.

Penalties for Not Insuring

An uninsured employer faces grave civil and criminal risks for failing to maintain continuous workers' compensation coverage. Not only can the employee sue the employer in tort for work-related injuries or diseases, in which suit the employee may recover amounts in excess of those allowed under workers' compensation, but the employer and those individuals responsible to act on its behalf may each be criminally charged for each day's failure to maintain continuous workers' compensation coverage.

Misdemeanor convictions can result in the potential imposition of a $2,500 fine and up to one year imprisonment for each day the employer is in violation of the requirement to maintain worker's compensation coverage. Felony convictions can result in the potential imposition of a $15,000 fine and up to seven years imprisonment for each day the employer intentionally violated this requirement. Further, the employer and those individuals responsible to act on its behalf may be required to pay all benefits awarded by a workers' compensation judge.

The Bureau of Workers' Compensation investigates employer compliance with workers' compensation laws and may initiate the filing of charges against employers and individuals responsible to act on its behalf if workers' compensation coverage is not continuously maintained.

Further, any individual, including competitors, may seek county district attorney approval to file a private criminal complaint against an employer who fails to maintain worker's compensation coverage when required to do so.

Reporting Requirements

First Report of Injury

The filing of an employer's first report of injury is mandatory when lost-time is equivalent of to at least one shift of work, or when there is a fatality. The employer's first report must be filed within 7 days of the date of injury, or within 48 hours of the death of an employee.

Other Reports/Claims Processing and Monitoring

Other reports that may that must be filed with the BWC within 21 days of the employer's notice of or knowledge of disability are: agreement for compensation, notice of compensation payable, temporary notice of compensation payable, or notice of denial.

BWC monitors first and last payment of compensation. Initial payment or notice of denial is due within 21 days of disability. Judges can assess penalties for delay of payments or failure to accept or deny the claim within 21 days, and repeated violations can lead to the BWC Director recommending discipline to the Insurance Department. The employee's loss of wage earning capability is used in determining the amount of compensation paid for partial disability claims.

EDI Standards

Pennsylvania is currently in the process of migrating from paper reporting and use of the IAIABC Claims Release 1 standard to Claims Release 3.0 for First Reports of Injury.

Contested Case Handling

Appeals Process

The levels of decision in the hearing process for contested cases are:

1. Hearing before a Workers' Compensation Judge
2. Hearing before the Appeal Board Commissioners
3. Appeal to the Commonwealth Court

Attorneys' Fees

The workers' compensation judges or WCAB commissioners approve attorneys' fees. Fees are limited to 20% of the claimant's award unless the judge determines otherwise. Fees are paid out of the claimant's award, except when assessed against the insurer for unreasonable contest.

Compromise and Release Agreements

Compromise and release (C&R) agreements are allowed. Parties can compromise and release indemnity and medical benefits, or leave medical benefits open. A Workers' Compensation Judge must approve the C&R upon finding that the injured worker "understands (its) legal significance".

Medical Care and Evaluation

Fee Schedule

2013 Medical Fee Schedule: http://www.portal.state.pa.us/portal/server.pt/community/fee_schedule/10424

Treatment Guidelines

Pennsylvania does not currently use treatment guidelines for workers' compensation.

Managed Care

Managed care organizations are not used in Pennsylvania.

Choice of Treating Physician

The PA Workers' Compensation Act gives employers the right to establish a list of designated health care providers. When the list is properly posted, injured workers must seek treatment for the work injury or illness with one of the designated providers for 90 days from the date of the first visit, after which they can obtain treatment from the provider(s) they choose. If the employer does not have a posted panel, the employee can seek treatment from their own health care provider.

An employee can initiate a change in an employer-chosen physician, as long as they stay within the posted list.

Rehabilitation

General Information

Vocational services are not addressed or required under the law; however, they may be provided. Compensation may be suspended by a judge for a claimant who refuses an ordered expert medical or vocational exam. Vocational experts are defined in the regulation. The insurer or self-insurer pays for the assessment or rehabilitation.

Rhode Island

Rhode Island Division of Workers' Compensation

Center General Complex

1511 Pontiac Avenue

Cranston, Rhode Island 02920

(401) 462-8100

http://www.dlt.ri.gov/wc/

Agency

General Information

The Division of Workers' Compensation (DWC) is part of the State Department of Labor and Training (DLT).

Responsibility for administration of workers' compensation is vested in the DLT and DWC and the Workers' Compensation Court.

The Division of Workers' Compensation monitors the workers' compensation system, ensuring that appropriate documents are filed to protect injured workers and employers, that claims are paid correctly, that all required employers have insurance coverage, and that insurance carriers report policy information to the Division. The Division also compiles information about injuries and costs, provides educational services, and investigates fraud. The John E. Donley Rehabilitation Center provides physical and vocational rehabilitation services for injured workers.

Mission Statement

To efficiently assist all injured workers and employers in Rhode Island by providing quality educational services and essential support. To improve the performance of the system by accurately monitoring its participants and ensuring compliance with the Workers' Compensation Act.

Legislative and Regulatory Links

Rhode Island Workers' Compensation Laws, Rules, and Regulations: http://www.dlt.ri.gov/wc/lawsrules.htm

Budget and Financing

Agency Funding Source

The Workers' Compensation Administrative Account funds the Donley Center, Workers' Compensation Fraud Prevention Unit, Workers' Compensation Court, and the Department of Labor and Industry. Each insurer is assessed a percentage of the gross premiums written in the preceding calendar year. Each self-insured employer (referred to in the statute as a "Certified Employer") is assessed a percentage of their simulated premium in the preceding year. The current assessment rate is 6.75% (Rhode Island Statute 28-37-13).

Operating Budget and Staff Size

Fiscal Year 2013 Budget $9,497,000

Staff Size: 41.1 FTE and 14 Medical Contractors

Funds

Second Injury/Subsequent Injury Fund

The Workers' Compensation Administrative Fund, formerly the Second Injury Fund, collects income each year through assessments on insurance companies, self-insured employers, group self-insured employers and mu-

nicipalities covered under the Workers' Compensation Act. The Fund supports these agencies:

- Dr. John E. Donley Rehabilitation Center
- Education Unit
- Workers' Compensation Court System
- Medical Advisory Board
- Workers' Compensation Fraud and Compliance Unit
- Department of Labor & Training's Workers' Compensation Unit
- Workers' Compensation Advisory Council

The Administrative Fund is also responsible to reimburse contributors to the fund for claims that fall within these sections of the Workers' Compensation Act:

Pre-1975 Injuries: RIGL § 28-37-9 provides for the reimbursement of compensation and medical payments for claims with injury dates before September, 1974. These claims were subject to a cap on benefits. If a totally disabled employee reached the cap, the insurer would be reimbursed for compensation benefits until the end of total disability or death.

Aggravation: RIGL § 28-27-4 provided for reimbursement of benefits for injured employees with a pre-existing work-related disability. This section was repealed on July 3, 1998. Injuries accepted prior to repeal are still eligible for reimbursement, but no new claims are accepted.

WCC Pretrial Overturned: RIGL § 28-35-20 (f) provides for reimbursement of payments made pursuant to an order of the Workers' Compensation Court that is later overturned or amended.

COLA Reimbursement: RIGL § 28-37-1 (b) (8) provides for reimbursement of insurer payment made for cost-of-living adjustments pursuant to RIGL § 28-33-17. The application period for this type of reimbursement has expired.

Partial Incentive Bonus: RIGL § 28-37-4 (i) provides for direct payment to injured workers who return to employment at wages less than those received before the work-related injury. Payment from the Fund makes up the difference between the pre-injury wages and the total of current wages plus compensation. This law was repealed in 1992, but by Supreme Court order the Fund is obligated to make payments to employees accepted prior to the repeal.

Self-Insurance Assessment Fund

The Self-Insurance Assessment Fund is administered by the Self-Insurance Unit of the DLT/DWC. The Fund is financed by assessment, which is based on the amount of surety posted for an individual self-insured in proportion to the total surety posted by all self-insureds. The self-insurer is then assessed that percentage of the self-insured unit's budget. This fund is established to finance the Self-Insurance Unit of the DLT.

Insurance Requirements and Resources

General Information

Effective January 1, 1999, every person, firm, public service or private corporation, including the State, that employs employees regularly in the same business is subject to the Workers' Compensation law.

Exemptions include: Sole proprietors, partners, and independent contractors. Certain real estate, agricultural and domestic service employees may be exempt. Any person who was appointed a corporate officer between January 1, 1999 and December 31, 2001, and was not previously an employee of the corporation is exempt, but can elect to be covered by filing a DWC-11C form with the Division of Workers' Compensation.

Private Insurance

The Rhode Island Department of Business Regulation has regulatory authority over workers' compensation insurance carriers. It has authority to issue licenses, set rates, discipline carriers, regulate group self-insureds, monitor performance, and perform other regulatory duties.

Rhode Island Department of Business Regulation
1511 Pontiac Avenue
Cranston, Rhode Island 02920
(401) 462-9500

Self-Insurance

The Self-Insurance Unit of the DLT/DWC has regulatory authority over workers' compensation self-insurers. The Unit certifies, regulates, and monitors the performance of self-insureds.

To qualify as a self-insurer, and employer must:

- Be financially sound;
- Annually post varied security requirements; and
- Annually submit an application, and disclose full tax and financial records, and submit to inspection and feasibility studies.

Penalties for not Insuring

There are civil and administrative penalties that can be imposed for each day of noncompliance. There are also criminal penalties, which can result in fines and possible imprisonment. For further information see RI Workers' Compensation Law, Section 28-36-15

Number of penalties assessed in FY2012: CY 2012 76 penalties
Dollar amount of penalties assessed in FY2012:CY 2012 $98,654.23

Reporting Requirements

First Report of Injury

The employer must file a first report for any work-related injury requiring any medical treatment or if the employee loses full wages for at least three consecutive days. The employer must also report any work-related death. Completing this form is not an admission of liability. A $250 fine may be imposed for failure to report or late reporting. The Claims Administrator may file the First Report on behalf of the employer. A first report is due within 10 days of an injury or knowledge of an occupational disease, and within 48 hours after a fatality.

Other Reports/Claims Processing and Monitoring

The DLT/DWC monitors the initial payment, periodic payments, and last payment of a claim.

Benefits can be paid either under a non-prejudicial agreement or under a memorandum of agreement. To terminate benefits under a non-prejudicial agreement, a termination of benefits form must be filed, and under a memorandum of agreement, a suspension receipt and an Itemized Statement of Compensation form must be filed.

The Workers' Compensation Court makes the final administrative decision for determining a claimant's permanent partial disability rating. Factors considered in determining the disability rating include:

- The impairment rating of the attending physician;
- Employee's loss of wage earning capability;
- Criteria as set forth by the courts;
- Employee factors (age, education, training, etc.);
- Use of the most recent AMA Guide to Physical Impairment;
- Use of an independent medical advisor.

EDI Standards

RI Division of Workers' Compensation has implemented a new workers' compensation information system. We are in the process of issuing an RFP for EDI vendor services for Claims Release 3 standard. We anticipate the RFP could be awarded by April 1, 2013 and testing could start by September 1, 2013. Voluntary submission could begin January 1, 2014. We anticipate mandatory submission by January 1, 2015.

We will concentrate initially on FROI maintenance type codes 00 and CO, then 01, AU, and UR. Accepting 02 will depend on test results. We will not accept 04 because the first report is a notice and not a claim for benefits in RI, so it is inappropriate to deny a first report.

We will concentrate on accepting SROI maintenance type codes IP, PY, RB, Sx, and FN. Accepting any maintenance type codes will depend on test results.

Contested Case Handling

Appeals Process

1. Pre-Trial Conference
2. Appeals to the Appellate Division of the Rhode Island Workers' Compensation Court
3. Appeal to the Rhode Island Supreme Court

Attorneys' Fees

The Workers' Compensation Court awards the costs of attorneys' fees, including fees for medical and other expert witnesses to employees who successfully prosecute and/or defend, in whole or in part, proceeding before the Court.

Costs are assessed against the employer by the Judge, by the Appellate Division on appeal, and by the Supreme Court on appeal consistent with the services provided before each tribunal.

Attorneys' fees are awarded out of the claimant's award for lump-sum settlements.

Compromise and Release Agreements

Compromise and release agreements are allowed. They must be approved by any Judge of the Court. However, if payment exceeds 104 weeks of benefits, the Chief Judge has to approve. These agreements terminate indemnity and medical benefits.

Upon payment of a compromise and release agreement, the employer is entitled to a duly executed release.

- Any decree may be vacated, modified, or amended within a period of six months of entry by filing a petition if it appears that the decree was: procured by fraud or does not accurately and completely set forth and describe the nature and location of all injuries sustained by the employee.

Medical Care and Evaluation

Fee Schedule

The Director of the DLT establishes a medical fee schedule of rules and rates of reimbursement for workers' compensation medical services. Hospital services are subject to the Hospital Rates (Effective July 1, 2012).

2012 Medical and Hospital Fee Schedule: http://www.risingms.com/RIFee/Pages/default.aspx

Hospital Rates (Effective July 1, 2012): http://www.dlt.ri.gov/wc/InfoLetters/2012-03.pdf

Treatment Guidelines

The Medical Advisory Board has promulgated thirty-seven (37) protocols and standards of treatment since its inception. The protocols were not designed as "cookbooks" of care, rather they outline options of appropriate methods and types of intervention from which physicians and other providers are to choose. Although primarily geared toward the entry level physician, i.e., the first treating physician, these protocols offer important information for all physicians and health care providers. Upon drafting and review by the Board, each protocol is put

in final form. It is then brought to public hearing for full discussion, final revisions, and promulgation.
http://www.courts.ri.gov/Courts/workerscompensationcourt/MedicalAdvisoryBoard/Pages/Protocols.aspx

Managed Care

Managed care organizations are authorized and utilized if approved by the Director of Labor and Training and the Director of Business Regulation.

Choice of Treating Physician

An injured worker may choose his/her first medical care provider. Treatment at an emergency room after the accident or by a company physician does not count as the first medical care provider. The first provider may refer the injured worker to a specialist without prior approval from the insurer. No matter who the treating physician is, the injured worker is entitled to receive a report from him or her within ten (10) days of each visit.

If an injured worker decides to change doctors, he/she must first find out if the insurer or self-insured employer has an approved list of physicians, otherwise known as a "preferred provider network". If so, the injured worker must either select a physician from that list or get the approval of the insurer or self-insured employer before he/she sees another doctor. If the employer or insurer does not have an approved list of physicians, these restrictions do not apply.

Rehabilitation

General Information

The Workers' Compensation law ensures that employees who are injured at work will receive all necessary rehabilitation services to assist them in returning to gainful employment. The State of Rhode Island's Department of Labor and Training (DLT) has a Rehabilitation Unit known as the Dr. John E. Donley Rehabilitation Center in Providence, Rhode Island.

The Donley Center offers comprehensive physical therapy and occupational therapy intervention to address injured workers who possess a variety of orthopaedic and neurological concerns. Each patient is evaluated by a licensed, registered physical therapist or occupational therapist. A treatment plan is created based upon the findings of that evaluation, and the functional demands of their job, and implemented by our professional staff. This treatment plan could include:

- Physical therapy
- Occupational therapy
- Aquatics

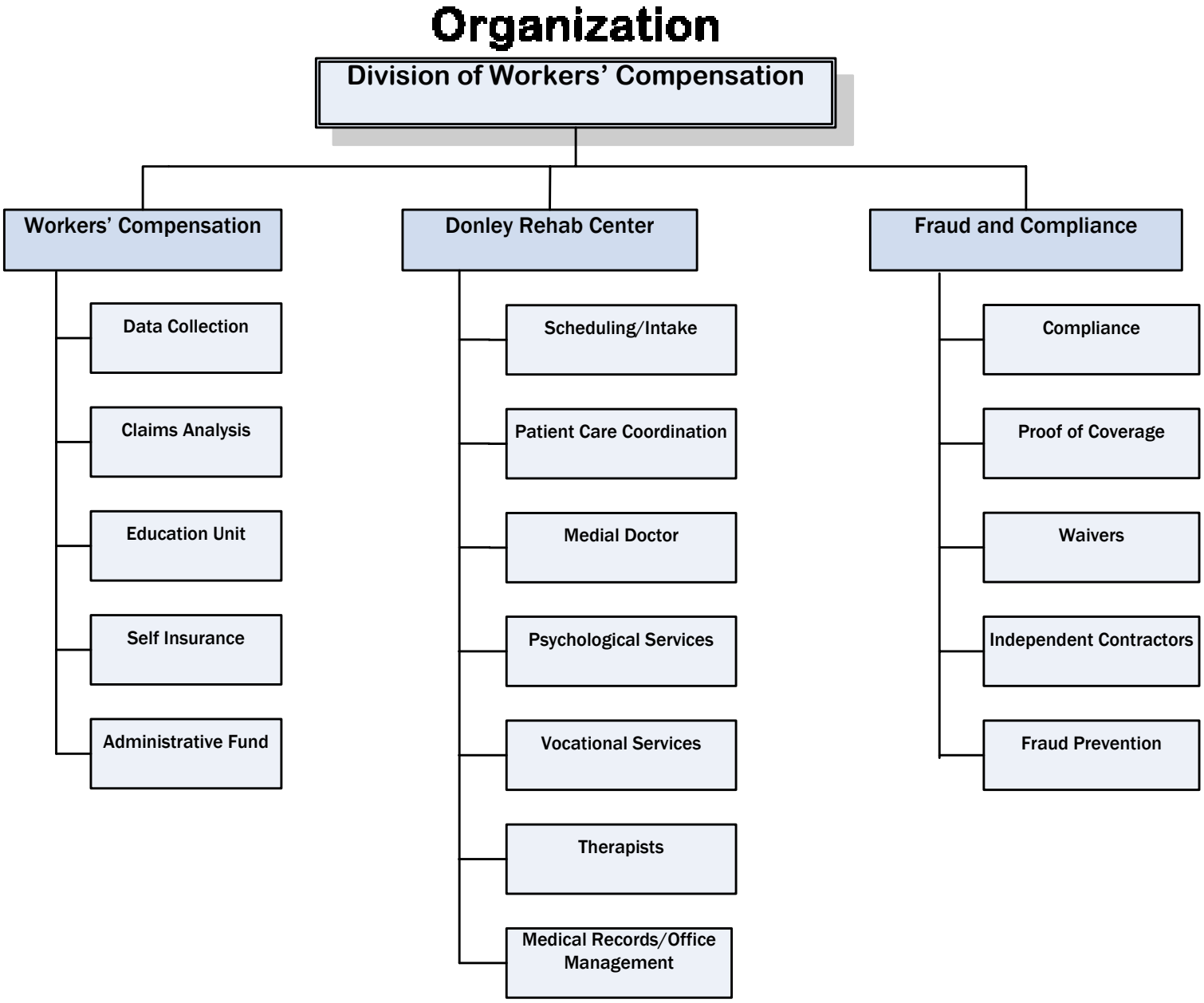
In addition, the Donley Center offers extensive Psychological Services and Vocational Services for specific clients in need of such services.

A medical doctor is also available on our staff to address secondary medical issues that may need monitoring throughout your rehabilitation process.

The Donley Center also houses the Rehabilitation Unit that provides professional certification for qualified rehabilitation counselors (QRCs) in the State of Rhode Island. The Court provides the approval of proposed rehabilitation plans generated by professional rehabilitation providers/QRCs in the State.

The Donley Center is funded by the DLT/DWC through the Workers' Compensation Administrative Fund. All services are provided to injured workers at no cost to them. Rehabilitation services are paid out of the Workers' Compensation Administrative Fund.

Workers' Compensation Division Organization Chart



South Carolina

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500

Columbia, South Carolina 29201

(803) 737-5700

http://www.wcc.sc.gov/Pages/default.aspx

Agency

General Information

The South Carolina Workers' Compensation Commission (WCC) is an independent State agency responsible for administering the workers' compensation law in South Carolina. The Commission works closely with the Governor, the General Assembly, and the Commission's many constituents to ensure that the workers' compensation system is fair, equitable, and responsive to the needs of the citizens of South Carolina.

Mission Statement

Provide an equitable and timely system of benefits to injured workers and to employers in the most responsive, accurate, and reliable manner possible.

Legislative and Regulatory Links

South Carolina Code of Laws (Title 42-Workers' Compensation): http://scstatehouse.gov/code/title42.php

South Carolina Code of Regulations (unannotated): http://scstatehouse.gov/coderegs/c067.php

Budget and Financing

Agency Funding Source

The WCC's source of operating funds is the General Fund which is financed by a premium tax assessment on carriers and self-insureds; and fines and fees.

Operating Budget and Staff Size

The WCC's operation budget is appropriated by the legislature and approved by the Governor.

Funds

Second Injury/Subsequent Injury Fund

The workers' compensation reforms passed by the General Assembly in 2007 provided, in part, for the closure of the Second Injury Fund on July 1, 2013.

Uninsured Employers' Fund

The UEF covers the payment of workers' compensation benefits to employees whose employers are in violation of State law requiring workers' compensation coverage. The Fund is financed by a portion of the premium tax assessment on self-insurers and carriers necessary to cover expenses. As of July 1, 2013, the UEF has been relocated to the State Accident Fund.

Insurance Requirements and Resources

General Information

Almost any employer who regularly employs four or more workers full-time or part-time is required to have workers' compensation insurance. There are some exceptions, including agricultural employees, railroads, and

railway express companies and their employees, and employers who had a total annual payroll during the previous year of less than $3,000, regardless of the number of workers employed during that period. Also exempt are Textile Hall Corporation and certain commission paid real estate agents.

Although most employers must purchase workers' compensation insurance, any employer may purchase coverage.

Private Insurance

The South Carolina Department of Insurance has regulatory authority over all insurance carriers. The Department of Insurance is responsible for issuing licenses, setting rates, disciplining carriers, and monitoring performance.

South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, South Carolina 29201
803-737-6160

Self-Insurance

The WCC has regulatory authority over workers' compensation self-insurers. Hundreds of employers in South Carolina are self-insured. In order to self-insure, an employer must apply, meet certain financial and other requirements, and be approved by the South Carolina Workers' Compensation Commission. An employer may self-insure as an individual organization, or as part of a group self-insurance pool or fund.

Self-insured employers and funds are regulated by the Commission. They are required to maintain reinsurance and a surety bond or letter of credit in an amount specified by the Commission.

Penalties for not Insuring

The penalty for failure to insure for workers' compensation is 10 cents for each employee per day during the period of non-compliance—minimum of $1.00 a day and maximum of $50.00 a day.

Reporting Requirements

First Report of Injury

Employers shall makes a record of all work-related injuries and retain the record for a period of two years.

Injuries requiring less than $2500 in medical treatment and which do not cause more than one lost work day or permanency may be paid by the employer with no written report required.

Employer will report injuries requiring $2500 or more in medical treatment, more than one lost work day, or permanency to the employer's claims representative immediately upon notice. The claims representative will report to the Commission within 10 business days after the occurrence and the employer's knowledge of all injuries requiring $2500 or more in medical treatment, more than seven lost work days, permanency, or denial of a claim.

Other Reports/Claims Processing and Monitoring

The WCC monitors the initial payment, periodic payments, and last payment of claims.

The employer's representative may terminate temporary compensation during the first 150 days after the employer has notice of the injury. An employee should receive a hearing within 60 days if they disagree with temporary compensation being terminated by the employer's representative within the first 150 days after the employer has notice of the injury. After 150 days, the employer's representative shall not terminate temporary compensation without the employee completing a return to work form, or an order to terminate temporary disability benefits from the Commission following a hearing.

The final administrative decision for determining a claimant's permanent partial disability rating is made by Commissioner(s). Factors used in determining a claimant's disability rating include:

- Impairment rating of the attending physician; and
- Employee factors such as age, education, training, etc.

EDI Standards

The South Carolina Workers' Compensation Commission will still accept Release 1 submissions for current Release 1 partners through December 2013. No new Release 1 Master Trading Partner Agreements will be accepted.
The South Carolina Workers' Compensation Commission will begin accepting the First Report of Injury (FROI) in IAIABC Version 3 form on November 1, 2012.
Current Release 1 trading partners' migration to Release 3 will be phased in between 11/1/2012 and 12/31/2013.

South Carolina EDI information: http://www.wcc.sc.gov/edi/Pages/default.aspx

Contested Case Handling

Appeals Process

1. Commissioner
2. Panel of Commissioners (no including the original hearing commissioner)
3. Circuit Court
4. State Court of Appeals
5. State Supreme Court

Attorneys' Fees

The WCC regulates attorney's fees. The maximum is one third of the award, excluding temporary total and medical coasts, and $2500 limit for uncontested death cases. Claimant's attorney fees are paid out of the award.

Compromise and Release Agreements

Compromise and Release or "clincher" agreements are allowed. An employee not represented by counsel is required to have a conference with a Commissioner, plus three other commissioners must agree. An employee represented by counsel is not required to have a conference, but has to have the approval of one Commissioner. There agreements usually terminate both the indemnity and medical benefits. It is very rare that a claim can be reopened after an agreement, unless there is evidence of fraud.

Medical Care and Evaluation

Fee Schedule

The Medical Services Division establishes and monitors billing and payment policies for medical services rendered to workers' compensation claimants and publishes the Medical Services Provider Manual.
Link to fee schedule: http://www.wcc.sc.gov/insurance/Pages/MedicalServicesDivision.aspx

Treatment Guidelines

South Carolina does not currently have treatment guidelines for workers' compensation.

Managed Care

In South Carolina, managed care organizations may be used at the employer/carrier's discretion.

Choice of Treating Physician

Employers or carriers select the treatment physician and authorize medical care. In order for an employee to change physicians, he/she must request a change from the employer or carrier. If the request is denied, the employee may request a hearing to ask a commissioner to order a change.

Rehabilitation

General Information

Rehabilitation of an injured employee is not specifically addressed in the workers' compensation law. However, treatment of the injured employee to lessen the period of disability is provided. The insurer pays for rehabilitation services.

South Dakota

South Dakota Division of Labor and Management

700 Governors Drive

Pierre, South Dakota 57501

(605) 773-3681

http://dlr.sd.gov/workerscomp/

Agency

General Information

South Dakota's Workers' Compensation program resides within the Division of Labor and Management (DLM) which is part of the State Department of Labor. The agency head is the Director.

The DLM is responsible for research, record keeping, conducting hearing, drafting legislation, and promulgating rules.

Reported Statistics (2012 Annual Report):
First Report of Injuries Received: 21,338

Mission Statement

To responsively provide dispute resolution and help people through investigations, enforcement, compliance, and education of workforce and discrimination laws.

Legislative and Regulatory Links

South Dakota Workers' Compensation Laws and Regulations: http://dlr.sd.gov/laws.aspx

Budget and Financing

Agency Funding Source

The DLM's primary source of operating funds in the General Fund and assessment of insurers in a special revenue fund. The budget is appropriated by the legislature and approved by the Governor.

The operating budget funds the following workers' compensation functions:

- Injury reporting and record keeping
- Examining and monitoring reports and forms
- Monitoring for timely filing and reporting
- Assessment of penalties for late payments and late reporting
- Education of workers, employers, claims adjusters, and attorneys
- Licensing and certification of self-insurers
- Research and statistics
- Dispute resolution

2012-2013 Operating Budget/Staff Size

The operating budget for FY 2013 is $893,000 with a staff size of 10.

Funds

Second Injury Fund

SIF, part of the state Division of Insurance, processes insurer and self-insurer reimbursement claims for subsequent work injuries occurring before July 1, 2001.

Insurance Requirements and Resources

General Information

The South Dakota Worker's Compensation Law covers all employers with only limited exceptions.

Exceptions:

- Domestic servants (unless working for an employer more than 20 hours in any calendar week and for more than six weeks in any 13-week period)
- Farm or agricultural labor
- One whose employment is not in the usual course of trade, business, occupation or profession of the employer (independent contractors, including real estate agents and owner-operators of trucks certified as independent contractors by the Department of Labor and Regulation; see "Coverage for Independent Contractors" below for more information)
- Certain elected officials of the state or any subdivision of government
- Workfare participants

Private Insurance

The Division of Insurance has regulatory authority over workers' compensation insurance carriers in South Dakota.

Division of Insurance
445 E. Capitol Avenue
Pierre, South Dakota 57501
(605) 773-3563
http://www.dlr.sd.gov/insurance/

Self-Insurance

The DLM has regulatory authority for South Dakota's self-insurers and issues licenses, sets rates, disciplines insurers, and monitors performance.

To qualify as a self-insurer in South Dakota, an employer must show proof of solvency, ability to pay claims, and post security.

Penalties for not Insuring

There is no criminal penalty for not insuring under the workers' compensation law, but injured employees will be entitled to double indemnity benefits and medical costs, and the employer will be subject to civil liability in an injury occurs.

Reporting Requirements

First Report of Injury

Filing of a first report of injury with the DLM is mandatory for fatalities and injuries that require medical attention other than minor first aid, or takes the employee away from work for seven or more days. The employer must file the first report within seven days of knowledge of the injury.

Additional Reports/Claims Processing and Monitoring

Additional Reports (Mandatory)

- Agreement
- Memorandum
- Monthly reports

Penalties can be assessed if payments are not prompt and denial behavior by insurers is monitored.

A carrier is allowed to terminate temporary total disability benefits without any required filing or hearing.

The Administrative Law Judges make the final administrative decision for determining a claimant's permanent partial disability rating. Factors used to determine the disability rating include:

- Use of the AMA Guides to Physical Impairment
- In the case of a dispute on the rating, the claim enters mediation or formal hearing.

EDI Standards

South Dakota does not use EDI to file reports. It has its own web-based electronic filing system, which all benefit payers are required to use.

Contested Case Handling

Levels in the hearing process:

1. Hearing before 3 ALJs and 2 Support Staff
2. Hearing before 1 Department Secretary and 1 Support Staff
3. Circuit Court
4. State Supreme Court

	Notes or Comments on Scope	*Number in FY2012*
Hearing before 3 ALJs and 2 Support Staff		20
Hearing before 1 Department Secretary and 1 Support Staff		2
Circuit Court		10
South Dakota Supreme Court		3

Attorneys' Fees

The DLM regulates and approves attorneys' fees. Attorneys are entitled to 25% of the disputed amount if the matter is settled without a hearing and 30% of the amount if the matter goes to hearing. Attorneys' fees are paid out of the claimant's award unless an insurance carrier unfairly refused payment.

Compromise and Release Agreements

Compromise and release agreements are allowed only when there is a bona fide dispute. They must be approved by the Workers' Compensation Specialist or ALJ. Agreements can be reopened if there is a change in physical condition.

Medical Care and Evaluation

Fee Schedule

The DLM sets maximum medical and hospital fees by rule. (The schedule cannot be obtained from our web site, only the conversion factors we use, which are found at http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=47:03:05:05.

Treatment Guidelines

South Dakota's treatment guidelines were repealed in 2011.

Managed Care

The DLM annually certifies managed care organizations, all carriers and self-insureds must operate a managed care plan.

Choice of Treating Physician

An injured worker may make the initial selection of his/her doctor or surgeon from all licensed doctors or surgeons in the state.

- Prior to treatment or as soon as reasonably possible after treatment has been provided, the worker must notify the employer of his/her choice of doctor or surgeon. The doctor or surgeon selected may arrange for a consultation, referral or other specialized medical services as the nature of the injury requires.
- To change doctors or surgeons, the employee must get written approval form the employer.
- Employees may seek a second opinion at their own expense without the employer's approval.

Rehabilitation

General Information

The law provides for vocational rehabilitation for injured workers in South Dakota. An injured worker can qualify for vocational rehabilitation services by proving that they are unable to return to usual work or 85% of pre-injury wage. The injured worker will receive weekly rehabilitation benefits while undergoing rehabilitation or job retraining. The insurer pays indemnity benefits. The Department of Human services is responsible for cost of tuition, books, etc.

Tennessee

Tennessee State Board of Workers' Compensation

220 French Landing Drive

Nashville, Tennessee 37243

(615)741-2395

http://www.state.tn.us/labor-wfd/wcomp.html

Agency

General Information

The Division of Workers' Compensation (DWC) is an autonomous unit of the State Department of Labor and Workforce Development as of April 29, 2013.

DWC administers the workers' compensation system and promotes a better understanding of the program's benefits by informing employees and employers of their rights and responsibilities. DWC administers a mediation program for disputed claims, issues orders for temporary and medical benefits, provides an administrative appeal of orders for temporary orders, encourages workplace safety, and oversees an information awareness program for educating the public on laws and regulations which define workers' compensation requirements. DWC ensures that companies properly provide benefits and both assess and collect penalties for noncompliance from employers and insurance companies.

DWC also administer the Second Injury Fund and manages a Drug Free Workplace Program. Medical Fee Schedule information and the Medical Impairment Registry Program are also housed within the Division. The Workers' Compensation Division has 8 area offices throughout the state.

Mission Statement

The mission of the Division of Workers' Compensation is to enhance the economic prosperity of Tennessee by providing an effective workers' compensation system that is fair to both employees and employers.

Legislative and Regulatory Links

Tennessee Workers' Compensation Act: (Annotated Version) can be obtained from Lexis Law Publishing. For information about ordering this publication, go to Workers' Compensation Law Book. To read or print a section of the law book, go to www.michie.com and select Tennessee as the jurisdiction. The Tennessee Code will be shown. Click the + sign to open the titles and go to Title 50, Chapter 6 for the workers' compensation law.

Rules of the Tennessee Division of Workers' Compensation: http://www.tn.gov/sos/rules/0800/0800-02/0800-02.htm

Budget and Financing

Agency Funding Source

Each insurer pays a 4% tax on gross premiums collected for workers' compensation insurance, plus a surcharge of 0.4% on gross premiums which is earmarked for the administration of the Tennessee Occupational Safety and Health Act. Each self-insured employer pays a 4% tax on the premium that they would have been required to pay in the private market and a surcharge of 0.4% on the simulated premium which is also earmarked for the administration of the Tennessee Occupational Safety and Health Act (Tennessee Statute 56-4-(306-207)). Up to half of the 4% tax is available to fund the Second Injury Fund. Penalties from the Uninsured program and an appropriation from the state's general fund are used for operating expenses of the DWC.

Operating Budget and Staff Size

The WCD's operating budget is appropriated by the legislature and approved by the governor.

The recommended FTE for FY 2012-2013 is 161 and the operating budget is $13,337,400.

Funds

Second Injury/Subsequent Injury Fund

The purpose of the Fund is to encourage employers to hire workers with existing handicaps or permanent disabilities. To claim benefits from the Fund, an employee must prove that he/she previously sustained a permanent disability and that, as a result of a second injury, he/she has become permanently and totally disabled. The Fund limits the employer's liability to the amount of disability caused by a new, or "second", injury.

The Fund also reimburses employers for all amounts paid pursuant to an order of a workers' compensation specialist, when a court subsequently finds that the injury was not compensable.

Funding for the Second Injury Fund is provided from the workers' compensation premium tax.

Uninsured Employers' Fund

The Uninsured Employers Fund (UEF) seeks to ensure that Tennessee employers comply with insurance coverage provisions of the Workers' Compensation Law. T.C.A. § 50-6-412.
The purpose of the UEF is to:

- Ensure that all employers comply with insurance coverage provisions of the Workers' Compensation Law.
- Penalize those employers who fail to comply with the law and fail to provide workers' compensation protection for their employees.

The UEF provides an administrative process to investigate and penalize employers who fail to carry workers' compensation coverage or to qualify as self-insured employers, as required by the Workers' Compensation Law. The administrative process includes notifying employers of possible penalties for violations of the insurance requirements of the Workers' Compensation Law and holding legal hearings called Show Cause Hearings.

When it is mandated by the Workers' Compensation Law, employers in the State of Tennessee are required to provide workers' compensation insurance for their Tennessee employees.

Insurance Requirements and Resources

General Information

Generally, Tennessee employers, not in the construction or coal mining industry, with five (5) or more full or part-time employees are required to carry workers' compensation insurance on those employees. Corporate officers and family members meeting the definition of employee are included in the count towards the total, regardless of whether or not the officer(s) elects to decline coverage.
Any person engaged in the construction industry is required to carry workers' compensation insurance on their employees. Effective March 28, 2011, construction employers in the contracting group designated by the National Council of Compensation Insurance (NCCI) must have workers' compensation insurance on all of their employees and themselves unless you are a sole proprietors or partners with no employees being paid directly by the property owner).

Employers in the coal mining industry with one or more employees are required to provide workers' compensation coverage. State and local governments and those employing farm laborers or domestic help are exempt, but may elect workers' compensation coverage.

Private Insurance

The Tennessee Department of Commerce and Insurance has regulatory authority over workers' compensation insurance carriers and self-insurers. The Department of Commerce and Insurance is responsible for issuing licenses, setting rates, and providing disciplinary measures.

Department of Commerce & Insurance
500 James Robertson Parkway
Davy Crockett Tower
Nashville, Tennessee 37243-0565

Individual Self-Insurance

Individual Self-Insurances must provide proper documents and securities. To review the self-insurance requirements for Tennessee, visit: http://www.state.tn.us/insurance/documents/SIadmitpkt.pdf

Group Self- Insurance

Tennessee does allow group self-insurance. Group self-insurers must provide requested documents including financial statements and must furnish excess Workers' Compensation Insurance as prescribed; pay tax assessments as prescribed; comply with all reporting procedures as prescribed; furnish necessary fiduciary bonds as prescribed; accept as future members of the Group financially sound employers who have a common interest as prescribed; and submit an application remittance in the amount of $500.00, payable to the Tennessee Department of Commerce and Insurance.

Penalties for not Insuring

Failure to insure for workers' compensation coverage will subject and employer to a fine of up to $100,000 for a first time offense; a second offense will prohibit an employer from continuing to operate business.

Number of penalties assessed in FY2012: 402
Dollar amount of penalties assessed in FY2012: $3,908,696

Reporting Requirements

First Report of Injury

The filing of a first report of injury with WCD is mandatory for injuries/illness resulting in a fatality, or eight or more lost workdays, medicals, incurred and or permanent impairment. The first report is due within 14 days of the knowledge of injury/illness.

Other Reports/Claims Processing and Monitoring

Other reports that are required to be submitted electronically: Certificate of Insurer; Notice of Cancelation, Reinstatement, or Endorsement; Notice of Change/Termination Benefits. Medical only claims are required to be filed on a First Report of Injury form.

The filing of medical or other information with verification of ability to work is required in order to terminate temporary total disability benefits. Penalties are assessed for untimely filing or payment.

The State court system makes the final administrative decision for determining a claimant's permanent partial disability rating. Factors used in determining the disability rating include:

- Impairment rating of attending physician;
- Employee's loss of wage earning capability;
- Criteria as set forth by the courts;
- Employee factors (age, education, training, etc.); and
- Use of the AMA Guide to Physical Impairment.

EDI Standards

Electronic Data Interchange (EDI) affords insurers and the Workers' Compensation Division a method of exchanging certain information electronically and thereby avoiding multiple entry of data into computer systems. EDI is fast, accurate, reliable and cost effective. Many insurers nationwide use EDI routinely and the Workers' Compensation Division has worked hard to make this service available for Tennessee's workers' compensation system.

Insurers sign a trading partner agreement with the Workers' Compensation Division. This agreement includes testing the reporting system to determine if the transmission mechanism is acceptable. Upon completion of testing, the Division will notify the trading partner of approval to submit production data. The International Association of Industrial Accident Boards and Commissions (IAIABC) offers education on reporting workers' compensation data electronically.

Proof of Coverage (POC) Information that must be submitted electronically to a vender that is IAIABC certified and approved by the Workers' Compensation Division. The National Council on Compensation Insurance is IAIABC certified and authorized to submit POC data on each insurance carriers' behalf.

Contested Case Handling

Appeals Process

	Notes or Comments on Scope	*Number in FY2012*
Step 1: Request for Assistance	Temporary Indemnity or Medical Benefits	4755
Step 2: Informal Mediation	Purpose is Agreed Resolution	2205
Step 3: Temporary Order	Orders Awarding or Denying Requested Benefits	2573
Step 4: Administrative Review	Appeal of Temporary Order	808

Attorneys' Fees

The DWC does not regulate attorneys' fees. The courts are authorized to assess attorney fees and costs against parties failing to cooperate in Benefit Review Conferences for last of good cause or in bad faith. Fees are regulated by law, and are subject to approval of the Judge, with a maximum of 20% of the total award. Fees are paid out of the claimant's award.

Compromise and Release Agreements

Compromise and release agreements are allowed. The agreement must be approved by the courts. It terminates indemnity and medical benefits, and the claim cannot be reopened.

Medical Care and Evaluation

Fee Schedule

http://www.tn.gov/labor-wfd/wc_medfeebook.pdf

Treatment Guidelines

Tennessee does not have treatment guidelines for workers' compensation. However, Legislation signed April 29, 2013 requires that DWC develop treatment guidelines by 2016.

Managed Care

Managed care organizations, i.e., PPOs or HMOs, are being used on a limited basis. It is not mandatory to use a managed care organization.

Choice of Treating Physician

Under Tennessee law, the employer or insurance carrier is not required to offer a second panel of physicians or a second opinion. If asked, however, the insurer or employer MAY provide a second panel. An employee may always seek a second opinion or obtain treatment with any physician at his/her own expense. However, only the restrictions of the authorized physician must be followed by the employer.

Rehabilitation

General Information

The workers' compensation law does provide for physical rehabilitation. The penalty for a claimant who refuses rehabilitation is termination of benefits. A claimant will continue to receive physical rehabilitation benefits if totally disabled. The insurer is in charge of paying the rehabilitation benefits.

Texas

Texas Division of Workers' Compensation

7551 Metro Center Drive, Suite 100

Austin, Texas 78744-1645

(512) 804-4000

http://www.tdi.texas.gov/wc/indexwc.html

Agency

General Information

The Division of Workers' Compensation (DWC) resides within the Texas Department of Insurance. Responsibility for administration of workers' compensation is vested in one full-time commissioner, appointed by the Governor.

DWC Responsibilities:

- Receives and monitors injury reports and maintain records
- Educated workers, medical providers, rehabilitation providers, claims adjusters, attorneys, and employers on rights and responsibilities and other information regarding the workers' compensation system.
- Certifies doctors who are placed on the Approved Doctor List
- Certifies self-insurers
- Compiles statistics
- Prepares statutory reports to the Governor and legislature
- Monitors employer compliance with statutory coverage requirements
- Conducts informal and formal dispute resolution and hears appeals from first formal hearing level
- Promulgates medical fee schedules and guidelines, treatment guidelines, and utilization review criteria.
- Regulates self-insured employers.

Mission Statement

The primary duties of TDI-DWC are to regulate and administer the business of workers' compensa-tion in Texas; and ensure that the Texas Workers' Compensation Act, Texas Labor Code, and other laws regarding workers' compensation are implemented and enforced. The basic goals of the Texas workers' compensation system are:

- Each employee shall be treated with dignity and respect when injured on the job.
- Each injured employee shall have access to a fair and accessible dispute resolution process.
- Each injured employee shall have access to prompt, high-quality medical care within the framework established by the Texas Labor Code.
- Each injured employee shall receive services to facilitate the employee's return to employment as soon as it is considered safe and appropriate by the employee's health care provider.

Legislative and Regulatory Links

Texas Workers' Compensation Act: http://www.tdi.texas.gov/wc/act/index.html
Texas Workers' Compensation Legislation Enacted: http://www.tdi.texas.gov/wc/dwc/legisupdate.html

Budget and Financing

Agency Funding Source

Every insurer pays an annual maintenance tax not to exceed 2% of the gross workers' compensation insurance premiums. Each self-insured employers pays a maintenance tax of not more than 2% on the total tax base of certified self-insurers. The self-insurance tax base is calculated by multiplying the amount of the certified self-insurers liabilities incurred in the previous year, including claims incurred by not reported, plus the

amount of expense incurred by the certified self-insurer in the previous year for administration of self-insurance, including legal costs (Texas 403.002 (Insurers) 407.103 (Self Insurers))

Operating Budget and Staff Size

The 2012-2013 appropriated budget to "effectively regulate the Texas workers' compensation system" was $34,155,648 for FY 2012 (ending August 31, 2012) and $32,055,648 for FY 2013 (ending August 31, 2013). DWC employs approximately 550 full time employees.

Funds

Subsequent Injury Fund

The Subsequent Injury Fund (SIF) is administered by the DWC staff. SIF is an account in the General Revenue Fund funded by insurance carriers from compensable death benefits on claims in which there is no legal beneficiary. SIF pays Lifetime Income Benefits to injured workers who become eligible (based on statutory requirements) for those benefits because of a second work-related injury.

The catalyst for triggering payment from the SIF is an order issued by a Benefit Review Officer or Hearing Officer at a benefit review conference or contested case hearing, respectively, to pay the portion of lifetime income benefits for which the carrier is not liable. Carriers are reimbursed by SIF for overpayment of benefits.

Insurance Requirements and Resources

General Information

Texas doesn't require most private employers to have workers' compensation insurance. Private employers who contract with the government are required to provide workers' compensation coverage for each employee working on the public project. Some clients may also require their contractors to have workers' compensation insurance.

Employers who choose not to have workers' compensation insurance must

- file an annual notice with TDI
- display notices of noncoverage in the personnel office and throughout the workplace
- give a written statement of noncoverage to each new employee.

If employers choose to provide workers' compensation, they must do so in one of the following ways:

- purchase a workers' compensation insurance policy from an insurance company licensed by TDI
- be certified by TDI to self-insure workers' compensation claims
- join a self-insurance group that has received a certificate of approval from TDI.

Private Insurance

The Department of Insurance has regulatory authority over Texas's workers' compensation insurance carriers.

Individual Self-Insurance

Large private employers may self-insure if they are certified by TDI. To qualify, an employer must

- provide information to TDI about its profitability, previous workers' compensation losses, and number of workers
- have certified safety programs at all job sites
- provide a minimum security deposit of $300,000 or 125 percent (whichever is greater) of the employer's existing workers' compensation liabilities
- have a minimum of $5 million of excess insurance coverage
- have a total unmodified Texas premium of at least $500,000 or nationwide premiums of $10 million
- pay fees and taxes necessary to support the administration of the program, including establishment of a guaranty fund for self-insured employers.

Group Self- Insurance

Private employers may also self-insure by joining with four or more private employers to establish a workers' compensation self-insurance group. The group must receive a certificate of approval from TDI.

The employers in the group must

- be engaged in the same or similar type of business
- be members of a bona fide trade or professional association that has been in existence in Texas for purposes other than insurance for at least five years before the establishment of the group
- enter into agreements to pool their liabilities for workers' compensation benefits and employers' liability in Texas
- provide required information to TDI, such as financial information about the members of the group, the governing classification code of the group or a description of operations for each member of the group showing that the members of the group are engaged in similar operations, and evidence of the required performance bonds
- provide a minimum security deposit of $300,000 or 25 percent (whichever is greater) of the group's total incurred liabilities for workers' compensation
- have an estimated annual premium subject to an experience modifier of at least $250,000 during the group's first year of operation and an annual standard premium of at least $500,000 thereafter
- have a minimum of $5 million per occurrence of excess insurance
- pay fees and taxes to support the administration of the program.

Penalties for not Insuring

There are no penalties for employers who elect not to maintain workers' compensation insurance, although they lose certain common-law protection if sued by an employee who suffers a work-related injury or illness.

Reporting Requirements

First Report of Injury

The employer must file a first report of injury with the insurance carrier no later than 3ight days after the notice of injury or knowledge of injury. The insurance carrier must electronically file information from the employer's first report of injury with DWC no later than the seventh day after receipt of a report where there is lost time from work.

Other Reports/Claims Processing and Monitoring

Other mandatory reports:

- Employer's First Report of Injury or Illness
- Employer's Wage Statement
- Payment of Compensation or Notice of Refused or Disputed Claim
- Employee's Notice of Injury of Occupational Disease and Claim for Compensation
- Report of Medical Evaluation
- Work Status Report

It is the carrier's duty to notify DWC of:

- Initial payment of indemnity benefits
- Change in the net benefit payment or income/benefit type
- Reinstatement of benefits
- Refusal to pay
- Termination or suspension of income or death benefits

The treating doctor or designated doctor determines the claimant's maximum medical improvement/impairment rating by using the current AMA Guide. Employees and carriers have the right to dispute an impairment rating. If an impairment rating given by a second physician is again disputed, it is handled through the dispute resolution process.

EDI Standards

28 Texas Administrative Code §102.11, §124.2 and §134.802 requires that certain data be submitted to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) by electronic data interchange (EDI).

Texas currently uses the IAIABC Claims Release 1 Standards for submission of First and Subsequent Reports of Injury. Also, Texas used Medical Release 1.0 for the submission of medical bill and payment information.

Contested Case Handling

Appeals Process

The levels in the appeals process include:

1. Benefit Review Conference: The BRC is an informal meeting held at a local TDI-DWC office where, the claimant meets with someone from the insurance company to discuss the disputed issues in front of a TDI-DWC Benefit Review Officer. If the dispute is resolved, an agreement may be written and signed by the claimant and the insurance carrier.

A party may also request a BRC to appeal a medical fee dispute decision on a fee dispute filed with the TDI-DWC Medical Fee Dispute Resolution section on or after June 1, 2012. A first responder request for a BRC must be accelerated by the TDI-DWC and given priority in accordance with the Texas Labor Code §504.055.

2. Arbitration: If the dispute was not resolved at the BRC, the injured employee and other parties to the dispute may agree to resolve the dispute through arbitration instead of proceeding to a contested case hearing. At arbitration an independent arbitrator chosen by TDI-DWC hears both sides of a dispute and makes a decision.The decision of the arbitrator is final and cannot be appealed.

A party may also request to resolve a medical fee dispute by arbitrator after a BRC for fee disputes filed with the TDI-DWC on or after June 1, 2012.]

3. Contested Case Hearing (CCH): Following a BRC, if all of the parties do not choose arbitration, a CCH is the next level of dispute resolution. A CCH is a formal hearing conducted by a TDI-DWC Hearing Officer who makes a decision about the disputed issue(s) that were not resolved at the BRC. Following the CCH, the Hearing Officer will issue a written decision and order.

4. Appeals Panel: After the CCH, any party that disagrees with the Hearing Officer's decision may request review of that decision by the TDI-DWC Appeals Panel. Instead of holding a hearing, the parties submit written statements describing their position that are reviewed by the Appeals Panel along with the Hearing Officer's decision and the record from the CCH. The Appeals Panel will issue a written decision, which is the final step in the TDI-DWC's dispute resolution process.

5. Judicial Review: If a party disagrees with the TDI-DWC Appeal Panel's decision, the decision may be appealed to a court of law for a decision.

	Notes or Comments on Scope	*Number in FY2012*
Benefit Review Conference		10,169
Arbitration		0
Contested Case Hearing		5,572
Appeals Panel		2,378
Judicial Review		180

Attorneys' Fees

Attorneys' fees are allowed based on time and expenses and must be approved by DWC. Guidelines are established by rule. Attorney fees come from the claimant's weekly benefits not to exceed 25% of each payment, with the exception that the carrier pays the claimant's attorney fees if the claimant prevails on a dispute. If the insurance carrier appeals a final DWC decision to the courts and does not prevail, the carrier must pay the claimant's attorney fees.

Compromise and Release Agreements

Texas has Compromise Settlement Agreements for claims with dates of injuries prior to 1/1/1991. The parties to the claim may settle/close out indemnity and medical benefits on those claims. For claims with a date of injury on and after 1/1/1991 Texas does not have Compromise Settlement Agreements.

Medical Care and Evaluation

Fee Schedule

In the Texas workers compensation system, reimbursement of medical services and treatments for non-network care is determined by fee guideline rules. These fee guideline rules are based on the Texas Workers Compensation Act and are adopted through the administrative rule making process.

For more information visit: http://www.tdi.texas.gov/wc/fee/index.html

Treatment Guidelines

Texas uses ODG guideline for treatment in workers' compensation: http://info.sos.state.tx.us/pls/pub/readtac$ext.tacpage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=2&ch=137&rl=100

Managed Care

Employers may provide workers' compensation coverage for their employees by participating in workers' compensation health care networks certified by TDI. These networks provide cost-effective health care for work-related injuries and illnesses. Because the networks specialize in treating injured workers, they also can help workers return to the job quickly and safely. Employers' premiums might be less if they participate in a network.

Insurance companies (including political subdivisions, individual certified self-insured employers, and groups of certified self-insured employers) may create or contract with workers' compensation health care networks to provide health care for injured workers.

For more information about certified workers' compensation health care networks, visit the workers' compensation networks page on TDI's website at www.tdi.texas.gov/wc/wcnet/indexwcnet.html.

Choice of Treating Physician

Employees receiving healthcare through a certified workers' compensation health care network must select a treating doctor from a list provided by the network. A change of physician is subject to network rules and requirements.

Employees not receiving health care through a certified workers' compensation health care network may choose any doctor willing to provide medical treatment unless the doctor was removed from the Division's Approved Doctor List. A request to change treating doctor must be approved by the DWC.

Rehabilitation

General Information

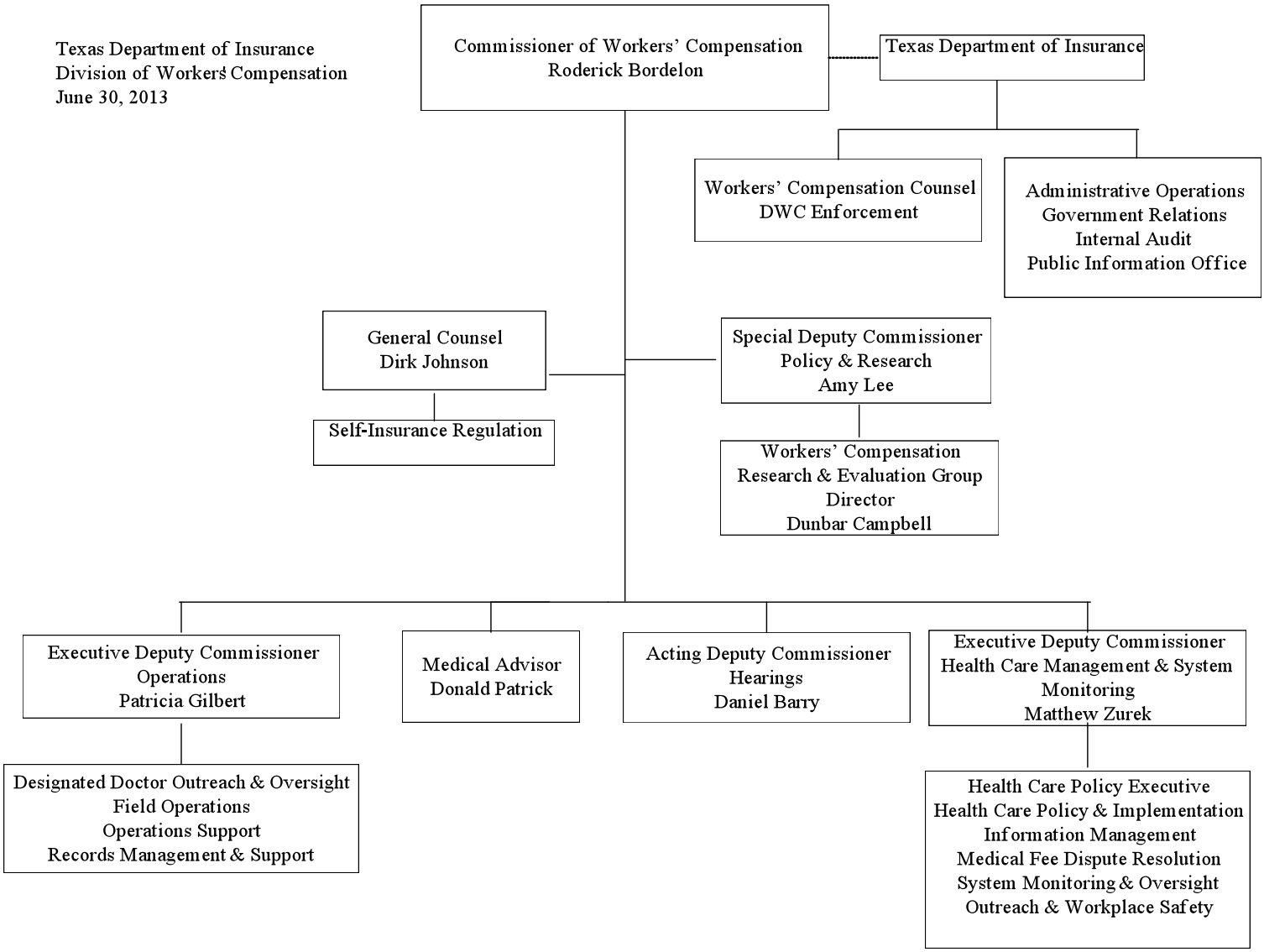
The workers' compensation law allows for vocational and physical rehabilitation.

Physical rehabilitation is a medical benefit and is paid for by the insurance carrier.

Vocational rehabilitation is not a medical benefit but may be provided and paid for by the insurance carrier. DWC determines which injured employees may be assisted by vocational rehabilitation and refers them to the Texas Health and Human Services Commission, Department of Assistive and Rehabilitative Services (DARS). An injured employee who is offered vocational rehabilitation services through DARS or a private provider of vocational rehabilitation services and refuses those services shall lose their right to receive Supplemental Income Benefits (SIBs).

Workers' Compensation Division Organization Chart

Texas Department of Insurance
Division of Workers' Compensation
June 30, 2013



Utah

Utah Industrial Accidents Division

160 East 300 South, 3rd Floor

P.O. Box 146610

Salt Lake City, Utah, 84114

(801) 530-6800 or (800) 530-5090

http://www.laborcommission.utah.gov/divisions/IndustrialAccidents/

Agency

General Information

Established by state law, the Industrial Accidents Division (IAD) monitors and administers the workers' compensation program for the state of Utah. The IAD's sections are established to work with injured workers, employers, physicians, adjusters and attorneys on various injury and compliance issues. Rules, procedures and certain medical fees are established by the IAD to ensure fair claims handling practices, compliance adherence and access to quality medical care.

Legislative and Regulatory Links

Utah Workers' Compensation Act and Administrative Rules: http://laborcommission.utah.gov/divisions/IndustrialAccidents/iadlaws.html

Budget and Financing

Agency Funding Source

Each insurer pays an amount of equal to or greater than 1% but equal or less than 4.25% of the total workers' compensation premium income. The assessment is determined annually by the Labor Commissioner (Utah 59-9-101 (2)).

Funds

Uninsured Employers' Fund

The UEF was established in 1994 to provide benefits to injured workers whose employers did not maintain the statutorily required workers' compensation insurance and otherwise cannot pay because of insolvency.
Money for this fund is collected by the Tax Commission from a surcharge on workers' compensation insurance premiums in Utah, in addition to an assessment to employers that are self-insured for workers' compensation. Penalties imposed against employers who fail to maintain workers' compensation insurance are also deposited to the UEF. Money collected is invested with the State Treasurer where interest is earned.
An independent actuarial review of the future liabilities is completed each year.

Employers' Reinsurance Fund

The ERF pays certain workers compensation benefits to eligible workers (and their dependents) as a result of work accidents that occurred prior to July 1994. For many years, the Fund acted as a reinsurer to the commercial insurance market (1) for claimants that exceed a specific period of benefits with the private insurer or (2) to pay the liability for pre-existing impairment of workers rendered disabled by an industrial accident.
With legislation passed in 1994, the ERF discontinued acting as a reinsurer for new injuries and it now only covers injuries that occurred up to June 30, 1994.

The fund had an unfunded liability in 1994, and it has been working since that time to generate sufficient money to fund the liability. In order to meet this objective, the fund must collect more money each year than it pays out. Money going into the fund is collected by the Tax Commission from a surcharge on workers' compensation insurance premiums in Utah, plus an assessment to self-insured employers. Money that is collected is invested with the State Treasurer where interest is earned.

An independent actuarial review of the future liabilities is completed each year.

Insurance Requirements and Resources

General Information

All employers are required to carry WC insurance except for the following employer/employee work situations: some employers of agricultural laborers, casual or domestic workers, real estate brokers, sole proprietors, partners and members of limited liability companies. Directors or officers of a corporation are considered employees and must exclude themselves from coverage in writing through their WC insurance company.

Three ways to obtain coverage in Utah:
1. By purchasing insurance from any private insurance carrier authorized by the Insurance Department to write WC insurance in Utah. An employer can contact their personal insurance agent who handles their auto, home or business liability insurance to see if they can write a WC policy for their company. Most insurance companies can write WC insurance in Utah.

2. By purchasing insurance through the Workers Compensation Fund, a mutual insurance entity is required by law to provide WC insurance to any employer in the State of Utah upon payment of the premium.

3. By being self-insured to pay WC directly to employees. Employers who wish to become self-insured must make application through the Labor Commission of Utah. Only very large employers usually meet the minimum requirement of $10 million net worth to qualify for self-insurance.
(801) 538-3800
1-800-439-3805

Private Insurance

The Insurance Department has regulatory authority over workers' compensation insurance carriers.

Utah Insurance Department
3110 State Office Building
Salt Lake City, Utah 84114
(801) 538-3800 or 1-800-439-3805
https://insurance.utah.gov/

Self-Insurance

Utah Code Annotated section 34A-2-201 provides the options by which employers can secure workers' compensation benefits for employees. Section 3 states that one of the options an employer has is to obtain approval from the division to self-insure i.e. pay compensation directly as a self-insured employer per the Workers' Compensation Act and the Utah Occupational Disease Act.

An employer must obtain approval from the Industrial Accidents Division, Labor Commission in order to become self-insured and maintain self-insured status.

An employer must have been in business for a period not less than five years. An employer in business less than five years may be considered only if their liability is guaranteed by their parent corporation which has a business history of no less than five years.

If the employer is a subsidiary, then a fully executed "Agreement of Assumption and Guaranty" by the parent, agreeing to indemnify all workers' compensation liability incurred while the subsidiary is self-insured in the state of Utah must be submitted. A division may not be self-insured if the parent company is not.

The Commission may utilize services such as Dun & Bradstreet (D&B) credit ratings for the purpose of evaluating a company's financial ability to pay. The employer will not be considered if they do not fall within the top two D&B ratings on estimated financial strength (5A or 4A), which means the net worth must be $10,000,000 or more.

Group Self- Insurance

Utah does not allow group insurance.

Penalties for Failure to Insure

The Labor Commission may impose a penalty against the employer of $1,000 or three times the amount of the premium the employer would have paid for WC during the period of noncompliance (whichever is greater). An uninsured employer may also be sued for personal injury in a court of law by an injured employee.

Reporting Requirements

First Report of Injury

An employer or its insurance company has 7 days after receiving an employee's report to submit an "Employer's First Report of Injury or Illness" to the Industrial Accidents Division. The employer or its insurance company must give the employee a copy of the report and a written statement of his/her rights and responsibilities. An employee must report a work related injury or illness within 180 day of occurrence to be qualified to receive benefits.

Other Reports/Claims Processing and Monitoring

Other mandatory reports:

- Employer must file a report of initial payment and last payment
- Physician's Initial Report of Injury or Illness
- Return to Work Release
- Suspension of Benefits
- Denial of Benefits
- Permanent Impairment Compensation Agreement
- Closure of Case Report
- Policy Reports
- Payment Reports

The IAD monitors for initial payment, monitors required time-frames, promptness of payment, and employer and physician reporting.

The IAD makes the final administrative decision for determining a claimant's permanent partial disability rating. The factors used in determining the disability rating include:

- Use of the IAD rating guide
- Use of Utah's Impairment Guides and the recent edition of the AMA guide to Physical Impairment, and
- Decision of IAD may be appealed to the Adjudication Division.

EDI Standards

Claims: FROI IAIABC Claims R3 mandatory
POC: IAIABC POC R2.1 mandatory; expect R3.0 production in the future
Medical N/A

FROI testing will resume on September 4, 2012 for trading partners not previously cleared to enter FROI production. Those trading partners must complete their FROI testing and be cleared into production no later than December 31, 2012

SROI tables are expected to be published in July 2012. SROI trading partner testing will commence July 1, 2013. All trading partners must complete SROI testing and be cleared into production no later than December 31, 2013.

Contested Case Handling

The Claims Resolution Program offers mediation to claimants, employers, insurance companies and medical providers. Mediation is not mandatory – both parties must agree to participate in the mediation process. The claims resolution conference brings both parties together with the help of a neutral facilitator to develop solutions for resolving their workers' compensation disputes to the mutual benefit of both parties. An ombudsperson can assist an injured worker not represented by an attorney, in the mediation process.

Appeals Process
The levels in the appeals process include:
1. Formal Hearing before an Administrative Law Judge
2. Review with the Labor Commissioner or three-member Appeals Board
3. Appellate Level before a Court Appellate Judge
4. Supreme Court

Attorneys' Fees

The IAD regulates attorneys' fees. Fees are paid out the claimant's award.

Compromise and Release Agreements

Compromise and release agreements are allowed in disputed cases and any future indemnity and medical benefits. These agreements must be approved by the Administrative Law Judge and terminate indemnity and medical benefits.

Medical Care and Evaluation

Fee Schedule

2013 Medical Fee Standards: http://laborcommission.utah.gov/media/pdfs/industrialaccidents/pubs/2013%20MED%20FEE%20Modified%2011-29-2012.pdf

2012: Medical Fee Guidelines: http://laborcommission.utah.gov/media/pdfs/industrialaccidents/pubs/2012MEDFEE.pdf

Treatment Guidelines

Utah does not cite the use of any particular treatment guidelines, but any guidelines used must be scientifically based and updated periodically.

Managed Care

The use of managed care organizations was authorized in Utah in 1993.

Choice of Treating Physician

The employer/carrier makes the initial choice in attending physician. In order to attain a change of physician, a change of physician form is required to be filed to the Commission and the carrier for approval.

Rehabilitation

General Information

The workers' compensation law provides for both vocational and physical rehabilitation. Rehabilitation training is paid for by the insurers on a voluntary basis. Any compensation or subsistence issued to a workers undergoing vocational rehabilitation is provided on a voluntary basis by the insurance carrier, otherwise the state provides vocational rehabilitation.

To qualify for rehabilitation and injured employee must have 90 days of lost time or more.

The criteria used in determining a "successful" rehabilitation is return to work.

Workers' Compensation Division Organization Chart

Vermont

Vermont Workers' Compensation Division

5 Green Mountain Drive

PO Box 488

Montpelier, Vermont 05601

(802) 828-2138

http://labor.vermont.gov/

Agency

General Information

The Vermont Workers' Compensation Division (WCD) is part of the State Department of Labor and Industry. The agency head is the Director of Workers' Compensation who reports to the Commissioner of Labor.

WCD Functions include:

- Injury reporting and record retention
- Claims processing and monitoring
- Public information and education about workers' compensation
- Licensing or certification of self-insurers and rehabilitation providers
- Dispute resolution and adjudication of disputes
- Monitoring employer compliance
- Assessment of penalties for non-compliance, late reporting or late payments

Legislative and Regulatory Links

Vermont Workers' Compensation Statutes: http://www.leg.state.vt.us/statutes/sections.cfm?Title=21&Chapter=009

Vermont Workers' Compensation Rules: http://labor.vermont.gov/Workers'%20Compensation%20Rules/tabid/311/Default.aspx

Budget and Financing

Agency Funding Source

The Workers' Compensation Administration Fund covers expenses to administer the Vermont Worker's Compensation Program.

Current Workers' Compensation Assessment Rates:

- Insurance Companies:
- Starting July 1, 2011 the assessment rate is 1.75%.
- July 1, 2010 the assessment rate was 1.425%.
- Self-Insured: 1% of workers' compensation losses during the preceding calendar year.

(Vermont 21-711).

Operating Budget and Staff Size

The WCD's operating budget is appropriated by the legislature and approved by the Governor.

Funds

Second Injury Fund

Vermont no longer has a second injury fund (repealed).

Insurance Requirements and Resources

General Information

Almost all of Vermont's 350,000 workers must be covered by the system. Most employers secure coverage by purchasing workers' compensation insurance. A limited class of employers may be approved as self-insurers.

Vermont employers must provide workers' compensation insurance if employer hires one or more employees on a full or part time basis in Vermont, or hires employees outside the state but they work for you in Vermont. 1-800-439-3805

Private Insurance

The Vermont Department of Financial Regulation has regulatory authority over insurance carriers.

The Department of Financial Regulation is in charge of:

- Issuing licenses
- Setting rates
- Disciplining carriers

Vermont Department of Financial Regulation
89 Main Street
Montpelier, Vermont 05620
(802) 828-3301
http://www.dfr.vermont.gov/

Penalties for Not Insuring

An employer who fails to provide workers' compensation insurance may be assessed a penalty of $50.00 per day, but not to exceed $5,000 for the period prior to receiving notice from the Commissioner of Labor. If you do not provide workers' compensation insurance within 5 days of receiving notice, you may be assessed a penalty of $150 per day, beginning 5 days after the date on which you received notice. Failure to provide workers' compensation insurance can have other serious consequences. It will have a negative impact on your legal defenses if you are sued by an injured employee. In extreme cases, it can also lead to a state order closing your business.

Reporting Requirements

First Report of Injury

Filing of the employer's first report with the WCD is mandatory for all injuries or illnesses that result in lost or medical treatment. The initial reports must be filed within 72 hours of the accident resulting in injury or illness.

Other Reports/Claims Processing and Monitoring

Other mandatory reports:
Intent to Terminate (in order to terminate temporary total disability benefits)

The WCD does monitor the initial payment, compensation rate, and annual payments of claims.

Factors used in determining the disability rating include:

- Impairment rating of the attending physician
- Use of the AMA Guide to Physical Impairment (current edition)
- Use of an independent medical physician

EDI Standards

Vermont uses the standard International Association of Industrial Boards and Commissions (IAIABC) flat-file format for First Reports of Injury (transmission type 148). Vermont uses Release 1.0 on mandatory basis.

Contested Case Handling

Levels in the hearing process in Vermont include:

1. Informal Conference with a specialist
2. Informal Conference with the WCD Director
3. Formal Hearing with a Hearing Officer or Arbitration
4. Court Hearing before a Judge

Attorneys' Fees

The WCD is responsible for approving and regulating attorneys' fees. Fees are paid out of the claimant's award.

Compromise and Release Agreements

Compromise and release agreements require approval by the WCD Director and may terminate all types of future benefits. A claim may be reopened only if there is a change in condition, fraud, or new evidence.

Medical Care and Evaluation

Treatment Guidelines

Vermont does not have treatment guidelines for workers' compensation.

Managed Care

The use of managed care organizations is authorized in Vermont.

Choice of Treating Physician

The employer has the first choice of treating physician. However, the claimant may change their treating physician by notifying the employer/carrier of the change in writing.

Rehabilitation

General Information

Vocational rehabilitation benefits are not provided to all injured workers. An injured worker may be identified and referred for VR one of two ways:

1. The work injury has disabled them from work for 90 days; or
2. They are otherwise identified as being unable to return to suitable employment.

If either of these developments has occurred and the insurance adjuster has not made a referral to a VR Counselor, the injured worker may contact the adjuster or the department to request such referral.

Entitlement Assessment

The first step in the VR process is the Entitlement Assessment. A VR Counselor reviews the worker's vocational profile (i.e. work history and experience) and medical status and interviews the injured worker then issues a written report containing their assessment. If the worker is unable to return to suitable work then they are found "Entitled" and the Counselor proceeds to work with the injured worker to develop a return to work (vocational) plan.

Suitable Work

Several VR determinations focus upon "suitable work". This refers to work for which the worker has the necessary physical capacities, knowledge, skills and abilities to perform. The work should also be located where the worker customarily worked, or within a reasonable commute. The pay goal is the worker's average weekly wage or at least 80% of that.

The Vocational (Return-to-Work) Plan

Once entitlement is established, the counselor works cooperatively with the injured worker and the adjuster to develop a vocational plan, (also known as an Individual Written Rehabilitation Plan [IWRP]). This is essentially a Return-to-Work plan. Vermont requires adherence to the following hierarchy, in descending order of preference, in developing a VR plan:

1. Return to the same employer in a modified/different job requiring VR services.
2. Return to a different employer in a modified/different job requiring VR services.
3. On-the-job training
4. New skill training or retraining.
5. Educational or academic program.
6. Self-employment.

The VR plan is individually tailored to assist the injured worker in returning to suitable employment. The plan should identify a job goal, milestones to complete the goal, costs, duration and party responsibilities. The counselor should indicate the reasons for the plan that is developed. VR plans require signed party agreement and department approval.

VR Choice The employer (or insurance carrier) may select the initial VR counselor. The injured worker has a right to change counselors if they are not satisfied with the one selected for them. The worker must file a Form VR 8 requesting a change in counselors.

Withdrawal or Termination

An injured worker may voluntarily withdraw from the VR process. They should indicate their desire to withdraw in writing. VR services may also be suspended or terminated if an injured worker does not cooperate or fulfill their obligations in the VR process. Such action requires documentation from the VR counselor.

Disputed Issues

If either the injured worker or the insurance carrier disagree over a VR matter, such as an entitlement decision, formulation of the VR Plan, or termination of VR, they should first contact the opposing party and provide reasons for their disagreement. The parties may resolve the matter between themselves. If a disputed matter is not resolved, either party may write to the department and request a conference for discussion, mediation and hopeful resolution. As with all workers' compensation matters, any party may request that the disputed issue be addressed at a Formal Hearing.

VR Counselors

All VR Counselors must be certified by the department. Certification requires a Master's degree in Counseling or Rehabilitation Counseling (unless Grand-fathered in) and work experience in the Vermont workers' compensation system. VR Counselors are professionals in their field and their work and opinions may be relied upon by the department in vocational rehabilitation matters.

Virginia

Virginia Workers' Compensation Commission

1000 DMV Drive

Richmond, Virginia 23220

(877) 664-2566

http://www.workcomp.virginia.gov

Agency

General Information

The Virginia Workers' Compensation Commission is the state agency which administers the Virginia Workers' Compensation Act.

The Commission also administers two other programs. The Criminal Injuries Compensation Fund, which provides certain benefits to individuals who have been the victims of crime. The Commission also adjudicates claims and disputes arising under the Birth-Related Neurological Injury Fund, which may provide benefits to children who have sustained statutorily defined injuries at birth. Both these programs are created and governed by specific statutes.

Mission Statement

The mission of the Virginia Workers' Compensation Commission is to strive for excellence by being an effective leader in providing public services by ethically administering our statutory duties and being responsive to the diverse needs of our customers.

Legislative and Regulatory Links

Rules and Regulations of the Virginia Workers' Compensation Commission: http://vwc.vi.virginia.gov/rules.htm

Budget and Financing

Agency Funding Source

Every insurer pays a 2.5% premium tax. Each self-insured employer is assessed a maintenance tax up to a maximum of 2.5% on what their premiums would have been in the private market. (Virginia 65.2-1000).

Operating Budget and Staff Size

The VWC's operating budget for fiscal year 2013 is $40,998,782. The VWC's staff size for 2013 is 266.

Funds

Second Injury Fund

Virginia's second injury fund covers permanent loss or loss of use (medically supported) for both first and subsequent injuries and is financed by a tax on carriers and self-insurers. Employers must be notified of the employee's preexisting condition.

The fund is utilized if there are additional periods of incapacity after the second permanent injury has been fully paid. The insurer pays the usual compensation and benefits, subject to partial reimbursement from the fund. Carriers are reimbursed for additional compensation on a pro-rated basis.

Uninsured Employer's Fund

This fund provides compensation to injured workers whose employers are required to carry coverage under the Act but who failed to provide workers' compensation coverage. The fund will pay compensation benefits and medical costs. It is administered by a third party with VWC oversight.

Insurance Requirements and Resources

General Information

Virginia law requires every employer who regularly employs three or more full-time or part-time employees to purchase and maintain workers' compensation insurance. If a business hires subcontractors to perform the same trade, business or occupation, or to fulfill a contract of the business, the subcontractor's employees are included in determining the total number of employees. Employers with fewer than three employees may voluntarily come under the Act.

Private Insurance

The Bureau of Insurance in the Virginia State Corporation Commission has regulatory authority over workers' compensation insurance carries and self-insurance and is responsible for:

- Setting rates
- Licensing carriers
- Monitoring performance

Virginia State Corporation Commission
Tyler Building
1300 E. Main St.
Richmond, Virginia 23219
(804) 371-9967
http://www.scc.virginia.gov/

Individual Self-Insurance

Based on the information in an application, and any other information that may be requested, the Commission will assess the applicant's financial status, the nature and hazard of the employment, the number of employees, the amount of payroll, the employer's claims experience (frequency, severity, and cost), the employer's ability to manage claims, and such other factors as may affect the viability of the applicant as an individual self-insurer for workers' compensation in Virginia.

This assessment results in a determination of whether the privilege of self-insurance can be granted, and what security is necessary. The security may be in the form of a bond from a licensed surety company, Certificate of Deposit, United States government obligations, Letter of Credit or cash, in the minimum amount of $750,000. Most security amounts are considerably higher than the minimum. The employer may also be required to carry excess coverage. If the applicant is a subsidiary of a larger corporation, a parental guarantee will usually be required.

Group Self- Insurance

A program for group self-insurance was authorized effective July 1, 1979. By statute, the State Corporation Commission is charged with the management of that program.

The State Corporation Commission's "Rules Governing Group Self-Insurers of Liability under the Virginia Workers' Compensation Act" (14 VAC 5-370-10 et seq.) outlines the requirements for obtaining a license as a group self-insurance association. It is the applicant's responsibility to review 14 VAC 5-370-10 et seq. and submit a complete filing. The listing that follows is not intended to be all-inclusive but simply highlight certain requirements.

1. Submit the appropriate application form, completed and signed.

2. Submit a copy of the entity's by-laws, certified by its Secretary.

3. Submit an appropriate rate filing and rating program with the Bureau's Property and Casualty Division.

4. Submit a list of the members' supervisory board and have a biographical affidavit (reproducible form enclosed) completed and signed by each of them in the original.

5. Submit an application, indemnity agreement and affidavit for each member of the group self-insurance association. The enclosed forms are to be utilized. No language should be deleted from the forms. Language added to the forms must receive prior approval from the Bureau.

6. Specific and aggregate excess insurance is required. Acceptable attachment points and coverage limits will be directed by the Bureau.

7. Proof of payment by each member of at least 25% of its estimated first year's contribution into a designated depository should include deposit tickets, check copies and a bank confirmation sent directly to the Bureau.
8. Submit a current financial statement of each member of the group self-insurance association demonstrating solvency and its financial ability to meet its obligations as a member.

9. Submit premium computation sheet for each member of the group self-insurance association. The computation sheets should support the composite listing of estimated annual gross contributions, which shall not be less than $350,000.

Penalties for Failure to Insure

The penalties for failure to insure in Virginia under the workers' compensation law can include:

- A fine of up to $5000
- Cease and desist business operations
- Class 2 misdemeanor

Reporting Requirements

First Report of Injury (FROI)

The first report of injury must be filed by EDI with the VWC for all injuries. Non-minor injuries (medical more than $1,000, lost time exceeding seven days, dispute, PPD, etc.) are due within 10 days of the knowledge of injury. Non-minor injuries include full denials which are also required to be reported via EDI within 10 days of knowledge. Minor medical accidents resulting in seven days or less of disability or less than $1000 in medical costs are due within 30 days of knowledge of injury.

Subsequent Report of Injury (SROI)

In addition to reporting the injuries to the VWC via EDI, all Trading Partners are required to report Subsequent Reports of Injury (SROI) according the IAIABC Claims Release 3.0 standard. SROIs require our Trading Partners to report all benefit types paid (indemnity and medical), the exact dollar amount paid and any full denial that is made after the claim is reported. Requirements for timely reporting can be found in the VWC's Implementation Guide.

Other Reports/Claims Processing and Monitoring

The VWC monitors claims for timely reporting of both the First and Subsequent Report of Injury which are filed via EDI.

The VWC monitors payments submitted via EDI to ensure agreement forms are received and Awards are entered reflecting the agreed upon periods of disability. If payments are received and an award has not been entered for the dates reflected on the EDI transaction, this will cause the VWC to generate a 20-Day Order-Payments Made in an effort to secure executed agreement forms.

Parties can agree on the final administrative decision for determining a claimant's permanent partial disability rating, or a hearing officer may make a judicial determination using the following factors:

- Impairment rating of attending physician
- Use of the American Orthopedic Guide
- Use of the AMA Guide to Physical Impairment
- Use of an independent medical advisor

EDI Standards

In Virginia, all accidents that occur on or after 10/1/08 are reported to VWC electronically via EDI using the IAIABC Claims Release 3.0 standard. As of 7/1/2012, all accidents with a date of injury prior to 10/1/08 that are considered open/active are required to be reported to the VWC electronically via EDI using the same release 3 standard. Specific information regarding the requirements for the VWC's entire EDI program can be found in our Implementation Guide.

Contested Case Handling

Hearing Process

The levels in the hearing process include:

1. Adjudication by a Deputy Commissioner either through an evidentiary hearing or an on-the-record proceeding.

2. Review of first level decision by three Commissioners

3. Appeal of right of a review decision by the Commission to the Court of Appeals of Virginia.

	Notes or Comments on Scope	Number in FY2012
Hearing before Deputy Commissioner		11,936 referred; 4,148 hearings held
Review by Commissioners		1,341 referred; 973 completed

Attorneys' Fees

The VWC regulates attorney's fees. There is no percentage or fixed basis for attorney's fees by statute and the Commission does not use a fee schedule. A "reasonable" fee is awarded taking into account the time consumed, the efforts expended, the nature of the services and the results. However, the Commission has adopted benchmarks to serve as guidelines for fee awards, such as 20% in compromise settlements and 15% in settlements that resolve permanent partial disability entitlement. Attorney's fees may be paid out of the claimant's award if ordered by the Commission. A claimant's attorney also may be awarded a fee out of payments that inure to the benefit of a health care provider or third party insurance carrier in contested cases that are held to be compensable.

Compromise and Release Agreements

Full settlement of claims is by Petition and Order. These settlements must be approved by the VWC and may terminate indemnity and medical benefits. The claim can only be reopened only if the settlement was obtained by fraud or mutual mistake or imposition.

Medical Care and Evaluation

Fee Schedules

Virginia does not utilize medical fee schedules. By statute, the liability of the employer/insurer for medical costs is limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person.

Treatment Guidelines

Virginia does not utilize medical treatment guidelines.

Managed Care

Managed care is not permitted in Virginia. Medical management of an injured worker's case is to be directed by the treating physician, and an insurance carrier cannot limit the treating doctor's medical management of a case or dictate the referral of a patient to a medical specialist or facility by its approval or disapproval of medical expenses.

Choice of Treating Physician

The initial treating physician is chosen by the employee from a panel of three physicians chosen by the employer. A change of physician is voluntary if parties agree; if not, a change may be ordered by VWC if good cause is shown upon application of either party.

Rehabilitation

General Information

The workers' compensation law provides for both vocational and physical rehabilitation. Vocational rehabilitation services may include vocational evaluation, counseling, job coaching, job development, job placement, on-the-job training, education and retraining. Compensation payments to injured workers under an award continue during vocational rehabilitation until the employee is able to return to work at a wage equal to or greater than the employee's pre-injury average weekly wage.

The Commission has adopted vocational rehabilitation guidelines: http://www.workcomp.virginia.gov/portal/vwc-website/HelpfulResources/RulesRegulations/VocRehab

Workers' Compensation Division Organization Chart

The Virginia Workers' Compensation Commission (VWC) administers the Virginia Workers' Compensation Act, and decides cases under the Act. It is headed by three commissioners. It is an independent State agency.

The commissioners are chosen elected by joint vote of both houses of the General Assembly and serve six-year terms. The Commission elects one of its members to serve as chairman for a three-year term.

Commission operations are overseen by the Commissioners. The Chief Deputy Commissioner oversees the Judicial Department including Deputy Commissioners and Regional Offices, Petitions and Orders, and the Clerk's Office. The Executive Director oversees the following Departments: Administration, Claims Services, Insurance, EDI Quality Assurance, Correspondence Management, Information Systems, Financial Services, Human Resources, Customer Contact Center, Project Management, and Education and Outreach.

The Chief Deputy Commissioner is responsible for managing the Commission's Judicial Division, is appointed by the full Commission and reports directly to the chairman. Twenty-two deputy commissioners, also appointed by the Commission, hold evidentiary hearings throughout the state to determine rights and liabilities of parties under the Act. A number of Deputy Commissioners have been certified as mediators by the Supreme Court of Virginia and conduct mediations of disputed issues and settlements upon request of the parties.

The Commission employs about 260 people in its central and regional offices. These people work in many departments.

Washington

Washington Department of Labor and Industries, Insurance Services Division

7273 Linderson Way SW
Tumwater, Washington 98501-5414
P.O. Box 44000
Olympia, Washington 98504-4000
(360) 902-5800
http://www.lni.wa.gov/

Agency

General Information

The Washington State Department of Labor and Industries (L&I) houses the State's worker's compensation system. The Insurance Services Division of L&I administers the workers' compensation system by providing medical and limited wage-replacement coverage to workers who suffer job-related injuries and illness.

Washington is the sixth largest workers' compensation carrier in the country with $12B in assets and is one of four monopolistic state managed systems. L&I writes nearly $2B in annual premium that covers nearly 170,000 employers and 2.4M workers. Employers report more than 3 Billion hours each year. Premiums and investment income earnings finance the program. About one-fourth of the premiums are paid by workers, while employers cover the rest. In most states, business pays the entire premium based on payroll. Eligible large employers can self-insure. There are approximately 360 self-insured employers who represent an additional 800,000 covered workers in the state.

The State Fund provides benefits to covered workers experiencing job-related accidents or illnesses, and provides services to employers, enabling them to meet their obligations under the law. Services to employers include establishing premium rates at the lowest level necessary to maintain actuarial solvency.

Claim managers oversee benefits to workers who are injured or become ill on the job. They also work closely with doctors, employers, and counselors to help severely injured workers return to paid employment. Washington's workers' compensation system is funded by premiums from employers and workers and income from investments.

The staff also provides compliance oversight for the activities of employers who qualify to self-insure their workers' compensation claims.

Benefits paid by the State Fund and self-insured employers to covered workers (or their dependents) who are injured or become ill in the course of their employment include:

- All medical costs related to the covered condition(s)
- Monthly disability payments to compensate for lost earnings
- Payment for the loss of, or lost function of, bodily parts (permanent partial disability)
- Monthly payments for life in the case of total permanent disability
- Voluntary structured settlements to certain workers meeting statutory criteria
- Burial awards and pensions to survivors for a fatal work-related injury or illness
- Physical and vocational rehabilitation benefits for qualified injured workers

Mission Statement

Keep Washington Safe and Working.

Legislative and Regulatory Links

Washington State Workers' Compensation Laws: http://apps.leg.wa.gov/rcw/default.aspx?Cite=51

Washington State Workers' Compensation Rules: http://apps.leg.wa.gov/wac/default.aspx?cite=296

RCW 51.16.035 requires L&I to set basic rates of premium that are the:

- Lowest necessary to maintain actuarial solvency of the accident and medical aid funds
- In accordance with recognized insurance principles
- Designed to attempt to limit fluctuations in premium rates

Budget and Financing

Agency Funding Source

The Department of Labor & Industries primary source of operating funds is from employer and worker premiums, and self-insurance assessments. L&I's operating budget is appropriated by the Legislature, and approved by the Governor and the Office of Financial Management.

2012-2013 Operating Budget/Staff Size

The operating budget for the FY 12 and FY 13 biennium was $169M and 1,051 Full Time Equivalents.

General Statistics for Fiscal Year 2012:

- Premium – $1.97B
  - Employers - $1.52B
  - Workers - $450B
- 101,500 new claims filed annually
  - 20,200 are new time-loss claims
- Approximately 39,000 claims are open at any given time – half of those are time-loss claims.

Funds

Accident Fund

The Accident Fund pays partial wage replacement, permanent disability benefits, structured settlements, and pensions for totally disabled workers and survivors of fatally injured workers, along with vocational retraining costs such as tuition and books. Only employers contribute to this fund.

Medical-Aid Fund

The Medical-Aid Fund pays for health care and private vocational services for injured workers. Employers and workers contribute equally to this fund. The Stay at Work fund is an account within the Medical-Aid Fund.

Supplemental Pension Fund

The Supplemental Pension Fund pays for annual cost-of-living increases for wage replacement and pension payments. Employers and workers for both state fund and self-insured employers pay equally into this fund.

Insurance Requirements and Resources

General Information

Generally, employers must provide workers' compensation coverage for their workers.

There are two ways to provide this coverage depending on the financial resources of the business. Most businesses participate in the state's workers' compensation program — the Washington State Fund. Companies with at least $25M in assets, and some governmental entities, may qualify for self-insurance. The Department of Labor & Industries, Insurance Services Division, manages the Washington State Fund. This fund derives its income solely from premiums paid by employers and their workers. The fund receives no money from general tax revenues.

All Washington workers must be covered through the State Fund or by a certified self-insured employer, unless subject to exclusion.

Private Insurance

Private insurance is not allowed in Washington State.

Individual Self Insurance

Employers with substantial resources (at least $25M in assets) and an effective accident prevention program may qualify to provide workers' compensation insurance coverage for their workers through self-insurance. To qualify, an employer must meet certain criteria as outlined in Washington Administrative Code (WAC) 296-15-021. A self-insured employer assumes all risks and costs of workers' compensation coverage.

Self-insured employers manage most aspects of their workers' compensation claims, including authorizing benefits according to Title 51 RCW and paying all benefits out of company funds, unless there is a dispute. When a dispute arises, L&I steps in to assist with claim management. L&I must certify self-insured employers. Reporting and recordkeeping for self-insured employers varies from State Fund requirements.

There are approximately 360 self-insured employers who represent 800,000 covered workers in the state.

L&I monitors compliance with Title 51 RCW by conducting program compliance audits. Audits are completed after the first year of initial certification, and then routinely at about 5-year intervals.

L&I can assess penalties against self-insured employers for:

- Unreasonable delay of benefits (25% of the delayed benefit or $500, whichever is more, paid directly to the worker)
- Failure to make records available for inspection (up to $500)
- Rule violations (up to $500)
- Failure to provide a copy of the claim file within 15 days of the worker's request ($500, payable to the worker)
- Failure to request claim allowance or denial within 60 days ($500, payable to the worker)
- Self Insured Employer Data Reporting System (SIEDRS) reporting penalties (progressive set of penalties)

Group Self-Insurance

Group Self-Insurance is allowed in Washington State for school districts and hospitals.

Penalties for Failure to Insure

The penalty for not insuring and reporting premiums is a maximum of $500 or 200 percent of the premiums due (whichever is greater). In addition, there is a penalty for having a claim while uninsured, which is a maximum of 100 percent of the cost of the claim. In addition, if an employer knowingly misrepresents the amount of his or her payroll or worker hours, the employer shall be liable to the state for up to 10 times the amount of the difference in premiums paid and the amount the employer should have paid.

FY12 Penalties Assessed: $37.8M
FY12 Penalties Collected: $14.1M

Discrepancies in the assessed versus collected dollars are related to the fact that many of the FY 12 penalties are in reconsideration or appeal status or are still in Collections; there have also been penalty adjustments, waivers, and determinations of uncollectible.

Reporting Requirements

First Report of Injury

In Washington State, the responsibility for filing a first report (claim) is solely the responsibility of the worker. The employer is only required to report the accident; they are not required to file a claim for compensation on behalf of the worker. The physician is responsible for assisting the worker in completing his/her portion of the report.

Time limits:

- Injured workers must submit initial report within one year from the date of injury, or two years with written notice from physician that he/she has an occupational disease or illness.
- Doctors must submit reports 5 days from the date of first treatment

Penalties can be assessed if a determination is made the employer engaged in claim suppression or if the doctor fails to file a report within 5 days of the date of treatment.

Additional Reports/Claims Processing and Monitoring

The department regularly reviews the percentage of growth of their workers' compensation medical costs and containment efforts. Their goal is to hold workers' compensation medical cost growth below 4% per year. (Excludes hearing loss claims).

L&I receives around 100,000 new state fund claims a year. Of these new claims over 80% are accepted but, less than 20% of accepted claims ever become time-loss claims. Even among claims that experience some time off work, 60% end up receiving 60 days or less of wage replacement payments. A relatively small number of injured workers develop long-term disabilities with six or more months off work.

Ensuring timely claim resolution is a key strategy of the department to reduce the chances that a workplace injury develops into a long-term disability and to promote job creation by keeping rates fair and stable. L&I regularly reviews the resolution rate of their time-loss claims and claim performance to prevent long-term disability.

Returning injured workers to work is central to L&Is mission, "Keeping Washington safe and working" by helping workers maintain connection to the workforce, supporting employers, and controlling long-term disabilty. The department measures the percentage of injured workers who return to work within six months of their date of injury, with a goal of returning eight out of ten workers to work within six months of their injury.

The department monitors periodic payments, the first payment, and promptness of payment of workers' compensation claims.

An injured worker must reach maximum medical improvement in order to have temporary total disability benefits terminated if the worker has not returned to work and has not been released.

The final decision for determining a claimant's permanent partial disability rating based on the medical opinion of a physician rests with the claim management staff. Factors used to determine a disability rating include:

- Impairment rating of the attending physician or independent medical examiner
- Use of the AMA Guide to Physical Impairment
- L&I rating guide

EDI Standards

Washington is a proprietary system and does not use EDI.

Contested Case Handling

The Board of Industrial Insurance Appeals (BIIA) is an independent state agency. It is separate from L&I. The BIIA's purpose is to hear and decide appeals from decisions of L&I.

When the BIIA receives an appeal, it will:

- Assign a docket number to the appeal;
- Mail a Notice of Receipt of Appeal to the parties; and
- Send a copy of the appeal to the Department of Labor and Industries.

If the Department reconsiders its decision, the BIIA will:

- Issue an Order Returning Case to Department for Further Action.

If the Department does not reconsider its decision, the BIIA will:

- Decide whether it has jurisdiction (the right to hear the appeal).
- If the BIIA does not have jurisdiction, the appeal will be denied and an Order Denying Appeal will be sent to the parties.
- If the BIIA has jurisdiction, the appeal will be granted and an Order Granting Appeal will be sent to the parties. An Order Granting Appeal does not mean that anyone has won or lost the Appeal. It only means that the BIIA agrees to hear the appeal.

After an appeal is granted, a mediation conference will be held in most cases. A mediation conference is an informal meeting of the parties with a mediation judge.

- All parties will receive a notice indicating the date, time, and location of the conference.
- The conference may be held in person or by telephone.
- Mediation is not a hearing – witnesses will not be called to testify. An attorney is not required, although the assistance of an attorney may be helpful.
- The mediation judge may schedule further conferences, if needed.

Hearings are like trials. The Rules of Evidence and Superior Court Civil Rules apply. Parties must be familiar with these rules in order to ensure that all their testimony and evidence will be admitted at the hearings.

When all hearings are completed and all evidence has been received, the hearing judge will issue a "Proposed Decision and Order," which is the hearing judge's decision on the appeal.

Any party who disagrees with any portion of the Proposed Decision and Order may request a review by the three Board Members. The request must be in writing and should be titled "Petition for Review."

Attorneys' Fees

The BIIA has the responsibility and authority to set attorneys' fees upon request if the matter is pending before the board. If the attorney's services are only provided at the department level, then the department sets the fees. The attorneys' fees are generally paid out of the claimant's award.

Compromise and Release Agreements (Structured Settlement Agreements)

A structured settlement offers a new option for some older workers. An eligible worker, the employer and L&I reach an agreement to close the claim and pay the worker an agreed-to amount of compensation, paid out in periodic payments. Workers may still receive medical treatment for conditions allowed on their claim. L&I does not participate in agreements between workers and self-insured employers unless one of the workers' compensation funds will be impacted. To be eligible, a worker must be at least 55 years of age and have an allowed claim (State Fund or self-insured) that is at least 180 days old. The eligible age for workers to participate will lower to 53 on January 1, 2015, and to age 50 on January 1, 2016.

Medical Care and Evaluation

Fee Schedule

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/default.asp

Treatment Guidelines

The medical treatment guidelines are written from a clinical perspective, to guide clinical care. Providers should consult the Medical Aid Rules and Fee Schedule (MARFS) for documentation and coding requirements.

The Medical Treatment Guidelines (also called Medical Practice Guidelines or Review Criteria) are evidence based and were developed by the Office of the Medical Director in collaboration with practicing physicians and advisors.

Some guidelines are intended to be educational tools for medical providers. Some guidelines and the review criteria are used by L&I in the Utilization Review program and claim management process to promote best practices and improve the health of injured workers. They are published by L&I, which is solely responsible for coverage decisions that may result from their use.

Although doctors are expected to be familiar with the guidelines and follow the recommendations, L&I also understands that guidelines are not hard-and-fast rules. Good medical judgment is important in deciding how to use and interpret this information.

More information: http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/TreatGuide/default.asp

Managed Care

As of January 2013, the department implemented a Medical Provider Network. Workers who suffer a job-related injury or illness can see any provider for their first visit to a doctor's office or an emergency room, but for ongoing treatment they must get care from a provider in the network. The network is intended to ensure injured workers receive high-quality medical care. Workers insured by L&I (State Fund) and by self-insured employers can now choose providers from the network. Over 18,000 medical providers applied to join the network, greatly exceeding expectations. As of June 1, 2013, more than 14,600 of these were fully approved. Providers who applied prior to January 1, 2013 can continue to treat injured workers while L&I finishes reviewing their qualifications. L&I has begun designing another feature of the network, a top tier of providers who will be eligible for incentives for using occupational health "best practices."

Rehabilitation

General Information

Vocational Rehabilitation Program: The law provides for both vocational and physical rehabilitation. The rehabilitation sections provides intervention services; vocational provider registration, audits, and investigations; consultation services; and therapist consultations.
The department purchases rehabilitation services from the private sector in accordance with the law. A Vocational Rehabilitation Counselor (VRC) makes the recommendation for training which must be approved by the claim manager. VRCs are in charge of monitoring the progress of training and recommending adjustments as needed.
If a claimant refuses to cooperate with rehabilitation, temporary total disability benefits may be reduced, suspended, or terminated. Rehabilitation is paid for by the State for State Fund covered workers. Injured workers undergoing rehabilitation may receive temporary total disability benefits and other reimbursements related to their rehabilitation program.

Centers of Occupational Health and Education (COHE): COHEs in four health care organizations help support medical providers' use of occupational health best practices and coordinate care for injured workers. University of Washington research has shown COHEs can save up to $470 per claim in the first year and up to $1,200 in the first four years. L&I has just recruited new COHEs that are expected to give around 98% of Washington's injured workers access to COHE services. The 2011 Legislature directed L&I to expand COHE access to half of all injured workers by December 2013 -- a goal L&I has already met -- and to injured workers statewide by December 2015.

Stay at Work: Through this new program, State Fund employers who provide light-duty or transitional work that allows an injured worker to "Stay at Work" while recovering from an injury can be reimbursed for half of the worker's wages and for the cost of instruction, tools, and clothing the worker needs to do the transitional job. The program took effect June 15, 2011. As of April 30, 2013:

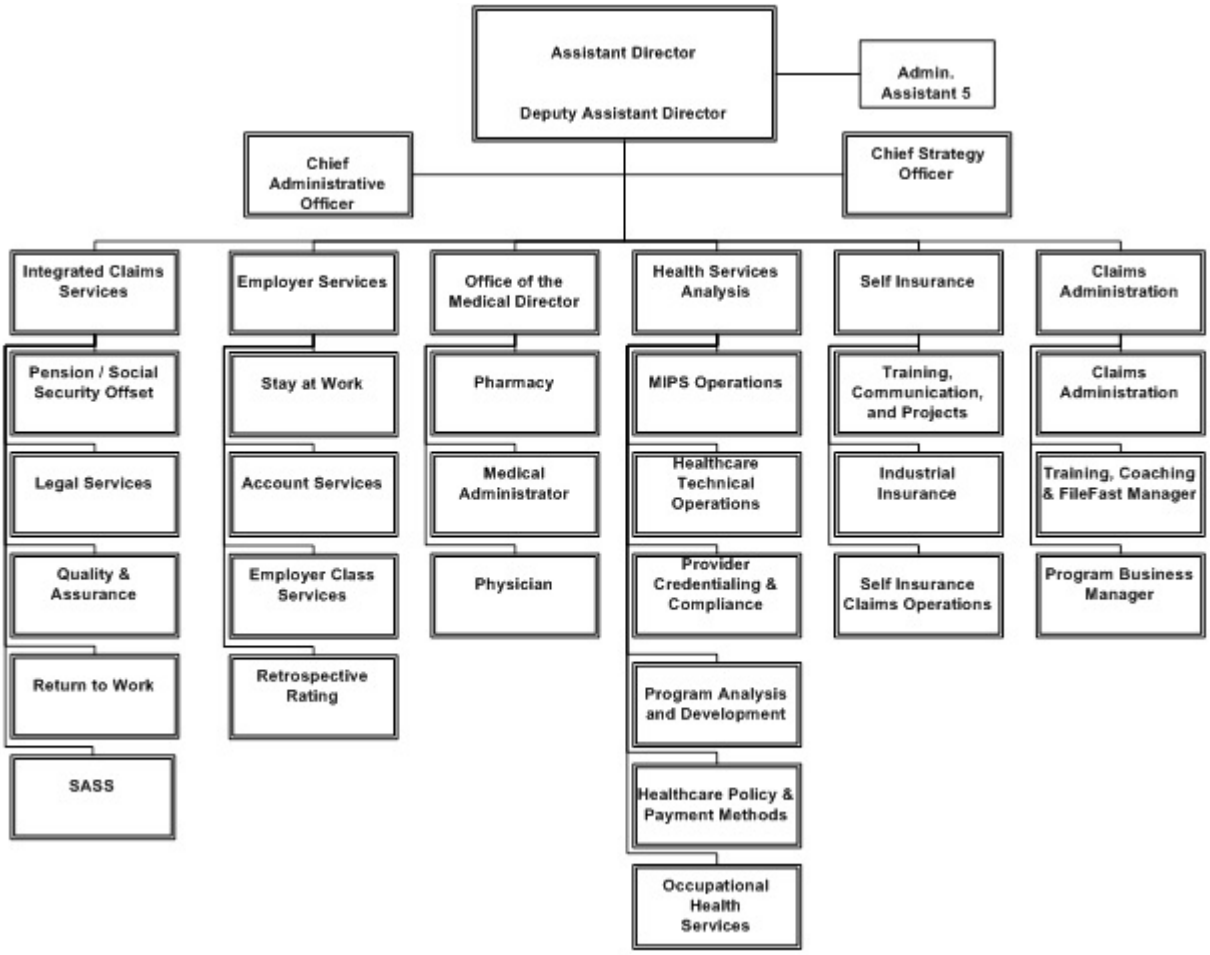
- Reimbursements paid on 6,302 claims (injured workers)
- 1,898 employers have participated
- $12.36M in reimbursements
- Approximately 137,200 time-loss days saved

Retrospective Rating (Retro) Program: Retro is a voluntary financial incentive program for State Fund employers. Participants earn a refund of a portion of their premiums if they reduce workplace injuries and lower claim costs. Participants also face the risk of additional premium assessments if they do not control their claim losses. 7% (12,000) of State Fund employers are enrolled in Retro and they account for nearly 50% of all premiums collected. Retro includes 45 groups or trade associations, representing 11,800 member accounts. An additional 181 accounts are enrolled individually.

Since 1981, the program has refunded over $2.3B in premiums to Retro employers.
In the most recent three calendar years, the Department has refunded:

- 2012: $139M
- 2011: $102M
- 2010: $114M

Workers' Compensation Division Organization Chart



West Virginia

West Virginia Offices of the Insurance Commissioner

1124 Smith St. 1124

PO Box 50540

Charleston, West Virginia 25305-0540

(304) 558-3386 or (888) TRY-WVIC

http://www.wvinsurance.gov/

Agency

General Information

In 2005, West Virginia signed into law a bill which privatized the state's WC system. As part of this bill, the Workers' Compensation Commission was transformed into a private mutual insurance company effective 01/01/2006. Workers' compensation benefit levels are still determined by the state and the state can still review claims decisions. However, the new mutual insurance company (Brick Street Mutual Insurance) took over the rest of the state's WC functions for claims involving injuries 07/01/2005 or later. In 2008, Brick Street was the state's only private carrier for regular WC claims through 06/2008. Effective 07/2008 other private insurance carriers are also allowed.

The West Virginia Offices of the Insurance Commissioner (OIC) oversees workers' compensation in the state. The Industrial Council was created within the Offices of the Insurance Commissioner by Senate Bill 1004 (WV Code §23-2C-5). In consultation with the Insurance Commissioner, the Industrial Council has been charged with establishing guidelines and policies designed to ensure the effective administration of the workers' compensation insurance market in West Virginia.

1. The Industrial Council shall:

   a. In consultation with the Insurance Commissioner, establish guidelines and policies designed to ensure the effective administration of the workers' compensation insurance market in West Virginia;
   b. Review and approve, reject or modify rules that are proposed by the Insurance Commissioner for operation and regulation of the workers' compensation insurance market before the rules are filed with the Secretary of State. The rules adopted by Industrial Council are not subject to sections nine through sixteen, inclusive chapter twenty-nine-a of the WV Code;
   c. In accordance with the laws and rules of West Virginia, establish and monitor performance standards and measurements to ensure the timeliness and accuracy of activities performed under Chapter twenty-three of the WV Code and applicable rules;
   d. Submit for approval by the Legislature, as an isolated and early discernable component of the Insurance Commissioner's budget, a budget for the sufficient administrative resources and funding requirements necessary for their duties.
   e. Perform all record and information gathering functions necessary to carry out its duties.
   f. Every two years, conduct an overview of the safety initiatives currently being utilized or which could be utilized in the workers' compensation insurance market and report said finding to the joint committee on government and finance. Each private carrier and self-insurance employee shall provide to the council, upon request, any information, statistics or data in its records requested by the council in performance of these duties.
   g. Perform all other duties as specifically provided in this chapter for the Industrial Council and those duties incidental thereto.
   h. Establish a method of indexing claims of injured workers that will make information concerning the injured workers of one insurer available to other insurers.

Mission Statement

The Offices of the Insurance Commissioner's mission is to ensure that a healthy, competitive insurance industry be accessible to all West Virginians. The Insurance Commissioner's primary goal is to make certain that the insurance industry in West Virginia provides excellent service to consumers. In addition, increase the number of quality insurance companies offering products throughout the state.

Legislative and Regulatory Links

West Virginia Workers' Compensation Rules Index: http://www.wvinsurance.gov/PolicyLegislation/WorkersCompRules.aspx

West Virginia Code: http://www.legis.state.wv.us/WVCODE/code.cfm?chap=23&art=1http://www.legis.state.wv.us/WVCODE/code.cfm?chap=23&art=1

Funds

Uninsured Employers Fund

W. Va. Code §23-2C-8 governs the administration of the Uninsured Employers' Fund. The Claims Services division provides oversight for this fund. This fund was established in order to provide a safety net for workers who are injured while working for an illegally operating employer. Once a claim is accepted into the Fund, the employer is responsible for reimbursement to the fund for all monies paid on their behalf.

Old Fund for the Offices of the Insurance Commissioner (OIC)

The "Old Fund" is the state's claims liability after the privatization of workers' compensation; otherwise, known as the legacy claims. The Claims Services Division provides the oversight for this fund. West Virginia has three third-party administrators (TPAs) administering the claims on the State's behalf. The TPAs under contract are: Sedgwick CMS, which has the largest portion of the old fund trauma claims; Wells Fargo Disability Management, which has the majority of State Occupational Pneumoconiosis (OP) claims; and American Mining Insurance Group that has the majority of Federal Black Lung (FBL) claims.

Insurance Requirements and Resources

General Information

West Virginia Workers' Compensation Rules: **§85-8-1**

Every employer is required to obtain West Virginia workers' compensation coverage for the protection of its employees.

An employer who is otherwise required to maintain mandatory West Virginia workers' compensation coverage is exempt from the requirement in the following circumstances:

a. An employer of domestic services as defined in subsection 3.3 of this rule is not required to carry West Virginia workers' compensation coverage for any individuals hired to perform such domestic services;
b. An employer of five (5) or fewer full-time employees in agricultural services is not required to carry West Virginia workers' compensation coverage for those employees;
c. An employer who is a casual employer;
d. An employer who is a church;
e. An employer who is engaged in organized professional sports activities, including an employer of trainers and jockeys engaged in thoroughbred horse racing: *Provided*, That the employer must carry coverage for its employees who are not participating in the organized professional sports activities. For example, an employer of jockeys and trainers engaged in thoroughbred horseracing may exempt such jockeys and trainers, but if the same employer also employs a driver to transport horses and equipment, the driver must be provided coverage;

f. A volunteer rescue squad or volunteer police auxiliary unit organized under the auspices of a county commission, municipality or other government entity or political subdivision, or a volunteer organization created or sponsored by a government entity, political subdivisions or an area or regional emergency medical service board of directors in furtherance of the purposes of the emergency medical services act of article four-c [§§16-4C-1 et seq.], chapter sixteen of this code: *Provided*, That if any such employers have paid employees, they must provide West Virginia workers' compensation for such paid employees; or

g. An employer of employees who are provided coverage for benefits under the federal Long shore and Harbor Workers' Compensation Act, 33 U. S. C. §901, et seq., is exempt from having to carry West Virginia workers' compensation coverage for such employees, but must provide West Virginia workers' compensation coverage for employees who are not provided coverage for benefits under the federal Long shore and Harbor Workers' Compensation Act.

Self-Insurance

The mission of the Self-Insurance Program is to provide self-insurance as an option for qualified employers operating in West Virginia. The Self-Insurance Unit was developed to administer the Self-Insurance Program and to assist current self-insured employers, employers desiring to apply for self-insurance status, and those individuals seeking program information.

§85-18-1.

4.1. Self-insurance status. An employer may become self-insured if the Commissioner, with the approval of the Industrial Council, determines the employer meets the financial responsibility and procedural requirements set forth in W. Va. Code §23-2-9, and in this rule.

4.2. An employer owned by another business may have its self-insured workers' compensation risks guaranteed by a parent, if the relationship between the employer and parent is adequately documented, as determined by the Commissioner, and if the parent can satisfy the financial responsibility requirements set forth in W. Va. Code §23-2-9 and this rule

4.3. Any employer granted the privilege of self-insured status shall give security or bond in the form, of the type, and in the amount required by the Commissioner, with the approval of the Industrial Council, pursuant to W. Va. Code §23-2-9 and this rule. Additionally, any employer granted the privilege of self-insured status shall abide by the requirements for maintaining, modifying, or terminating the self-insured status, as set forth in W. Va. Code §23-2-9 and this rule.

Penalties for not Insuring

In accordance with W. Va. Code St. R. §85-2-6.2, the OIC may assess self-insured employers or private carriers a penalty of up to $500 per occurrence for failure to timely report claims information to the OIC.

Reporting Requirements

First Report of Injury

The claimant's employer shall report to the private carrier every injury sustained by any person in its employ within five (5) days of the employer's receipt of the notice of an employee's desire to file a claim.

Additional Reports/Claims Processing and Monitoring

Additional Reports (Mandatory)
The third party administrators provide a variety of reports for the Claims Services Division to monitor activity. Examples: Total Reserves, Subrogation, Claims Closings, Settlements, etc.

In addition, the Claims Services Division conducts monthly quality assurance reviews, quarterly large loss claims staffing and on-site semi-annual best claims practice reviews to maintain efficiency and compliance amongst the multiple accounts.

EDI Standards

EDI mandated FROI and SROI reporting was initially implemented beginning in 2004 when self-insured employers began self-administering claims. The scope of the mandate was expanded in 2008 to include the private carriers selling workers' compensation coverage in West Virginia. West Virginia uses the IAIABC's Claims Release 3.0 Standard.

Contested Claims Handling

Levels in the hearing process:
1. Office of Judges
2. Board of Review
3. WV Supreme Court

Attorneys' Fees

An award of reasonable attorneys' fees and costs actually incurred in reversing an unreasonable denial decision shall be paid by a private carrier or self-insured employer.

Reasonable attorneys' fees incurred in reversing an unreasonable denial of compensability or an initial award of temporary total disability shall be the attorney's fees allowed pursuant to W. Va. Code §23-5-16. Attorney's fees shall be payable only upon the conclusion of all litigation and appeals if the denial decision has been reversed and if the Office of Judges has determined that the denial decision is unreasonable.

Compromise and Release Agreements

Compromise and Settlement agreements are allowed. The claimant and the Insurance Commissioner, other private insurance carriers, or self-insured employer, whichever is applicable, may negotiate a settlement of any and all issues in a claim or claims, except for medical benefits for non-orthopedic occupational disease claims, pursuant to the requirements of W. Va. Code 23-5-7 and the regulations herein set forth. An insured employer is permitted to participate in the settlement of a claim only to the extent that the employer is permitted to do so under the terms of the applicable workers' compensation insurance policy.

Workers' Compensation Rules of the West Virginia Insurance Commissioner: 85-12

Medical Care and Evaluation

Fee Schedule

The fee schedule serves as a "maximum allowable" and is applied to all workers' compensation medical care except for care provided under an OIC approved Managed Health Care Plan (MHCP). The fee schedule in West Virginia covers:

- Ambulatory Surgical Center
- Clinical Labs
- RBRVS-Based Procedures
- HCPCS Level II
- Biological and Injectables
- Anesthesia
- Hospital Inpatient Services
- Hospital Outpatient Serives
- Out-of-State Health Care Services
- Pharmacy Services
- Expert Witness - (Code 99075) See WV 85 CSR Series 1 (§85-1-17)
- Travel Expenses
- Funeral Expense

Visit: http://www.wvinsurance.gov/WorkersCompensation/WCManagedHealthCarePlansFeesschedule/Schedule.aspx

Treatment Guidelines

West Virginia has state specific treatment guidelines that were developed by the Heath Care Advisory Panel.

Treatment guidelines are established in legislative rule 85.20 and became effective January 20, 2006. The guidelines cover: Eyes, Cervical Musculoligamentous Injury (Sprain/Strain), Herniated Cervical Disc, Low Back Spain/Strain, Herniated Lumbar Disc, Lumbar Fusion, Shoulder Injury, Carpal Tunnel, Meniscal Injury, Foot, Ankle, Physical Medicine, Audiological Exams, Multi-disciplinary pain managment, Complex Regional Pain Syndrome, Pneumonconiosis, Long-term Opioid Therapy

To access the guidelines, visit: http://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/wc/c-wc-rule-20.pdf

Managed Care

Managed care organizations are allowed in West Virginia.

§85-21-4. Minimum Plan Standards.
4.1. Employers, managed health care plans acting on their behalf, private carriers, or third party administrators may submit to the Commission, or upon termination of the Commission, the insurance commissioner, a proposed managed health care plan and if approved, can require its injured workers to use health care providers authorized by the managed health care plan for care and treatment of the injured workers' compensable injuries. The Commission, or upon termination of the Commission, the insurance commissioner, retains sole discretion in approving proposed managed health care plans. All managed health care plans submitted for approval shall include the following features:

Choice of Treating Physician

If the carrier or self-insured employer has a managed care program, the claimant must select a physician within that program, unless emergency care is needed.

Rehabilitation

TITLE 85

EXEMPT LEGISLATIVE RULE

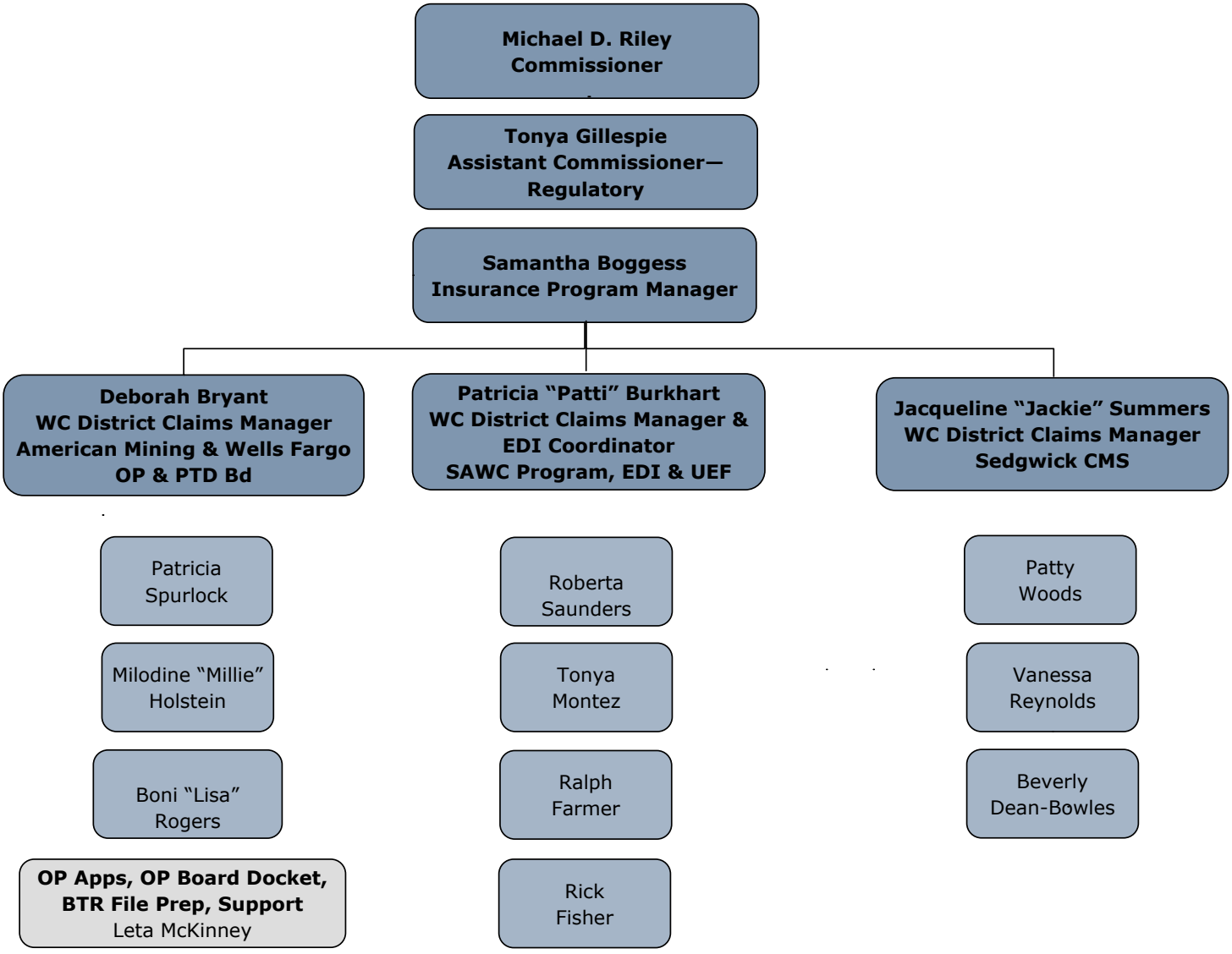
WORKERS' COMPENSATION RULES OF THE WEST VIRGINIA INSURANCE

COMMISSIONER

SERIES 15

VOCATIONAL AND PHYSICAL REHABILITATION
http://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/wc/c-wc-rule-15.pdf

OIC — CLAIMS SERVICES (WC)



Effective 12/01/12

Wisconsin

Wisconsin Workers' Compensation Division

201 East Washington Avenue
Madison, Wisconson 53703
(608) 266-1340 or (866) 265-3142
http://dwd.wisconsin.gov/wc/

Agency

General Information

The Worker's Compensation Division (WCD) is part of the Wisconsin Department of Workforce Development (DWD). Responsibility for administration of the worker's compensation program is vested in an administrator who reports to the secretary.

Functions of the WCD include:

- Claims analysis, monitoring and adjudication
- Assessing penalties for late payments or late reporting
- Enforcing compliance with the requirements for insurance and self-insurance
- Educating the public
- Managing and retaining records

Mission Statement

DWD: Advancing Wisconsin's economy and business climate by empowering and supporting the workforce.

WCD: To effectively and efficiently:

1. Promote healthy, safe work environments
2. Maintain a balanced system of services
3. Ensure compliance with the provisions of the Wisconsin Worker's Compensation Act

Legislative and Regulatory Links

Wisconsin Worker's Compensation Act: http://dwd.wisconsin.gov/dwd/publications/wc/WKC-1-P.htm

Other Wisconsin Legal Documents: http://dwd.wisconsin.gov/wc/legal/

Budget and Financing

Agency Funding Source

Each insurer and self-insured employer is assessed based on the indemnity paid for claims first closed in the previous calendar year. The assessment for each insurer and self-insured employer is determined by multiplying its previous calendar year "first closed" claims' total indemnity payments by a rate determined by the department (s. 102.75 Wis. Stats.).

Operating Budget and Staff Size

The WCD 2013 operating budget is $12.5 million and the staff size is 103 full time employees.

Funds

Work Injury Supplemental Benefit Fund (WISBF)

The WISBF is administer by the WCD and financed by payments assessed against the insurer or self-insured employer of $20,000 for an injury to a worker resulting in the loss of a hand, arm, foot, leg, or eye; $20,000 for a fatality; and, all the death benefits due in no-dependency cases. There are four funds under the WISBF.

Second Injury Fund: Section 102.59, Wis. Stats.

Under the Second Injury Fund the WISBF covers any permanent disability for at least 200 weeks where at the time of injury there was a pre-existing permanent disability for at least 200 weeks. It is not required that the employer is notified of the pre-existing condition prior to injury.

The employer pays for benefits for a permanent disability caused by the second injury, and the Fund pays additional compensation equal to an amount which was paid for the second injury or would have been paid for the first injury, whichever is less.

Children's Fund: Section 102.49, Wis. States.

Under the Children's Fund the WISBF pays for benefits for the support of minor dependent children of employees who died as a result of a work related injury. Payments begin after the primary death benefit is paid, and they are payable in support of each child in the amount of 10% of the primary death benefit. Payments continue until the child reaches the age of 18. If the child is physically or mentally incapacitated, however, the payments may be continued beyond the 18th birthday, but they may not continue for more than a total of 15 years.

Barred Claims Fund: Section 102.66, Wis. Stats.

Under the Barred Claims Fund the WISBF pays compensation to individuals who sustain occupational injuries or disease which are meritorious but otherwise barred by the statute of limitations.

Supplemental Benefits: Section 102.44, Wis. Stats.

Under the Supplemental Benefits Fund the WISBF provides for additional benefits for older claims whereby the injured worker has been on continuous temporary total disability, or is permanently and totally disabled.

Uninsured Employers Fund

The Uninsured Employers Fund (UEF) pays worker's compensation benefits on valid worker's compensation claims filed by employees who are injured while working for illegally uninsured Wisconsin employers. When a compensable claim is filed, the UEF pays the injured employee worker's compensation benefits as if the uninsured employer had been insured.

The UEF is funded through penalties assessed against employers for illegally operating a business without worker's compensation insurance. The penalties are mandatory and non-negotiable. In addition, the department pursues reimbursement from each uninsured employer of benefit payments made by the UEF under s. 102.81(1), Wis. Stats., to the employee of that uninsured employer or to the employee's dependents. The UEF uses aggressive collection action (including warrants, levies, garnishment and execution against property) to secure satisfaction of penalty assessments and reimbursement of claims paid by the fund.

The UEF applies only to injuries occurring on or after July 1, 1996. Uninsured Employers Fund claims filed for injuries occurring prior to July 1, 1996 are not valid and will be denied.

Insurance Requirements and Resources

General Information

Wisconsin employers that meet specific requirements are required to carry worker's compensation insurance unless they qualify for Self-Insured status. Employers receive the assurance they will not be sued for damages, medical care and lost wages if their employees get injured while working.

If employees get hurt on the job, employers can direct them to their insurance company's worker's compensation system for quality medical and prompt payment of benefits and an early return to work.

For more information on Wisconsin insurance coverage requirements by type of business, visit: http://dwd.wisconsin.gov/wc/employers/

Private Insurance

The Wisconsin Office of the Commissioner of Insurance (OCI) and the Wisconsin Compensation Rating Bureau (WCRB) both have regulatory authority over worker's compensation insurance carriers and monitor their performance. While OCI issues licenses, disciplines carriers, and oversees other regulatory performance, WCRB recommends rates to OCI and maintains worker's compensation policy data.

Wisconsin Office of the Commissioner of Insurance
125 South Webster Street
Madison, Wisconsin 53703
(608) 266-3585
http://oci.wi.gov/

Wisconsin Compensation Rating Bureau (WCRB)
20700 Swenson Drive, #100
Waukesha, WI 53186
(262) 796-4540
https://www.wcrb.org/wcrb/wcrbhome.htm

Self-Insurance

The WCD has regulatory authority over self-insurance for the purpose of worker's compensation.

The State and its political subdivisions may self-insure without further order of the DWD if they do not carry a policy covering all or part of their risks, and if they agree to report faithfully all compensable injuries and agree to comply with the Worker's Compensation Act and rules of DWD and WCD .

1. An employer desiring an exemption from the duty to insure must file an application on Department form WKC-7211, which may result in a hearing before the Self-Insurers Council.
2. Corporations, limited liability companies, and limited partnerships shall be registered in the office of the Wisconsin Department of Financial Institutions.
3. If the applicant is a corporation, limited liability company, or a partnership and is a wholly or majority owned subsidiary, a guaranty of worker's compensation payments must be submitted on a DWD form, executed by the ultimate or top parent company, and be accompanied by a certified copy of a resolution adopted by the board of directors of the top parent company, authorizing and directing the execution of the guaranty.

4. Applications by corporations must be accompanied by a certified copy of the resolution adopted by the applicant's board of directors authorizing and directing the execution of the application and agreement forms. Applications by organizations other than corporations shall be signed by one or more persons possessing authority to act for the applicant. Partnerships must submit a consent by all the partners that all individuals executing the application have the authority to act for the applicant partnership.
5. All applicants, when submitting an initial request for self-insurance, shall submit audited financial statements (which include the opinion of a certified public accountant) for a minimum of the latest five years. To remain self-insured, unaudited quarterly and audited annual financial statements must be submitted as soon as they become available. Companies which submit Form 10Q to the SEC electronically need not send quarterly reports to DWD, but must send the annual report to shareholders.
6. It is recommended that the employer employ persons located in Wisconsin with knowledge of claims administration under the Wisconsin's Worker's Compensation Act and Administrative Code, as well as knowledge of occupational safety and health. The persons may be employees of the applicant, its parent company, a subsidiary company, or a service company hired by the employer and acceptable to DWD.
7. The employer must have acceptable safety and health performance as measured by worker's compensation statistics and other occupational injury and illness information, including, but not limited to, the employer's federal Occupational Safety and Health Administration (OSHA) compliance and their experience modification factors for the past few years.
8. The employer shall furnish satisfactory security (guaranty bond and excess worker's compensation insurance), financial reports and reports on outstanding liabilities before and after self-insurance is granted, not renewed, terminated or revoked, as the Department requires to assure the payment of all past, present, existing and potential worker's compensation liability.

   * Security:
   The minimum amount is $500,000. The amount may be greater based upon the analysis of each employer's financial capacity, and upon the likelihood and severity of injury or disease within the employer's occupational classifications.

   * Excess insurance:
   Excess insurance policies must be procured from a worker's compensation insurance carrier licensed by the Wisconsin Commissioner of Insurance to write worker's compensation insurance in Wisconsin, and must be written upon the basis of rates and policy form filed with and approved by the Wisconsin Compensation Rating Bureau, P.O. Box 3080, Milwaukee, Wisconsin 53201-3080. (Phone: (262) 796-4540) An actual copy of the excess policy must be on file with the Bureau. Again, excess insurance retention and upper limit of indemnity amounts are based upon the individual analysis of each employer's ability to withstand catastrophe. Any contract between an unauthorized carrier and a self-insurer must be reported to the Department immediately upon inception of the agreement.

Penalties for not Insuring

Wisconsin enforces mandatory penalties if an employer does not obtain and maintain a worker's compensation insurance policy when required to have one. If an employer does not comply, they risk one or all of the following:

- A penalty of double the insurance premiums that should have been paid during the uninsured period, or $750, whichever is greater. Under certain circumstances, the employer may be subject to a penalty of $100 for each day that it is uninsured, up to 7 days. (ss. 102.82(2)(a) and 102.82(2)(ag), Wis. Stats.)
- Closure of the business, including a suspension of all operations. (s. 102.28(4), Wis. Stats.)
- Liability for uninsured benefit claims for which the injured employees are eligible.

  (s. 102.28(5), Wis. Stats.)

Number of penalties assessed in FY2012: 1,755.
Dollar amount of penalties assessed in FY2012: $5.3 million.

Reporting Requirements

First Report of Injury

The first report of injury form is for the employer to report every work-related injury to its insurance company. If an employee is out more than 3 days due to a work related injury, or there is PPD, a copy is to be sent to the WCD by the employer's worker's compensation insurance carrier, not by the employer (unless the claim is a fatality). Except for fatalities, the information on this form must be sent electronically by the employer's worker's compensation carrier to the WCD.

Fatal Injuries: Employers subject to Chapter 102, Wis. Stats., must report injuries resulting in death to the WCD and to their insurance carrier, if insured, within one day after the death of the employee.

Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. The insurance carrier must then report the lost time claim to the WCD within 14 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the WCD.

Other Reports/Claims Processing and Monitoring

Other required reports:

- First and final payment reports
- Wage reports
- Temporary partial disability reports
- Medical reports

Complete reporting requirements can be found in DWD 80.02 of the Wisconsin Administrative Code: http://dwd.wisconsin.gov/dwd/publications/wc/WKC_1_P_11/5%20DWD_80.pdf

For compensable claims, the WCD monitors and enforces initial payment and accuracy of total payment requirements for both insurance carriers and self-insured employers. Penalties are assessed for late payments, failure to make payments, untimely reports, or falsifying reports.

PPD and PTD ratings are determined by application of statute and medical reports. The

WCD completes the disability rating and notifies the insurer of the rates. A dispute resolution specialist makes the final PPD rating based upon the attending physician's impairment rating and the use of WCD's rating guide.

EDI Standards

Wisconsin uses the standard International Association of Industrial Accident Boards & Commissions (IAIABC) formats for First Report of Injury Release 1 (148, FROI, WKC-12, etc.) and Subsequent Report Release 1A (A49, WKC-13, etc.).

The WCD currently accepts the First Report of Injury and the Subsequent Report of Injury via the EDI 148 and A49 transmissions. For the 148 First Report of Injury all of the Maintenance Type Codes except the AU (Acquired Claims) are accepted. For the A49 Subsequent Report of Injury the IP (Initial Payment), FN (Final), and S1 (Suspension) are accepted. Medical reports or wage information are not accepted via EDI. Medical reports must be sent to the WCD via paper and wage information must be sent to the WCD using the Internet WKC-13A on the WCD's pending reports website. All claim information for fatalities, Perm Totals or litigated claims must be sent to the WCD via paper.

Contested Case Handling

Appeals Process

Formal hearings are held with an ALJ. These are semi-judicial proceedings. Witnesses are sworn in before testifying as in a court room. The parties have a right to present their own witnesses and cross-examine witnesses presented by other parties. Exhibits of documents and reports are entered into the formal hearing record. A court reporter records all testimony. Hearings generally result in payment of some or all of a claim or dismissal of the application.

The ALJ will gather all the facts at the hearing. After the hearing the ALJ will issue an order (decision) that either allows or denies the claim. If the claim is allowed, an order will be issued stating the amount of disability and how much compensation and/or medical expense is to be paid.

Any party has the right to appeal an ALJ order. If a party wishes to appeal an order, a Petition for Commission Review (WKC-28) must be filed within 21 days of the mailing date of the ALJ order. On this form the appealing party states the points of disagreement with the order. The Labor Industry Review Commission (LIRC) will review the hearing record. LIRC can affirm, set aside or modify the ALJ order. All parties will receive a copy of the LIRC decision. Any party may also appeal the LIRC decision to the Circuit Court, Court of Appeals and, ultimately, the Wisconsin Supreme Court.

	Notes or Comments on Scope	*Number in FY2012*
Hearing before an ALJ		641
Commission Review (Appeal)		200
WI Circuit Court		25
WI Court of Appeals		12
WI Supreme Court		2

Attorneys' Fees

The WCD approves and regulates attorney fees. Attorney fees can be awarded up to 20% of any compensation which is in dispute. If compensation paid is not in dispute, fees of 10%, up to a $250 maximum, can be awarded. All fees are paid from the claimant's awards.

Compromise and Release Agreements

Compromise and release agreements are allowed if approved by an ALJ. These agreements terminate indemnity and health care benefits. The WCD has discretion to review an agreement if a petition to reopen is filed within a year after approval. A claim can be reopened if there is fraud, further developments, or inequity.

Medical Care and Evaluation

Fee Schedule

The WCD does have authority to set reimbursement rates for medical and hospital fees. Fees are set according to certified private vendor data bases. If a provider submits a medical or hospital fee dispute, the WCD will determine whether the insurer has properly reduced the fee charge.

Treatment Guidelines

Wisconsin has state specific treatment guidelines for worker's compensation that are established under chapter DWD 81 of the Wisconsin Administrative Code.

These guidelines cover:

- Medical Imaging
- Low Back Pain
- Neck Pain
- Thoracic Back Pain
- Upper Extremity Disorder
- Complex Regional Pain Syndrome of Upper and Lower Extremities
- Inpatient hospitalization
- Surgical procedures
- Chronic management

WI treatment guidelines can be found at: http://dwd.wisconsin.gov/wc/medical/DWD81.pdf

Managed Care

Managed care organizations are authorized providers, but employers may not require an injured worker to use those providers.

Choice of Treating Physician

The employee is allowed one change of the treating physician with notification to the insurer. Any subsequent changes require prior approval by the insurer.

Rehabilitation

General Information

If an injured worker is unable to return to previous employment because of a permanent disability or restriction, he or she may be eligible for vocational rehabilitation services which may include job placement assistance or retraining.

To be eligible for vocational rehabilitation services an employee must:

- Have a compensable work related injury for which vocational rehabilitation benefits have not been settled through a compromise agreement

- Submit to the employer at time of injury documentation of work restrictions so that the employer may determine if work is available within permanent restrictions and make an offer of "suitable" employment. Within 60 days the employer should determine if work is available.
    - NOTE: A "suitable" position is one that pays at least 90% of the wage at time of injury and meets the permanent work restrictions established at the end of the healing period.
- Be unemployed or employed in a less than "suitable" position
- Have a determination of eligibility for vocational services by the Division of Vocational Rehabilitation (DVR)

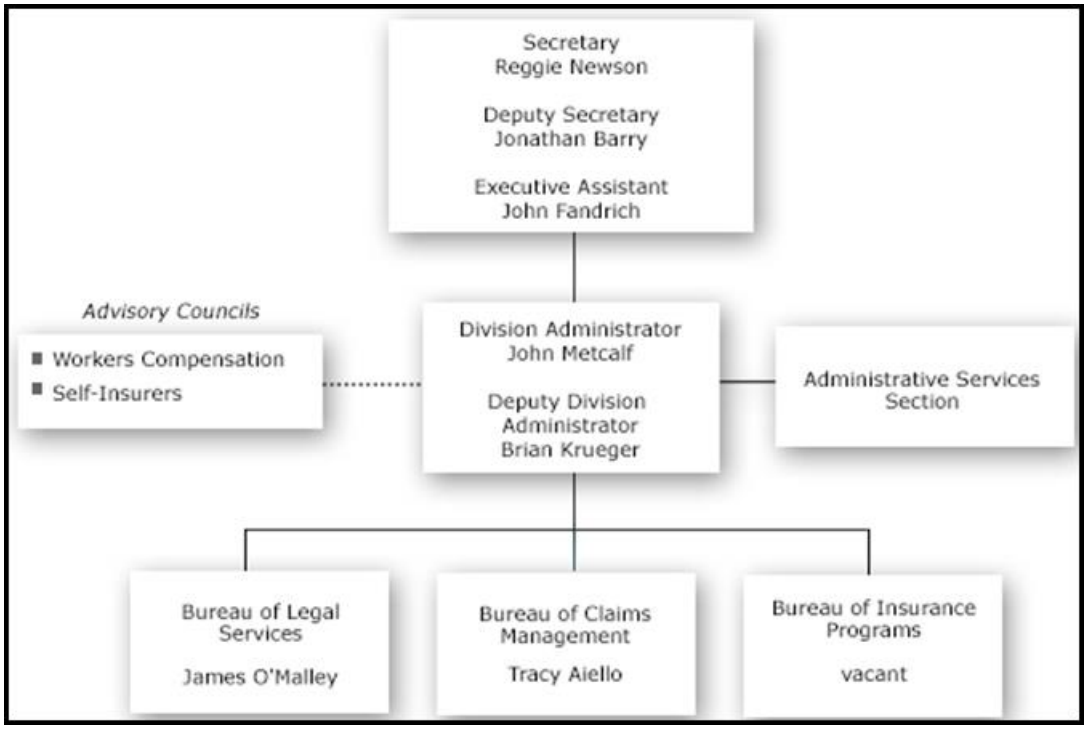
Injured workers will receive vocational rehabilitation services from either a public or private vocational rehabilitation program. DVR is a public program and will provide services if the disability is very severe and is consistent with the order in which it is providing services. If DVR cannot provide the needed services, an injured worker will be served within a private vocational rehabilitation network.

If there is no dispute regarding the need for vocational rehabilitation (retraining), the insurer or self-insured employer is responsible for paying the weekly TTD benefit for each week of rehabilitation. The insurer or self-insured employer is also required to reimburse mileage for travel to and from rehab, and to provide a meal allowance.

If DVR provides any financial aid or any other services [e.g., developing and writing the Individualized Plan for Employment (IPE)], the insurer or self-insured employer is not required to pay or to contribute any monies toward the cost of tuition, books, fees, etc.

If vocational services are provided by a private vocational specialist, the insurer or self-insured employer is responsible for paying the specialist's fee and the cost of tuition, books, fees and other expenses related to the retraining program.

Workers' Compensation Division Organization Chart



NOTE: The Bureau of Insurance Programs Director position is no longer vacant; it is headed by Joseph Moreth

Wyoming

Wyoming Workers' Compensation Division

1510 East Pershing Boulevard, South Door, 2nd Floor

Cheyenne, Wyoming 82002

(307) 777-6763

http://wyomingworkforce.org/employers-and-businesses/workers-compensation/Pages/default.aspx

Agency

General Information

The Workers' Compensation Division (WCD) is responsible for administering the Workers' Compensation Program, collecting workers' compensation premiums and providing medical, wage and disability benefits to workers injured on-the-job in a covered occupation. WCD resides within the Office of Workforce Safety and Compliance.

The responsibility for administration of workers' compensation and OSHA is vested in a single administrator. WDC offers:

- Administrative and Fiscal Services
- Business Analyst Services
- Case Support Services
- Claims
- Internal Audit and Compliance Services
- Access to the Medical Commission
- Settlement Services
- Training Services

Legislative and Regulatory Links

Wyoming Labor Statute and Rules: http://wyomingworkforce.org/tools-and-resources/Pages/statutes-and-rules.aspx

Budget and Financing

Agency Funding Source

The WSCD's operating budget is appropriated by the legislature and approved by the Governor. Operating funds come from an employer premium tax.

Funds

Second Injury Fund

There is no second injury fund in Wyoming.

Insurance Requirements and Resources

General Information

Wyoming is a monopolistic fund. The state fund is the only source of workers compensation insurance coverage available.

Private Insurance
Private insurance is not allowed in Wyoming.

Self-Insurance
Self-insurance is not allowed in Wyoming.

Penalties for Not Insuring
An employer who does not provide workers' compensation coverage shall be enjoined in an action from engaging or continuing in business until required payments are made and the employer complies with the workers' compensation law.

Reporting Requirements

First Report of Injury
The filing of the first report of injury to WCD is mandatory for all injuries and is due within 10 days after the injury becomes apparent. Penalties are assessed for failure to file first reports.

Additional Reports/Claims Processing and Monitoring
It is also mandatory to file medical documentation with WCD. WCD monitors for initial payment, periodic payments, last payment, and promptness of payment.

In order to terminate temporary total disability benefits, a worker must qualify for permanent partial or permanent total disability benefits or restoration of earning power or gainful employment.

The final administrative decision for determining a claimant's permanent partial disability rating is made by WCD, unless the decision is contested. If contested, the Office of Administrative Hearing or the Medical Commission makes the final decision. Factors for determining the disability rating include:

- Impairment rating of attending physician
- Employee's loss of wage earning capability
- Criteria set forth by the courts
- Employee factors such as age, education, training, etc.
- Use of the AMA Guide to Physical Impairment.

EDI Standards
Wyoming does not use EDI.

Contested Case Handling

Levels in the hearing process

1. WCD determination (administrative)
2. Evidentiary hearing by the Office of Administrative Hearings or the Medical Commission
3. Review by the District Court
4. Appeal to the Supreme Court

Compromise and Release Agreements

Stipulations are allowed and in contested matters need to be approved by the OAH and Medical Commission. These agreements may terminate indemnity and medical benefits. A claim may be reopened if there is proof or duress or incompetence.

Medical Care and Evaluation

Fee Schedule

WCD has the authority to set medical and hospital fees. Published fee schedules are available for medical, hospital, chiropractic, psychological, radiology, anesthesia, orthotics/prosthetics, drugs, and physical therapy.

http://soswy.state.wy.us/Rules/RULES/8192.pdf

Treatment Guidelines

Wyoming Department of Workforce Services, Division of Workers' Compensation has adopted Work Loss Data Institute's Official Disability Guidelines (ODG) to provide decision support for evidence-based medical and return-to-work management for workers' compensation claims.

Choice of Treating Physician

A change of physician may be approved by petitioning WCD and giving reasons for the change.

Rehabilitation

General Information

The workers' compensation law allows for options for injured workers to choose a disability award or up to four years of vocational rehabilitation. Vocational rehabilitation is paid for by the employers.