Table of Contents Workers Compensation Examiner Training Manual

Resources used to create this manual:

DWD Website: www.dwd.state.wi.us
DOA Website: www.doa.state.wi.us
Chapter 102; Workers Compensation Act

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What is Workers Compensation?

Workers Compensation covers the medical expenses and lost income of employees if they are hurt in the course of doing work-related activities in accordance with Chapter 102.

Worker's Compensation Brief History

Before 1911, the only recourse to a worker who was injured in the course of his or her employment was to sue his or her employer in a civil or “tort” action, which was the same remedy available to a person injured under other circumstances. The tort remedy, however, had a major problem: it required the worker to prove that the injury occurred because the employer was negligent. In tort actions the employer had three almost unbeatable common law defenses: (1) that the worker was also negligent, (2) that the worker knew of the dangers involved and “assumed the risk,” or (3) that the injury occurred because of the negligence of a “fellow employee.” Under this system it was very difficult for workers to recover against their employers. If they won, however, there were no dollar limits on what a jury could award.

It is noted that after 1905 judges and juries in Wisconsin began returning verdicts more favorable to injured workers. This growing trend in tort litigation began to make employers nervous because they believed that as time went on more and more injured workers would get more and more favorable verdicts. Thus for this reason, among others, many employers became increasingly open to the idea of eliminating tort litigation by adopting some sort of worker’s compensation program.

In 1911, Wisconsin adopted a Workmen’s Compensation Act. This remedy is essentially a “no-fault” system under which a worker no longer has to prove negligence on the part of the employer, and the employer’s three common law defenses are eliminated. The intent of the law was to require an employer to promptly and accurately compensate a worker for any injury suffered on the job, regardless of the existence of any fault or whose it might be. In return, the WC Act limited the amount of money that a worker could recover. Thus, workers are only entitled to (1) certain wage loss benefits, (2) the cost of medical treatment, (3) certain disability payments and (4) payments for vocational rehabilitation retraining. Under the pre-WC Act tort system, workers had been able to recover for pain and suffering, loss of enjoyment of life and other damages that a jury might award. This is no longer possible under the WC Act.

Since 1911 the WC Act has undergone numerous changes and refinements. However, the main values have not only remained intact but have also been strengthened. One of those values is universal coverage. Nearly all employers in Wisconsin are covered, including both public and private employers. The only employee exceptions to the WC Act insurance requirement are domestic servants, some farm employees, volunteers (including volunteers of non-profit organizations that receive money or other things of value totaling not more than $10.00 per week) and religious sect members that qualify and are certified for an exemption. In addition there are a few classes of workers who are covered by federal laws instead of the WC Act.

WHO IS COVERED BY THE WORKER'S COMPENSATION LAW?

All employees working for an employer (other than farmers) with three or more workers are protected immediately by the Worker's Compensation Act. Employers with fewer than three workers come under the law if they pay wages of $500 or more in any quarter of a calendar year. Their workers are covered 10 days after the end of that quarter. Farm workers are covered if the farm employer has six or more employees on 20 or more days in a calendar year.

Nearly all workers in Wisconsin are covered. This includes both public and private employers. Nearly all private and public employees in Wisconsin are covered under the Act, including employees who are family members (except for farmers in some cases), minors, part-time employees and corporate officers.

There are a few classes of workers who are covered by federal laws and are not covered by the Act. Employees of the federal government (such as postal workers, employees at a veteran's administration hospital, or members of the armed forces) are covered by federal laws. People who work on interstate railroads are covered by the Federal Employers Liability Act. Seamen on navigable waters are covered by the Merchant Marine Act of 1920, and people loading and unloading vessels are covered by the Longshoremen’s and Harbor Worker’s Compensation Act.

The only employee exceptions to the Act’s insurance requirement are: (1) domestic servants, (2) any person whose employment is not in the trade, business, profession or occupation of the employer, (3) some farm employees, (4) volunteers, including volunteers of non-profit organizations that receive money or other things of value totaling not more than $10.00 per week, (5) religious sect members that qualify and are certified for an exemption, (6) employees of Native American tribal enterprises (including casinos), unless the tribe elects to waive its sovereign immunity and voluntarily become subject to the Act. Virtually all other workers and employers are subject to the Act

Section 102.03 provides that liability for worker's compensation shall exist under the Act only where the following conditions occur:

1. That the employee sustains an injury

2. At the time of the injury, both the employee and the employer are subject to the provisions of the Act.

3. At the time of the injury, the employee is performing service growing out of and incidental to his or her employment.

4. The employee's injury has not been self inflicted

5. The accident or disease that causes the employee's injury arises out of his/her employment.

6. There must be a hazard specific to the employment present.

***Most important thing to remember: The injury has to arise out of employment and the employee has to be in the course of employment.

Compensable…..or not compensable??

INJURY DEFINED

To become entitled to Worker's Compensation benefits, an employee must sustain an injury defined in section 102.01(2) of the Wisconsin Workers Compensation Act.

Injury defined: "mental or physical harm to an employee caused by accident or disease. Some injuries caused by mental stress without trauma are excluded.

ACCIDENTAL INJURY

An injury is a "fortuitous event, unexpected and unforeseen by the injured person."

OCCUPATIONAL DISEASE

Broadly defined, occupational diseases a mental or physical harm resulting from occupational exposure, but that is not as sudden or traumatic as to fir within the definition of an accident.

Example: 1. Carpal tunnel syndrome as a result of continual typing. 2. Hearing loss as a result of repeated exposure to loud machinery. 3. Cancer as a result of exposure to asbestos.

The date of injury for an occupational disease is the date of disability or, the last day of work for the last employer that caused the disability.

PERSONAL COMFORT DOCTRINE

An employee who is on a coffee break, lunch break, smoke break, going to the washroom, getting a drink of water, or fresh air…. is held not to have deviated from employment if he or she is on the employer's premises. The extent of departure has to be reasonable.

FIGHTS

An employee who deliberately engages in a fight with a co-employee has stepped out of the course of employment**.**

HORSEPLAY

Employees participating in horseplay may still be compensated for injuries depending on the following factors:

1. The extent & seriousness of the deviation
2. The completeness of the deviation (i.e. whether it was …. abandonment of duty.)
3. The extent to which the practice of horseplay had become an accepted part of the employment, and
4. The extent to which the nature of employment may be expected to include some horseplay.

GOING AND COMING

An employee is in the course of employment when going to and coming from his or her employment in the ordinary and usual way WHILE ON THE EMPLOYER'S PREMISES.

PARKING LOT

An employer's designated parking lot has been considered part of the premises.

An employee is considered to be in the course of employment while taking a direct route between and employer's designated parking lot and the premises if he or she is going in the ordinary and usual way. If a direct route is not taken, the employee may be considered not to be in the course of employment, when while he or she is in the parking lot.

TRAVELING EMPLOYEE

An employee whose employment requires travel is deemed to be performing service in the course of employment at all times while on a trip, except when engaged in a deviation for purely private and personal purposed. Acts that are reasonably necessary for living, such as eating, sleeping and reasonable recreation are not regarded as deviations from the employment.

CARPOOLING

An employee who voluntarily participates in a private, group, or employer-sponsored carpool, vanpool, commuter bus service or other rideshare program that has as its sole purpose the mass transportation of employees to and from work is not performing services growing out of and incidental to his or her employment.

IDIOPATHIC FALL

If a fall cannot be causally connected to any hazard or zone of danger associated with work environment, and is due to force solely personal to the employee, it is characterized as idiopathic and does not result in liability. Cement floors and other hard floors are not considered a special hazard of employment.

NONTRAUMATIC MENTAL INJURY

Although non-traumatic mental injury may be clearly work related, worker's compensation liability will only exist if the injury resulted from extraordinary stress…"a situation not greater dimensions: then "the countless emotional strains and differences that employees encounter daily w/o serious mental injury."

INJURIES COVERED BY THE LAW

The worker's compensation law of Wisconsin defines an injury as any mental or physical harm due to workplace accidents or diseases, including accidental damage to artificial limbs, dental appliances and teeth. Injuries covered include:

- **Physical harm** or injury such as bruises, burns, cuts, fractures, crushing injuries, hernias, sprains, strains, stiffness, amputation, loss or paralysis of part of the body, sudden loss of hearing, sudden loss of vision and disfigurement.

- **Mental harm** including nervous disorders, hysteria, and traumatic neurosis. The effects of brain hemorrhage caused by an industrial accident may also result in such harm. If the injury is mental harm or emotional stress without a physical trauma, the injured employee must show that it resulted from a situation of greater dimensions than the day-to-day mental stresses and tensions which all employees' experience.

- **Accidental injury** such as physical or traumatic mental harm occurring suddenly and unexpectedly as a result of some employment-related activity.

- **Occupational disease** is chronic physical or mental harm caused by exposure over a period of time to some employment-related substance, condition or activity. Occupational disease includes loss of hearing and deterioration of bodily functions. Examples of common types of occupational disease are dermatitis (skin trouble), infection, silicosis, tuberculosis, pneumonia, lead poisoning, multiple chemical sensitivity and respiratory disease. In addition, occupational disease includes deterioration of bodily function caused by working conditions over a period of time. For instance, hernias and back trouble caused by repetitive motion or repeated strain over a period of time are considered occupational diseases under the law.

  Occupational Deafness. Benefits are payable if prolonged exposure to noise causes permanent partial or total loss of hearing.

  Eye glasses and hearing aids may be replaced only when a personal injury entitles the employee to medical treatment or payment of worker's compensation benefits. If a pair of glasses drops to the floor, with no personal injury, there is no payment or replacement.

How the State of Wisconsin Provides Workers Compensation Coverage for Injured State Employees

The State Workers Compensation Program is similar to self-insurance by private employers. Worker's compensation benefits are paid directly by the state from general revenue and program revenue sources.

The Bureau of State Risk Management in DOA, the University of Wisconsin System have claim units within, but benefits are paid from one central fund account maintained by DOA. DOA's administrative costs include program management, claims adjusting services, vendor-furnished claims services, and an annual assessment paid to the Department of Workforce Development (DWD).

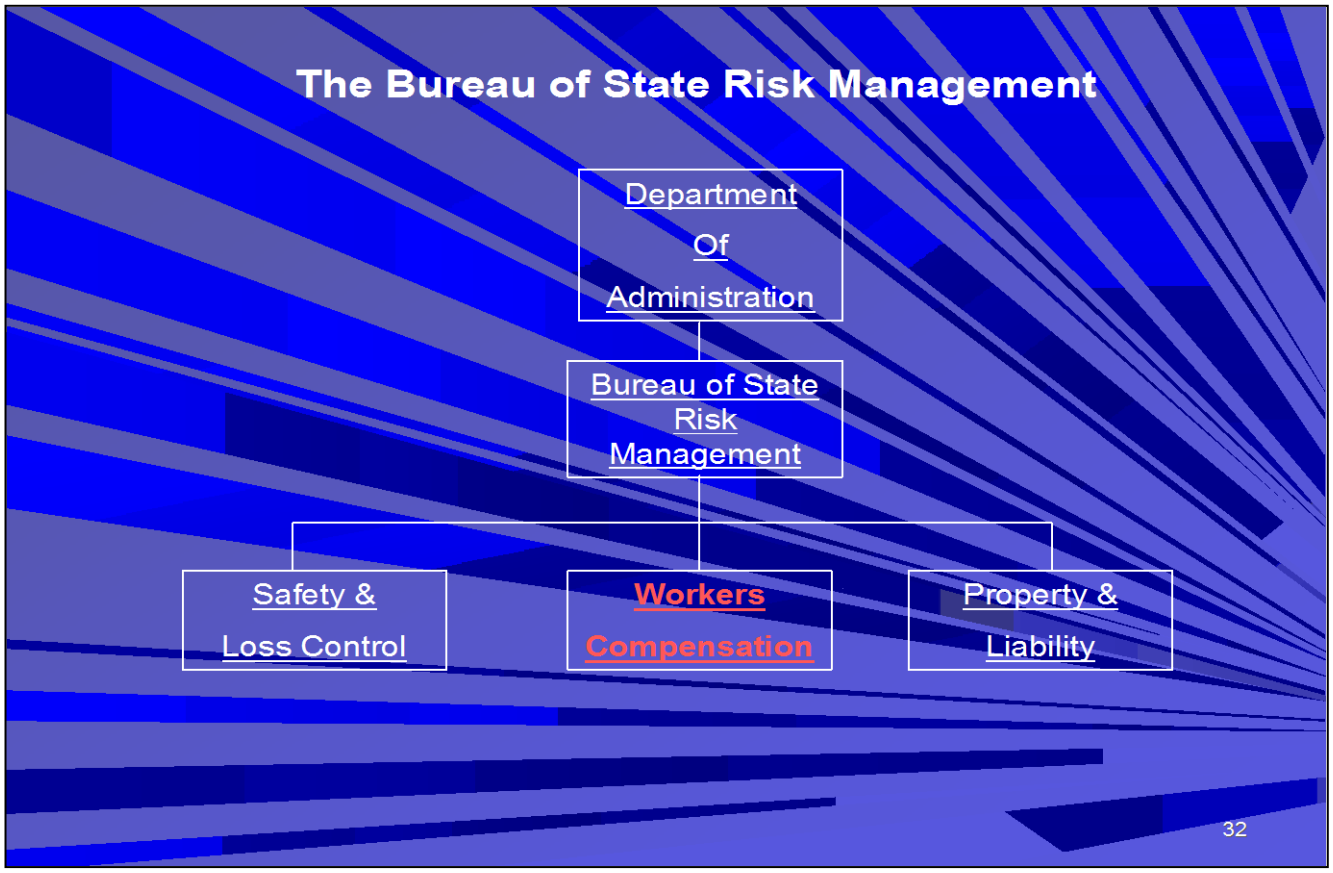
DOA assesses premium annually based on benefits and administrative costs for the prior fiscal year. Assessments are levied against each state agency and the University System. Assessments against the 6 largest agencies (Health & Social Services, Corrections, DOT, UW System, DWD, and Natural Resources) are based on 100% experience. "Experience" means the actual claims costs incurred the previous year. The remaining smaller agencies are assessed premium on the basis of 50% experience and 50% exposure. "Exposure" means the extent of losses that are estimated for the year based on the degree of accident danger present in the different types of employees working for the agency. For example, agencies with many office clerical workers will have less exposure than agencies with many outdoor construction workers. Those agencies with higher exposure will pay a greater share of the premium allocation than those with less exposure. Another reason for this modification is that smaller agencies cannot absorb the costs of catastrophic injuries as easily as larger agencies. Therefore, a percentage of the costs of such an injury will be shared by all agencies.

Statutory Authority

The following section of Chapter 102 allows for the Department of Administration to handle Workers Compensation claims for injured State employees.

102.08 Administration for state employees.

The department of administration has responsibility for the timely delivery of benefits payable under this chapter to employees of the state and their dependents and other functions of the state as an employer under this chapter. The department of administration may delegate this authority to employing departments and agencies and require such reports as it deems necessary to accomplish this purpose. The department of administration or its delegated authorities shall file with the department of workforce development the reports that are required of all employers. The department of workforce development shall monitor the delivery of benefits to state employees and their dependents and shall consult with and advise the department of administration in the manner and at the times necessary to ensure prompt and proper delivery.

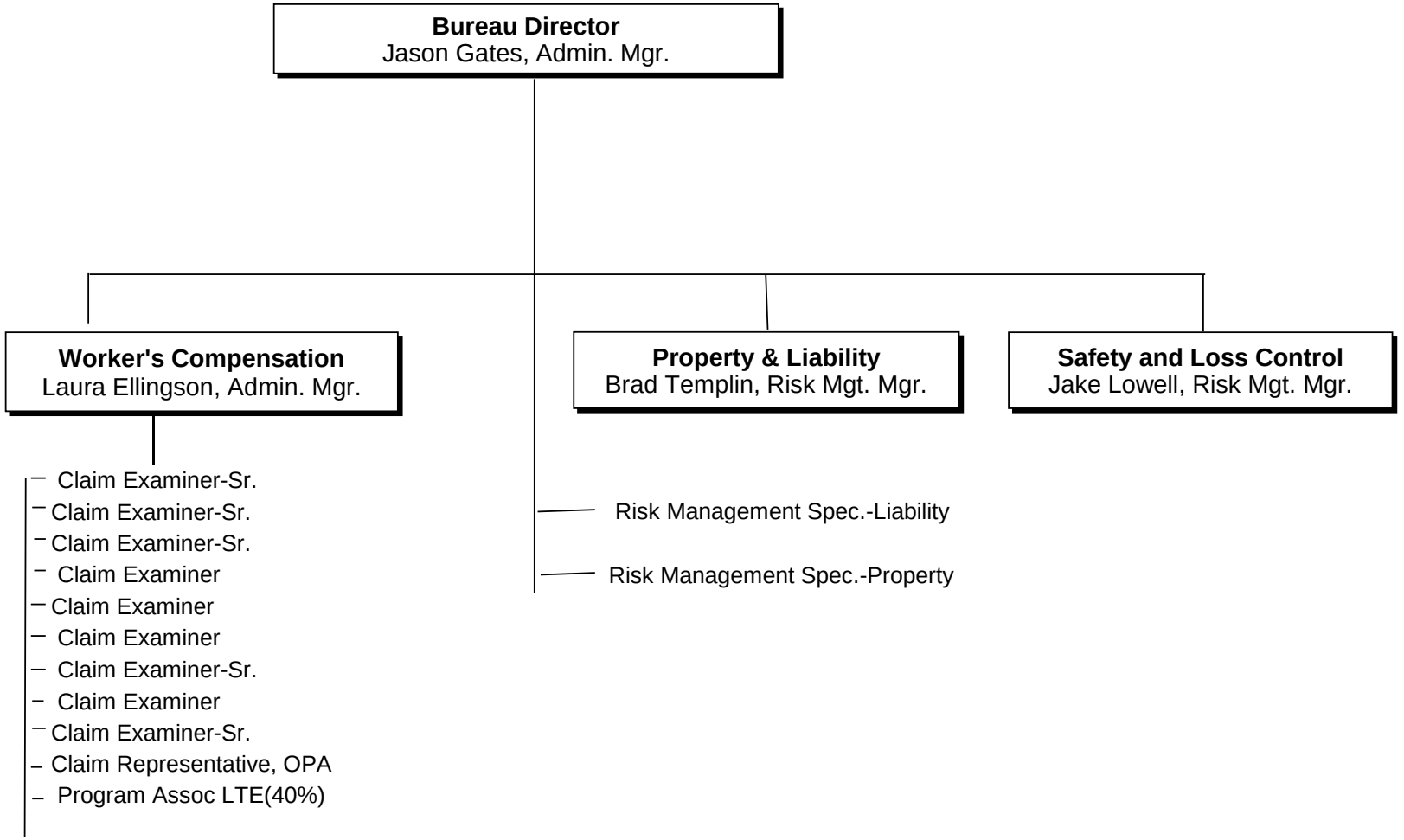


Above is a chart showing the configuration of the Workers Compensation Unit within the State. The Workers Compensation Unit is part of the Bureau of State Risk Management within the Department of Administration.

The Bureau of State Risk Management also houses the Safety and Loss Control Unit and the Property/Liability Unit.

Below is an Organization Chart of the Bureau

DEPARTMENT OF ADMINISTRATION
Division of Enterprise Operations
Bureau of State Risk Management
February 1, 2023



WHAT PROCESS DOES AN INJURED EMPLOYEE FOLLOW WHEN FILING A WORKER'S COMPENSATION CLAIM WHERE THERE IS NO DISPUTE

A major purpose of the worker's compensation law is to ensure prompt and proper payment of claims. Administrative rules hasten the process and protect the parties involved. Under Wisconsin law, the employer or insurance company takes the initiative by paying benefits in non-disputed cases. The division insures that correct payments are made by requiring complete reports from employers, insurance companies and doctors, and by careful examination of the evidence.

Procedure For A Non-disputed Claim

1. The employee gives immediate notice of injury to the employer. Notice must be within two years.

2. When the employee is injured or learns of an occupational disease, he or she gets needed medical attention. The employee sees a doctor as soon as possible and continues treatment as necessary.

3. The employer files reports with its insurance company or internal claims department if self-insured.

4. The employer files a report within seven days after the injury with the insurance carrier or the carrier's administrator. The insurer or its administrator will then file the report by the 14th day with the Division. This report is called "Employer's First Report of Injury or Disease." The employee does not receive a copy of this report.

5. The Division sets up a record of the case and sends the employee an information brochure.

6. The insurance company obtains a medical report on the nature of the injury or disease from the doctor or employer.

7. The most common cause of delay or interruption of compensation payments is lack of medical information from the attending doctors. If an interruption in compensation payment occurs, it is advisable for an injured employee to call the doctor's office to find when the last medical report was sent to the employer or worker's compensation insurer and what was said in that report.

8. The insurance company contacts the employee for details of the accident and the extent of injury or illness. The worker should give a complete statement, particularly of the physical symptoms connected with the disability. If there are any doubts about the statement, the employee need not sign it. The

insurance company must have a certain amount of information to handle the claim, and this is the basic purpose of the statement. Incomplete or inaccurate information may cause the company to deny the claim and withhold benefits. The worker must be given a copy of the signed statement.

9. If there is agreement about the claim, the insurance company or self-insured employer will promptly begin paying benefits to the employee for lost wages. The insurance company or employer is also responsible for paying authorized, reasonable, necessary medical and associated costs directly to the health care provider.

10. The employer or insurance company sends the Division a follow-up report within 30 days showing that payment of benefits has begun, or explaining the reasons for denial.

11. The employee receives the first check, usually within 15 days after the date of injury. If payment is not received, the worker should call the employer or its insurance company to find out if a problem exists. If there is a problem with the claim, the employee can write or call any of the Division offices listed at the front of this publication.

12. At the end of the period of disability, the insurance company usually writes a letter informing the employee that payment will be stopped as of a certain date.

13. An employee may safely sign a receipt for payment because the claim remains open for 6 or 12 years (depending on the date of injury) from the date of last indemnity payment.

14. The employer and insurance company make out a "supplementary" report, sending one copy to the Division, and one copy to the employee when final payment has been made.

15. A report from a health care practitioner must accompany the final report, and a copy must be given to the employee if there has been any permanent disability or if the temporary disability exceeds three weeks

What are the Supervisor's Responsibilities?

- **Make sure injured employee receives immediate medical treatment**
- **Complete all required reports, investigate what caused the injury & take steps to correct any problems**
- **Maintain contact with the employee**
- **Show a caring attitude**
- **Offer transitional work, "light-duty."**
- **Keep track of employee's progress**

Duties and Responsibilities of Agency Workers Compensation Coordinators (WCC)

Within each agency there is an assigned Workers Compensation Coordinator (WCC.) The assigned WCC is usually a payroll and benefit person within the agency, however, some human resource managers, or safety personnel have taken on this role. The DOA Workers Compensation claim staff works in unison with the Agency WCC to ensure the prompt and fair handling of claims. DOA Workers Compensation staff will arrange for the training of new WCC's for both general workers Compensation and for Enterprise.

II. Duties and Responsibilities of the WCC:

1. Obtain initial injury report (incident report) from injured worker's supervisor. Assure the injury report is complete.

2. Gather the following completed forms:

- *Employer's First Report of Injury or Disease* ***(DWD WKC-12),***
- *Employee Workplace Injury or Illness Report DOA* ***(DOA 6058),***
- *Supervisors & Safety Coordinators Investigation Report for Injury or Illness DOA* ***(DOA- 6437).***
- *Employee Fund Coding* ***(DOA 6733)***

All of these forms can be found on the DOA Site:
http://www.doa.state.wi.us/

Please see the forms section of this manual for an example of all above

3. Enter the information from the "First Report of Injury," into the RMIS (Risk Management Information System) within 48 hours. (All WCC will be trained on this duty upon assignment, but they can also reference the RMIS Manual on the DOA site:
http://www.doa.state.wi.us/. E-Mail, fax, or inter-D hard copies of all forms outlined above. If all forms are not yet gathered, forward what you currently have and send the remaining forms once completed. Do not sit on the forms until you gather all.

4. Provide the injured employee with benefits information (medical payments, disability income benefits) and other Worker's Compensation Program information. Maintain regular contact with the employee during the course of the claim.

5. Process internal forms necessary for benefits management. Prepare wage and disability calculation for injured employee and complete the following forms:

- ***WKC-13a*** *- Wage Information*
- ***WKC-13*** *- Supplementary Report on Accident and Injury*
- *TTD/TPD Benefits for Job Related Injuries* ***(DOA 6026)***

Training to complete the above forms will be provided upon the WCC initial training with DOA.

6. Coordinate involvement of supervisors, risk manager and safety officer on each Worker's Compensation claim, assuring the accident or disease is well documented, the injured employee is assisted and supported, risk and safety factors are responded to appropriately, and all documentation is provided to the coordinator.

7. Serve as liaison between the agency and the claims examiner. Keep the claims examiner apprised of any problems with the claim, investigate the circumstances of each claim and, on request of the claims examiner, conduct specific investigations and assist with internal and formal investigations.

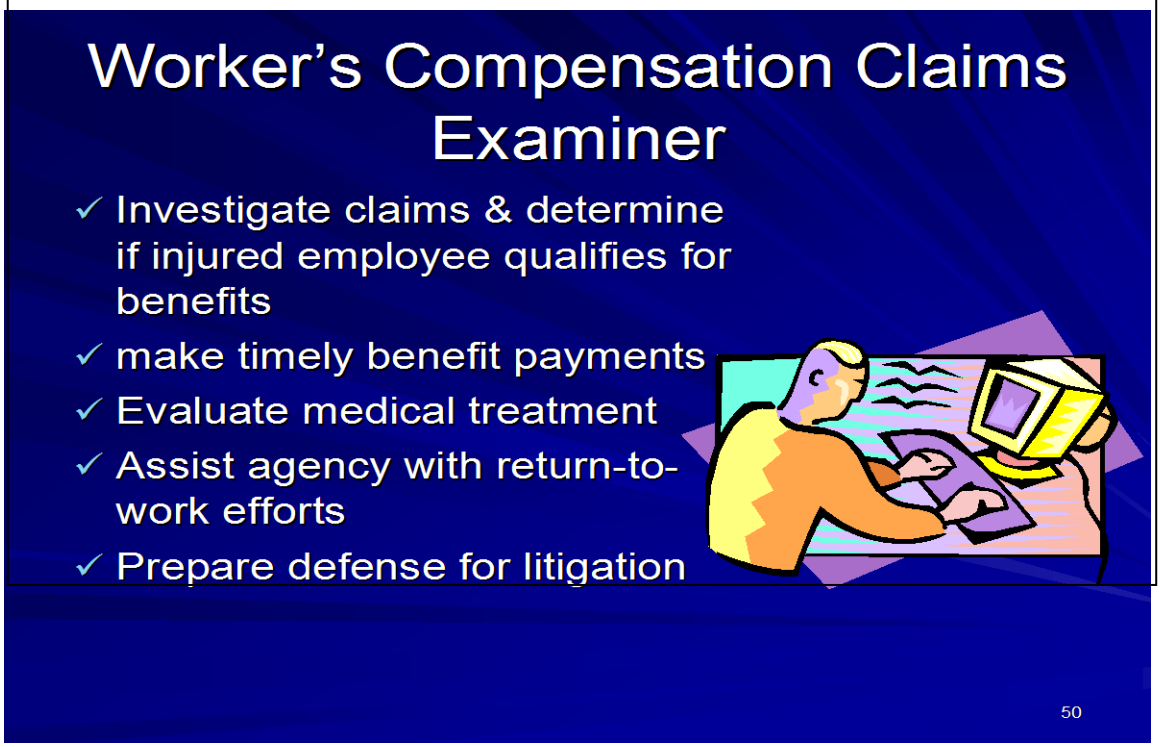
8. Maintain agency records on each claim and on agency worker's compensation costs, injury statistics and other relevant data. (Most Agency WCC now utilizes the RMIS reporting features as opposed to keeping manual paper statistics).

9. Assure OSHA 300 logs are completed and maintained. For direction and help with OSHA, WCC's should contact DOA's Safety Manager located in the same office as the Workers Compensation Unit.

10. Coordinate agency return to work (RTW) efforts by contacting the employee's Supervisor to assure readiness for any necessary accommodations and to identify suitable transitional work. Obtaining return to work approvals from the treating Physician and notifying the employee to return to work.

11. Obtain and review medical documentation from the injured employee and clarify with the Doctor's office directly when documentation is not clear.

12. Calculate, or provide information to payroll to calculate, accrued paid leave restoration and retirement credit.



The workers compensation rules & regulations are administered by a person called a "workers compensation claims examiner." This person, or team of persons, will investigate claims to determine whether the employee qualifies to receive benefits. In order for an employee to be entitled to Workers Compensation Benefits, the injury must arise while the employee is "in the course," of their employment and also "out of their employment." Just because you are at work when an injury happens, does not mean that your employer is responsible. Take for example the employee who is walking down a hallway on their way to a meeting. His/her knee buckles and surgery is recommended. Is this a compensable injury? Well, let's do the test. Was the employee in the course of employment? Yes, they were walking to a meeting. Did it arise out of their employment? No, nothing specific to their employment made their knee give way, so the injury is not compensable. It is also true that if the floor was wet, causing the employee to slip and injure their knee, the claim would be compensable. The wet floor created a hazard, thus creating a situation in which the injury arose out of and in the course of employment. If qualified, the examiner will continue to work with the employee, physicians, supervisors, and agencies to make sure proper benefits are paid at the appropriate rates and to help return the worker to his/her job as quickly and safely as possible. In the unfortunate event that there are disagreements, the Examiner will also prepare the case for litigation.

MORE DETAIL AS TO THE ROLES AND RESPONSIBILITIES WORKER'S COMPENSATION CLAIMS EXAMINER

I. Accident Report Form Processing

- Review completed Accident Report forms for errors.
- Review initial file information for red flags, inconsistencies, or potential high exposure injuries(head, spinal cord, psychological, recommended surgeries)
- Assist WCC with calculating wages, TTD and TPD in accordance with DWD rules

II. Investigations

- Obtain factual information to determine the State's liability, by:
- Making 3-point contact,
- When necessary, taking recorded statements of claimants, witnesses and supervisors when necessary, Requesting medical records and suspending claims when necessary
- Place special emphasis on the investigations of neck, back, head, carpal tunnel and stress claims.
- Assign private investigation firm when surveillance is warranted.

III. Medical Records

- Receive medical records and bills from providers, or coordinators.
- Forward HIPAA and provider list request when there is a need for pre-injury medical
- Evaluate medical records and approve payment of bills. Forward bills to medical bill audit vendor for review and payment.
- Pay mileage, or out of pocket expense directly to injured employees
- Pay vendors directly following review of bills

IV. Compensability

- Analyze claim to determine compensability (e.g., did the injury arise out of employment; is the injury claimed related to the work accident; does the injury meet legal definitions of "injury"?).
- Accept, suspend or deny the claim within 14 days of the reported injury.
- Notify claimant, agency, providers and DWD of any denials and provide appeal procedures.

V. Disbursements

- Make prompt payment of TTD, TPD, PPD, LOEC, PTD and VTD.
- Make prompt payment of medical bills not covered by the bill auditing firm, mileage out of pocket expenses and other claims costs.
- Calculate Permanent Partial Disability (PPD) payments.

VI. Litigation

- Forward complete copy of file, along with litigation summary and exposure, to DOJ.
- Forward all ongoing medical/or information received to DOJ for filing.
- Obtain settlement authority from Claim Manager if exceeds authority of 30K
- Attempt to compromise claim when warranted.
- Attend hearing when possible.

The Five Different Classifications of Claims

1. **Near Miss (NRMS) -** No injury, no lost time, no medical treatment

2. **Incident Only (Inc) -** Injury, but no medical treatment of lost time from work

3. **Medical Only (MED)** - Injury, medical treatment, but less than 4 days lost from work

4 **Lost Time (LT)** - Injury, medical treatment, 4 or more days lost from work

5 **HAZ Duty (HAZ) -** Injured while engaging in a hazardous type duty, medical treatment, 4 or more days lost from work. (For example a Correctional Office

It is not mandatory for Agency WCC to enter Near Miss and Incident Only claims into the RMIS as DOA does not create a paper file. DOA does however encourage Agencies to enter these claims into the RMIS for their own claim tracking purposes.

Medical Only claims should be entered into the RMIS within 48 hours of the reported injury. Agency medical claims are assigned to one specific Claim Examiner. For example, all Medical Claims submitted by the Department of Natural Resources will be handled by one specified Claim Examiner within DOA.

Lost Time and Hazardous Duty claims should be entered into the RMIS within 48 hours of the reported injury. These claims are distributed amongst the Claim Examiners in accordance with claim load. For example; if one Examiner received 10 claims in a week and another claim examiner received only 8 new claims, the next Lost Time, or Hazardous Duty claim will go to the Examiner with only 8 claims. The goal is to keep the Examiners fairly even with claim count and work load.

So How do Claims Arrive At DOA and What is the Process After The Claim Arrives?

Basic All Claims Management

Claims received

1. DOA has made it mandatory for Agencies to enter their new claims into the RMIS This task is assigned to the Agency WCC, or WCC Backup person.

**A "claim" consists of an "employee's First Report of Injury Disease," (WKC12)completed by the injured employee's supervisor.

Every morning, the assigned DOA Risk Management Staff employee will print a report which shows all claims entered into the RMIS Web the following day.

From this list a claim file is created and distributed to either a Claim Examiner.

Determine if the claim information is complete

The assigned Claim Examiner will first check over the claim forms and the information in the RMIS to make sure it is accurate and verify if changes are indicates. Make the changes if/when verified.

So what is the next step in the claim handling process?

If the claim is a "Medical Only Claim" here is what happens:

Determine if the claim is compensable

1. A claims examiner receives a new claim. The claims examiner reviews the information within the claim to determine compensability, the claim must arise out of employment, occur in the course of employment, and be causally related to the employment.

1a. If the claim is compensable the claim examiner will set appropriate reserves and continue to monitor medical treatment and make every effort to control cost of medical treatment. The goal of the claim examiner is to get the injured employee to maximum medical improvement/or end of healing and close the file.

1b. If the claim is not compensable, the claims examiner sends a “denial of compensability” letter to the claimant, copy to the employer. The claims examiner will set a diary to review the claim for closure.

1c. If the claim is questionable, the claim examiner will send a suspension letter to the claimant. They will immediately begin gathering information to determine if the claim is compensable, or not. This may entail sending HIPAA forms to the employee, gathering prior medical records and/or scheduling an IME, or record review.

Monitoring claim activity

2. Upon determining compensability the claims examiner will set a diary to review the claim for closure in 60 days if there is no activity. “Activity” is usually the receipt of medical bills and treatment notes. The claims examiner will review the treatment notes to ensure the bills that are being paid are related to the date of injury. Also, the claims examiner will monitor the treatment to ensure treatment is reasonable and necessary for the current injury. If reasonability and necessity is in question the claims examiner may choose to refer the claim to case management vendor or for an Independent Medical Evaluation for a second opinion on necessity of treatment. If a bill is received for treatment that is clearly unrelated to the current injury a denial letter is sent tot he medical provider. Bills that are related to the current injury should be paid according to process

When to close claim

3. The claims examiner will continually be reviewing medical records to monitor for an end of healing status. If end of healing has been reached the claim should be closed.

Application for Hearing

4. If an application for hearing is received, the claim examiner should make sure all file tasks are completed to date and that the RMIS notes are updated. The file should be given to the designated claim examiner who will transfer the claim to an Examiner next on the list for a new litigated claim. Again, this is determined by current litigated file count per examiner.

If the claim is a "Lost Time, or Haz Duty Claim" here is what happens:

Determine if claim is compensable

1. An Examiner receives a new claim either as a "New," claim, or a "File Transfer." A "New," claim is coming directly from the Agency, via the RMIS. A "File Transfer," is a claim already in RMIS, but was previously a "medical only claim," or an "incident." claim, that has now become "Lost Time/ Haz Duty Claim."

   The claims examiner will review the claim to determine compensability. A useful tool when determining compensability is the Three-point-contact. This is contact with the injured employee, employer and doctor (or representative, e.g., nurse). This should be done within 24 hours of receipt of the claim. A step by step procedure for the three point contact and recorded statements come later in this manual. (Page 27)

   To be compensable the claim must arise out of employment, occur in the course of employment and be causally related to the employment.

   1a. If the claim is compensable the claims examiner will send the WKC-12, First report of injury (attached), WKC-13a (attached) to DWD within fourteen days of the date of loss. Forwarding forms to DWD is completed via the DWD Web and discussed later in this manual.

   1b. If the claim is not compensable, the claims examiner sends a "denial of compensability" letter to the claimant, carbon the employer, faxed to DWD, and the claim file. Also, a WKC-12, First report of injury, along with a WKC-13 and WKC-13a, must be entered into DWD indicating that the examiner is denying the claim. The claims examiner will set a diary to review the claim for closure.

   1c. If the claim needs to be suspended to investigate further, the claims examiner will send the WKC-12, First report of injury, WKC-13, and WKC-13a to DWD with rationale for investigation within fourteen days of the date of loss. Again, forwarding forms to DWD is completed via the DWD Web and discussed later in this manual.

Monitoring Medical Treatment

2. The claims examiner will obtain and review medical treatment information and keep in close contact with the injured employee and the employer to assure that all possible return to work efforts are being utilized. Also, it is necessary to monitor medical treatment to make sure that all treatment is reasonable and necessary. The claims examiner will forward an authorization and medical provider list to the claimant for signatures. When the claims examiner receives this back all past medical records will be requested and reviewed.

When reviewing medical treatment the determination of whether or not to utilize claims management services(IME, nurse case management) must be made.

Determine if medical treatment is related to the work injury

3. The claims examiner will carefully review all medical bills and treatment notes to be sure that the provider is only billing us for treatment that is relevant to the work injury. If the bill is related to the work injury then the bill will be uploaded into the MBA (Medical Bill Auditing Companies)web portal. If the bill is not related, to the work injury or if the claim has not been accepted yet, a denial or suspension letter is sent to the medical provider.

Disability payments

4. The claims examiner will receive a WKC-13 and WKC-13A from the agency.WCC. After reviewing these forms for completeness and accuracy disability (indemnity) payments must be made to the employee as long as they remain off work and are authorized off by a doctor. This payment is made from calculations on the DOA-6026

Determine if medical treatment has been completed

5. The goal of the Examiner is to return the employee to work as quickly as possible and to obtain an end of healing. If medical treatment has been completed obtain a final medical report. and send it to DWD along with the final WKC-13. If the treating MD assigns Permanent Partial Disability (PPD), the examiner must calculate the rating into benefits and pay as accrued. The pay in accordance to the state PPD rate. Upon payment of the final PPD and updated WKC-13 should be submitted to DWD and the file is closed. If no PPD is assigned, the claim can be closed when medical treatment has been completed.

Hazardous Duty Claims Management

A hazardous duty claim is a claim where the injury occurs to a protected class employee in the line of duty. Hazardous duty claims are handled in the same manner as Lost Time Claims with one exception. The claimant receives 230.36 benefits, which means the employee gets paid their full wage instead of two-thirds paid under workers compensation benefits. The employing agency determines if the claimant receives the 230.36 benefits and handles all aspects of indemnity. Workers compensation only deals with the medical aspect of Hazardous Duty claim.

THREE - POINT CONTACT

Contact with the injured employee, employer and doctor (or representative, e.g., nurse) must be made within 24 hours of receipt of the claim. All contacts must be properly documented and reasonable efforts must be made to document the contacts, such as leaving messages and follow up if no response to your message in 24 hours.

INJURED EMPLOYEE CONTACT:

1. Clarify the description of the injury if the Employee Report does not contain enough information to explain how the injury occurred and if the injury was sustained on the job and in the course of employment.

2. Clarify what body part(s) was injured.

3. Clarify the injury date - the claim must be filed within two years after the date of injury. If the exact date of injury cannot be determined, the date of injury must be the first date that a reasonable person knew or should have known that the injury was a result of employment. At times, the date the injured employee first sought treatment could be the date of injury. Request the injured employee to follow up in writing documenting the exact date of injury. If necessary, a letter should be sent to the doctor clarifying if/when the Doctor told the injured employee his/her condition was a result of his/her work duties.

4. Clarify the date and time the injured employee left work.

5. Clarify the injury location - whether the injured employee was on the employer's premises and/or in the course of employment.

6. Clarify prior problems and prior claims.

7. Clarify the name of the attending physician. The injured employee should be contacted to see if he/she was physically examined by a doctor.
Identify the date the injured employee was first treated. If there was a delay in treatment and the injured employee is requesting disability benefits since the date of the injury, question the injured employee. If the injury was such that he/she could not perform work duties, why was there a delay in seeking medical treatment?

8. Date of next medical appointment.

9. Date of return to work. Determine if return was full time, part time, and for what hours and days, and at what wages.

10. Determine and document restrictions placed on the injured employee.

11. Identify witnesses to the injury and their addresses.

12. Determine if the injured employee has a second job, if he/she is able to perform the duties associated with the second job, the name of the employer, the wages paid, the work schedule, the date of return to work, and if the employee cannot return to the second job, whether the second employer can provide modified work.

12. Clarify any other pertinent information on the Employee's Report which has not been completed or needs to be clarified.

EMPLOYER CONTACT:

1. Clarify the injury, the location of where the injury occurred and the date/time of the injury.

2. Ask if the employer has any concerns/protests of the claim, and if so, document any pertinent facts for further follow-up. If an incident report or other information was completed and not sent to you, please request a copy.

3. Verify the injured employee's first day off work and verify the work schedule for the first seven calendar days of disability.

4. Verify the injured employee's wages

5. Verify the injured employee's return-to-work date.

6. If the injured employee has not returned to work, inquire of the employer if modified work is available.

DOCTOR (OR REPRESENTATIVE) CONTACT:

1. Request a description of the injury given to the doctor by the injured employee.

2. Verify the first date of treatment, the treatment the doctor performed, and further recommended treatment.

3. Obtain the doctor's diagnosis of the injured employee's medical condition.

4. Ask if the injured employee has been released to return to work. If so, is the release is for full time or part time, and are there any restrictions?

5. Ask the doctor to verify if the injured employee is able to perform his/her work duties?

Recorded Statements

Determine is a recorded statement is necessary

1. Recorded statements are used as an effective means to verify facts and determine the legitimacy of a claim. Recorded statements can also be a helpful tool in determining the appropriate course of action to be taken on a claim (i.e. medical case management, utilization review, IME, etc.). A recorded statement most importantly will preserve evidence for a potential future hearing.

To determine if a recorded statement is necessary refer to the criteria below:

- ✓ The injury was unwitnessed.
- ✓ The injury occurs just prior to a strike, a job termination, a retirement, a layoff. The end of seasonal work, the end of a probation period or just after a worker has returned to work from a leave of absence.
- ✓ The injury occurs in an area where the employee normally should not be working.
- ✓ The injury involves an activity that the worker normally should not be doing.
- ✓ The injury is not reported promptly.
- ✓ The details of the injury are vague or contradictory.
- ✓ The employee is disgruntled, a poor performer or has unexplained absences shortly before the injury.
- ✓ The employee is new to the company or job, has a history of frequent job changes, or is in financially difficulty.
- ✓ The employee has several other family members also receiving workers compensation benefits or other “social insurance” benefits, e.g., unemployment.
- ✓ The employee earns extra money by moonlighting or is in college, is known to participate in contact sports or physically demanding hobbies such as horseback riding or mountain climbing.
- ✓ The employee has a history of frequently sustaining injuries of a subjective nature.
- ✓ The employee receives income from workers compensation benefits and collateral sources that meet or exceeds regular wages.
- ✓ The employee is difficult to reach at home or return calls that have incongruous background noises.
- ✓ The employee frequently changes physicians, medical providers or attorney.
- ✓ The employee recently purchased one or more disability policies.
- ✓ The employee demands quick settlement on decisions or commitments.
- ✓ The employee is unusually familiar with workers compensation claims handling procedures and laws.

- ✓ The employee is consistently uncooperative.
- ✓ The injuries are subjective, i.e., pain, headaches, nausea, inability to eat or sleep, etc.
- ✓ The accident report is inconsistent with the diagnosis or the diagnosis is inconsistent with the treatment.
- ✓ Extensive treatments, testing and procedures are performed for relatively minor or subjective injuries.
- ✓ The treating physician is known for handling suspect claims.
- ✓ The injured worker refuses a diagnostic procedure to confirm the injury
- ✓ A lab or separate facility in which the referring physician has financial interest performs the treatment or testing.
- ✓ The treatments extend for lengthy time periods without any bills being issued.
- ✓ The treatment dates occur on Sundays, holidays or other unusual times.
- ✓ The employee does obvious doctor shopping.
- ✓ The employee had a family trauma immediately prior to the accident.

***Please be aware that the above criteria are simply guidelines. Claims experience, intuition, and common sense will be the most valuable guide when assessing the need to take a recorded statement.

Prepare questions

2. The claims adjuster will decide which questions to ask the claimant in the interview to obtain the needed information. Some general questions to use as a guide follow:

Address/telephone number?
Social security number?
Age? Birth date?
Height? Weight?
Married? Spouses name?
Current employer? Length of employment? Title? Specific duties?
Confirm injury date. When reported. Who reported to (coworker, supervisor).
Witness? Name/Address/phone number.
Injury events?
Current physical complaints?
Current treatment?
Prior work comp claims?
Preexisting conditions related to current condition?
Recent auto/home injuries?
Hobbies/non work-related activities?
Address any red flags not previously discussed

Call claimant and take recorded statement

2. All Examiner have the ability to take a recorded statement from their Teams account. The claims adjuster will call the claimant and use the following introduction and then address continue on with addition questions. One the accident is clearly laid out on the statement, the Adjuster should bring the statement to a close.
3.

Here is an example of a recorded statement introduction and closing

Introduction

"This is _____ and I am speaking with _____ by telephone at _____ on __/___/____. Please state your full name and spell your last name. Before we begin this interview, are you aware I am recording this conversation? Do I have your permission to do so? Are you currently on any medication that may interfere with your understanding of my questions?"

Closing

"I do not have any further questions at this time. Is there anything you would like to add to this interview? To end the interview, were you aware I recorded this conversation? Did I have your consent to do so? This is _____ completing this interview with _____ at _____ on ___/__/___."

Document in ENTERPRISE

4. Listen to the recording and make notes in ENTERPRISE to include any information obtained from the recorded statement and the action plan for the claim.

Three-Day Waiting Period

In addition to medical, hospital and doctors' expenses, the law provides for the payment of weekly benefits for temporary and permanent disability. ***One of the most difficult concepts for a new claim examiner to understand is the three-Day waiting period.*** The follow 5 pages will attempt to help the new examiner to understand, but it is not until the examiner actually handles several, or many Lost Time claims, will there be a true grasp.

Three-Day Waiting Period For Temporary Disability

To eliminate minor claims for temporary disability, the law requires a three-day waiting period for all disabilities lasting seven days or less. (Sundays are not included in the three days unless the employee usually works on Sundays.) Temporary disability benefits are never paid for the day of injury.

No Waiting Period Required If Out Over Seven Days

If, because of the injury, the employee is unable to work at any time after the 7th day of injury, compensation is paid for the entire period including the three-day waiting period. Payment for the lost time will include all days of disability up to that date, but not including the date of injury. If an injury causes both temporary and permanent disability, there is no waiting period and temporary benefits start from the first day. For example, amputations causing a day or two loss of work payments are required for temporary disability and the PPD disability caused by the amputation.

Date: **May 3, 2007**

To: **All Workers Compensation Coordinators and back-ups.**
DOA Work Comp Staff

From: **Laura Ellingson**

Subject: **Revision to Waiting Period Memo**

It has come to our attention that there are inconsistencies in counting waiting period amongst all of us. Because of this lack of uniformity, we have re-visited the Wisconsin Workers Compensation Statutes and the instruction provided as to how to count waiting period. Please note this memo and method of counting waiting period should replace the prior memo and method set forth by us in 2004.

102.43 If the injury causes disability, an indemnity shall be due as wages commencing the 4th calendar day from the commencement of the day the scheduled work shift began, exclusive of Sundays only, excepting where the employee works on Sunday, after the employee leaves work as the result of the injury an shall be payable weekly thereafter, during such disability. If the disability exist after 7 calendar days from the date the employee leaves work as a result of the injury and only if it so exist, indemnity shall also be due and payable for the first 3 calendar days, …..

102.43 is the section of the Worker's Compensation Act outlining the waiting period, however, when reading this section, one is still left confused. Let me try and clarify DWD's interpretation of 102.43.

- There is a work related injury that causes an employee to **leave work during a work shift**. (Meaning the employee is absent from part of his/her work shift.)

- Leaves work as the result of the injury," means **leaves the employers premises**. (Insurance letter 431 also attached for your reference.)

- The last day worked will be the day the employee **leaves the employers premises, during a work shift**, **as a result of the injury**.

- The three day waiting period will be the 3 days after the employee leaves the premises, during a work shift, as a result of the injury, regardless of whether or not the employee is actually off of work.

- There is a reported work related injury and the employee completes their shift; they do not return to work the next day (they "stay away") because of the injury. The last day worked is the day they completed the work shift.

- Sunday is not counted as one of the 3 days in the 3-day waiting period unless the employee works on Sunday.

- Sunday is always counted in the 7 days for determining if a disability exists beyond the 7th day after the last day worked.

- Sundays are not paid regardless of whether or not the employee normally works on Sunday.

- Don't forget the employee still has to be authorized off of work by a Doctor, in order for us to consider paying TTD and the claim has to be deemed compensable.

- Don't forget in order to pay TTD for the waiting period, there of course has to be lost wages within those three days, authorized by a Doctor **and** disability must exist beyond the 7th day from the established LDW.

  Examples:

  1. Employee normal schedule 7:30 am - 4:00 pm, M - F.
  Injury occurs 1:00 pm - M
  Employee reports injury and leaves work 1:30 pm - M and goes to Dr.
  Authorized off work T, W, TH
  Returns to work F

  3-Day waiting period is triggered when the employee leaves work 1:30 - M
  Last Day Worked(LDW) = M
  3-Day waiting period is T, W, TH
  No TTD due as employee returned to work F and disability did not exist beyond the 7th day.

2. Employee normal schedule 7:30 am - 4:00 pm, M - F.
Injury occurs 1:00 pm - M
Employee reports injury 1:00 pm - M, but works the entire day.
Employee goes to Doctor on T, 9:00 am - and does not come into work
Employee returns to work W

3-Day waiting period is triggered when the employee leaves work during work shift, however, since the employee never reported to work on T, the LDW would still be M.(employee finishes work shift and does not return(stays away)because of the injury)

LDW = M

Waiting period = T, W, TH
No TTD due as employee returned to work W

3. Employee normal schedule 7:30 am - 4:00pm, M - F.
Injury occurs 1:00 pm - M
Employee reports injury, but does not leave work during shift and continues to work regular hours until…
Three weeks later on T(T-3) the employee goes to the Doctor at 1:00 pm and worked part of T-3.
The employee is authorized off of work for 7 days.

3-Day waiting period is triggered when the employee loses time during work shift which is T-3.

LDW T-3

Waiting period = W-3, TH-3, F-3
TTD due S-3, M-4

Since the employee was not authorized off beyond the 7th day, TTD would not be due during the waiting period.

4. Employee normal schedule 7:30 am - 4:00pm, M - F.
Injury occurs 1:00 pm - M
Employee reports injury, but does not leave work during shift and continues to work regular hours until…
Three weeks later on T(T-3) the employees goes to the Doctor at 8:00 a.m. The employee did not go into work at all on T-3.
The employee is authorized off of work for 7 days.

3-Day waiting period is triggered when the employee completes their shift and does not return to work (stays away).

LDW M-3

Waiting period = T-3, W-3, TH-3

TTD due F-3, Sat-3 and M-4

Since the employee was not authorized off beyond the 7th day, TTD would not be due during the waiting period.

If you have questions, or are confused about counting waiting period, please contact the examiner assigned to your agency, the claim representative handling the file, Sarah Sonnenberg, or me. I strongly encourage you all to go to the DWD website, which has multiple great examples of how to count waiting period.

http://www.dwd.state.wi.us/wc/Letters/insurance/pdfs/3daywaiting.pdf

Worker's Compensation Benefits
What exactly is an injured employee entitled too?

- ✓ Medical
- ✓ Temporary Total Disability(TTD)
- ✓ Temporary Partial Disability(TPD)
- ✓ Permanent Partial Disability(PPD)
- ✓ Permanent Total Disability(PTD)
- ✓ Loss of Earning Capacity(LOEC)
- ✓ Vocational Temporary Disability(VTD)
- ✓ Death Benefits
- ✓ Mileage reimbursement

<u>The following pages will discuss each of the above in greater detail.</u>

Choice of Doctor and Payment of Medical Expenses

An employee who is **injured at work or suffers from an occupational disease**, is entitled to payment of all medical, surgical and hospital treatment relating to the injury including: doctor bills, hospital bills, medicines, medical and surgical supplies, crutches and artificial limbs. In addition, an injured employee is entitled to compensation for lost time and traveling expenses incurred for treatment or examination.

All **reasonable and necessary medical expenses** must be paid by the employer, or by the insurance carrier, whether or not weekly benefits are also due for temporary or permanent disability.

Selection of a Doctor

When a worker reports an injury, the employer shall offer the worker **the right to select a doctor of the worker's choice for treatment**. The employee may select any physician, psychologist, chiropractor or podiatrist licensed to practice in Wisconsin. If the injury creates an emergency situation, the employer may make whatever arrangements are necessary for immediate treatment. Once the emergency passes, the worker has the right to select a doctor for future treatment.

Employee Allowed First And Second Choice Of Doctor

The law recognizes that if the employee does not have confidence in the first doctor, recovery may be delayed. If the employee is not satisfied with the first doctor s/he chooses, **a second choice is allowed**. While the worker must notify the employer of this second choice, the employer may not object to it.

After changing doctors once, any further change may be made only by mutual agreement between the employee, employer and insurance carrier. If the attending doctor refers the employee to a specialist or a series of specialists, this referral is still considered to be treatment by one doctor. If several doctors in one partnership or clinic are seen, these are all considered one doctor.

Failure to notify the employer of the initial selection or of a change of doctors can lead to a disputed claim and the possibility of the injured employee having to pay for the entire cost of treatment.

Any Doctor In an Emergency

In an emergency situation, **an employee can go to any doctor** for treatment. The employer should be notified as soon as possible thereafter.

Examination by Employer's Doctor

On **written request**, an employee should submit promptly to a reasonable examination by any doctor (physician, chiropractor, psychologist or podiatrist) named by the employer or insurance company. Independent Medical Examination *(See Next Page)*

Refusal of Treatment

No compensation is payable for disability of an employee if the disability was caused by, or aggravated by, an unreasonable refusal or neglect to submit to or follow reasonable medical or surgical treatment. However, an employee may refuse surgery, which might endanger life or limb.

Out of State Treatment

The employee may treat with a medical practitioner not licensed in Wisconsin, **by mutual agreement with the insurer**. The insurer's consent is not necessary if the out-of-state treatment is based on a referral from a practitioner licensed in Wisconsin.

Independent Medical Examination

Under the Worker's Compensation Act, s. 102.13, an insurance company or self-insured employer may request that an injured worker submit to reasonable examinations by a physician, chiropractor, psychologist, dentist or podiatrist of its choice. This examination is usually referred to as an independent medical examination.

When compensation is claimed for loss of earning capacity, the insurance company or self-insured employer may request that the injured worker submit to reasonable examination(s) by a vocational expert of its choice.

An independent examination may be requested by the insurance company or self-insured employer in order to determine compensability, the extent of disability, necessity of treatment and type of treatment, and to evaluate permanent disability or loss of earning capacity. Because the injured employee is not a patient or client of the independent examiner, no patient-physician or patient-client privilege exists.

The Department generally considers as reasonable one independent examination every six months. Additional independent examinations, however, may be requested if there is a substantial change in an injured worker's medical condition; for example, the injured worker has surgery. The insurance company or self-insured employer must schedule additional independent examinations with the same practitioner, unless permission is granted by the Department to change independent examiners.

The insurance company or self-insured employer may choose any independent examiner within a 100 mile radius of the injured worker's primary place of residence. If the injured worker is treating with a practitioner whose office is located more than 100 miles from the injured employee's primary place of residence, the insurance company or self-insured employer may require the injured worker to submit to an independent examination in the area where the injured worker's treating practitioner is located.

The insurance company or self-insured employer is responsible for the costs of the independent examination. The insurance company or self-insured employer must make payment in advance to the injured worker for all expenses, including transportation, meals, lodging and wage loss, necessary to attend the independent examination. The injured worker is entitled to full wage replacement, rather than the temporary disability rate, for all time lost from work to attend the examination. The mileage reimbursement must be for the total round trip miles.

The request for an independent examination must be in advance and in writing and must notify the injured worker of the following:

- The proposed date, time and place of the examination and the identity and area of specialization of the examining physician, chiropractor, psychologist, dentist, podiatrist or vocational expert.

- The procedure for changing the proposed date, time and place of the examination.

- The injured worker's right to have his or her physician, chiropractor, psychologist, dentist or podiatrist present at the examination, at the injured worker's expense.

- The injured worker's right to receive a copy of all reports of the examination that are prepared by the examining physician, chiropractor, psychologist, dentist, podiatrist or vocational expert immediately upon receipt of these reports by the insurance company or self-insured employer.

- The injured worker's right to have a translator provided by him or herself present at the examination if the injured worker has difficulty speaking or understanding the English language.

Upon receiving the required, written notification from the insurance company or self-insured employer, the injured worker must submit to the independent examination. If the injured worker unreasonably refuses to submit to the examination or in any way obstructs the examination, an administrative law judge in the Worker's Compensation Division, may bar compensation during the period of refusal.

Bill Payment

Determine if bill should be paid under Worker's Compensation Benefits

1. When a medical bill is received the claims adjuster determines if the bill should be paid under worker's compensation benefits. If the bill is not covered under worker's compensation benefits the claims examiner will send a denial of payment letter to the provider, carbon the employer. If the bill is covered under worker's compensation benefits the claims adjuster must determine whether to pay the bill internally or externally.

Determine if bill should be paid internally or externally

2. Bills that are always sent to the MBA Company include outpatient medical provider, chiropractor, physical therapy, hospital outpatient, and hospital inpatient. Bills that should not be sent to the MBA Company include ambulance charges, anesthesia, medical supplies, outpatient emergency room, work hardening, pharmacy charges, mileage, telephonic case management, all indemnity, and all expense charges.

External bill payment

3. Bills that are paid externally are sent to the billing MBA Company to possibly receive a rate reduction. Bills that should be paid externally should be scanned and uploaded into the MBA web portal.

MBA upload to the RMIS

4. The MBA Company sends a weekly file containing all bills they have processed via the File Transfer Protocol site for uploading onto the RMIS. A claim examiner uploads the file, which posts each payment made the MBA to the proper claim in the RMIS. Procedures for this can be found on the G drive: G:\Riskmgmt\STAR\Corvel\CorvelUpdateProcedure.doc

Internal Bill Payment

5. When paying bills internally use the RMIS. Refer to the RMIS manual for instructions as shown below.

MAKING A PAYMENT – instructions LINK =G:\Risk Management \Riskonnect\Riskonnect ENTERPRISE\Process\WC Process

Temporary Total Disability Benefits (TTD)

- Replaces wages if employee is 100% off of work and authorized off by a Doctor

- Pays 66 2/3 of gross average weekly wage taken over the prior 52 weeks.

- Maximum per week is currently $961.00, set forth by DWD. This is subject to yearly increases**.**

  If an employee is taken completely off of work by a Doctor and the claim is compensable, the Workers Compensation Examiner will need to pay the injured employee TTD. The Agency WCC will compute the actual TTD rate and forward to the Claim Examiner to make payments. The WCC will also forward a TTD payment request to the Examiner bi-weekly and the Examiner will make the TTD payment. TTD payments are sent by the Examiner in synch with the regular payroll checks, so the injured employee should receive TTD on the same schedule as their normal payroll check would have arrived.

Calculating Wage - Basic Summary

The TTD rate for a non-self restricting employee is computed at 66.67% of the *higher* of the:

- Hourly wage at the time of injury multiplied by the number of regularly scheduled hours of work, *or*

- Taxable gross earnings paid by the insured in the 52-weeks prior to the week of the injury divided by the number of ***weeks worked (or in a pay status, as in paid vacation and sick leave)*** in that same period.

Note: TTD and PPD rates can be no higher than the maximum rate in effect for the year of the injury. Include only earnings from the job of injury; earnings from another job are not included in calculating the average wage.

Common errors**:** not counting overtime when it is part of the regular schedule; not including shift differential; not including all taxable earnings, such as incentive pay, bonuses and overtime in gross earnings; incorrectly counting "weeks worked/paid"; and using wages earned from other than the insured (in Wisconsin we don't). A serious error is not documenting wages. *The WKC-13A should report only confirmed, not estimated, wages.*

The following pages will provide an example of all the forms related to wage computation and benefit payment, as it applies to TTD. Please note that some of the forms are statutory, while other forms are created and used by the claim examiner.

WAGE INFORMATION SUPPLEMENT

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

Read instructions on reverse carefully before completing.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

Employee Name	Employee Social Security Number	Date of Injury

Employer Name

Name of Insurance Company or Self-Insured Employer (do not list adjusting company)

Claims Handling Address (number, city, state, zip code)

Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)

1. Hourly Wage Multiply — Equals — Add — Equals

a. Hourly rate at time of injury:	x	b. Hours per week: (fill in "usual scheduled hours," check the box you use to set the wages)	=	c. Base weekly rate: (See reverse for computing rates for time and a half employees)	+	d. Additional weekly compensation from Section 3 below: (exclude tips)	=	e. Average weekly earnings: (hourly)
☐ Standard Base $_____ ☐ Piece Rate (if higher than the standard rate) ☐ Standard base rate plus tips Tip Rate only: $_____ Base + Tip $_____		☐ **Normal scheduled hours:** _____ Includes those hours paid at time-and-a-half: **(See Instructions)** _____ ☐ Actually Worked: (use with piece rate, or tips in Section 1a.) _____ ☐ Expand to: (See Section 4) 24 ☐ Expand to Normal Full-time: _____ ☐ Seasonal: (See instructions) 44		$_____		$_____		$_____

2. Gross Wage Divide — Equals — Add — Equals

a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips)	÷	b. Number of weeks worked in 52-week period prior to injury:	=	c. Base Gross Wage:	d. Additional weekly compensation from Section 3 below:	=	e. Actual average weekly earnings:
$_____		_____		$_____	$_____		$_____

3. Additions to Cash Wage Received by Employee Per Week (Mark any that apply)

☐ Free meals (Number/week) _____ Weekly Amount $_____
☐ Room (Number of days/wk _____ Weekly Amount $_____
☐ Tips Amount/Week $_____ (Add only to Section 2d., not 1d.)
☐ House or Apartment Weekly Amt $_____ ☐ Check if this is continued during disability

☐ Fuel Weekly Amount $_____
☐ Lights Weekly Amount $_____
☐ Other Weekly Amount $_____
Total Weekly Value: $_____

4. Part-Time Employment (Worked less than 35 hrs/wk) Divide — Equals

Part of Class Determination	1. Normal number of hours scheduled per week:	2. Number of other part-time employees doing same work on same schedule:	÷	3. Number of full-time employees doing the same type of work:	=	4. _____% ☐ Yes, part of class (2 divided by 3 is greater than 10%) ☐ No, not part of class (2 divided by 3 is less than 10%)
	_____	_____		_____		

(Choose a, b or c that applies)

a ☐ Employee worked **less** than 24 hrs/wk, **is part of a class and does not restrict** availability for work. Check the box listed as "expand to" in Section 1b above with number of scheduled hours shown as 24.

b ☐ Employee worked less than 35 hours/wk, but **is not part of a class and does not restrict** availability for work. Check the box in Section 1b listed as "Expand to Normal full-time" and enter the number of hours which full-time employees normally work for the employer in this occupation.

c ☐ Employee works less than 27 hrs/wk., and **restricts availability** for work. Check the box in Section 1b listed as "Normal Scheduled Hours" and enter the number of normal scheduled hours. If the employee does not have "normal scheduled hours", leave Section 1b blank and complete all parts of Sections 2 and 5 using the 100% option of the result in Section 2e in Section 5b. **Attach the self-restriction statement**. See instructions on reverse for an **exception to using 100% in Section 5b.**

Important: These options are the only circumstances for which you will use a number other than the "normal hours scheduled" to compute weekly hourly wages. Use normal hours scheduled or actual hours worked (piece rate, time and 1/2 or tip rate) in Section 1b unless 4a, 4b or 4c applies.

5. Weekly Wage and TTD Rate Computation Multiply — Equals

a. Weekly Wage (Greater of #1 or #2 above) $_____	X	**b.** ☐ 66.67% **OR** ☐ 100%(see 4.c)	=	c. Weekly TTD Rate: $_____

Insurance Claim Representative	Telephone Number ( )

(See reverse side for instructions)

Instructions for Completing the Wage Information Supplement, Form WKC-13-A

These instructions will help you complete the WKC-13-A and compute the TTD rate correctly. If more help is needed, please contact a wage specialist at (608) 266-3264 or 261-6532, or send an e-mail to **wcwage@dwd.state.wi.us.** Section DWD 80.02(2)(c) of the Wis. Admin. Code requires insurers, including self-insured employers, to submit this form within 30 days after the injury. It must be submitted for every claim where the TTD rate is less than the maximum rate for the year the injury occurred. For a reference to the maximum rates, see our website at: **http://www.dwd.state.wi.us/wc_train**

Section 1a- Hourly Rate at Time of Injury: Enter the standard base rate at the time of injury. Include in the hourly rate any additional hourly amounts which the employee received at the time of injury, e.g., shift differentials. For employees receiving time-and-a-half, enter the standard base rate, not time and a half rate. If this employee did not have an hourly rate but had a weekly, bi-weekly or monthly salary and has scheduled hours of work, divide the salary by the number of hours worked in the pay period to arrive at the hourly rate. If an employee is paid solely by commission or by mileage or some other method where scheduled hours are not used, the TTD rate will be based only on gross earnings. In such a case, enter "NA" in Section 1 and go on to Section 2. For employees paid on a piece work basis, compute the hourly piece work rate by dividing the earnings from piece work by the number of hours actually worked while on piece rate. Exclude time and a half earnings and hours in this computation. Use the piece rate amount only if the resulting rate is higher than the standard hourly rate. If the employee received tips, compute the additional hourly amount of tips. Enter that amount next to **"tip rate"** and add the hourly tip rate to the standard hourly rate to get the "standard base rate plus tips". Compute the tip rate by dividing total tip earnings (only the earnings received in tips) by total hours actually worked on a tip basis. The total hourly rate must be at least the legal minimum hourly wage.

Section 1b- Hours Per Week: Enter the normal number of hours scheduled (regular fixed schedule) at the time of injury). Include the number of hours the employee is paid at the time and a half rate. If the employee does not have regular scheduled hours, enter the number of hours which full-time employees normally work for the employer in this occupation. Include scheduled hours paid at a time-and-a-half rate in the number of "normally scheduled hours". If scheduled hours vary by more than 5 hours from week to week during the 90-day period immediately preceding the injury, use the number of hours that is normal for full time employees for this occupation. Check the box "Actually Worked" in Section 1b and enter the hours actually worked if the hourly rate in Section 1a is piece rate or includes tips. Check the "seasonal" box with **44** hours entered for employees who meet the definition of **"seasonal"** employees in s.102.11(1)(b) Wis. Stats. Seasonal employment cannot exceed 14 weeks. For part time employees, follow the instructions in Section 4.

Section 1c- Base Weekly Rate: Multiply the hourly rate in Section 1a times the hours used in Section 1b. For employees who worked a time and a half schedule at the time of injury and at least 13 consecutive weeks immediately prior to the injury, use the following formula: multiply the standard rate times the normal scheduled hours excluding those hours paid at the time-and-a-half rate; then multiply the time and a half rate times the time and a half hours, and add the two results to get the Base Weekly Rate.

Sections 1d & 1e- Hourly Wages/Additions to Base Average Weekly Wages and Average Weekly Earnings: Enter here and in Section 2d (except for tips) the weekly value of any other type of compensation the employee received, as shown in Section 3.

Section 2a-e Gross Wages and Average Weekly Earnings Enter the gross wages and the number of weeks the employee worked on that job (same type of work) in the 52-week period prior to the date of injury. When counting weeks for Section 2b, do not Include the week of injury in the 52-week period. Count partial weeks as whole weeks. Include tips and additions to wages from Section 3 in section 2e. For employees who worked less than 6 weeks, TTD will be determined solely by the hourly rate in Section 1 or, if the employee does not have an hourly rate, by wages paid in a "same or similar" occupation. Enter "same or similar" wages in Section 2e and skip 2a, 2c and 2d. Complete the computations in Sections 2c, d and e for all others.

Section 3- Additions to Cash Wages: Enter the weekly value of any additional compensation paid to the employee. This value is added to the computations in Sections 1 and 2. The standard value of **"meals"** and **"room"** is set in Wis. Admin. Code DWD 80.29 and DWD 272. The value of all other items is set by common marketplace value to the employee.

Section 4- Part-Time Employment: Complete this Section for all workers at less than the maximum TTD rate if they were scheduled to work less than 35 hours per week at the time of injury.

Part of Class Determination: Complete this part before choosing and checking the applicable Section 4a, 4b or 4c. If the employee's regular work schedule varies by more than 5 hours per week during the 90-day period immediately preceding the injury, always consider the employee as "not part of class". Choose Section 4a, 4b or 4c that applies to the employee before doing the computations in Sections 1 or 2 to set the wage for the employee. If you check Section 4b, you will need to check the box in Section 1b "expand to normal full-time" and enter the number of normal full-time hours there for this occupation. Use the number of hours that are normally considered as full-time for that employer for that occupation to compute the wage.
Self Restriction: An employee "self restricts" employment if he/she limits his/her availability on the labor market to part-time work only and was not employed elsewhere. If you indicate that the worker self-restricts in Section 4c and wages are set at 100%, you must attach a copy of a self-restriction statement signed by the employee, stating the limitation to part-time and that he/she was not working elsewhere at the time of injury. A sample statement can be found in the training website at **http://www.dwd.state.wi.us/wc_train**.

Section 5-- Wage and Rate Computation: Enter the wage used to compute the TTD rate (the higher amount from Section 1e or 2e). The rate in Section 5c is computed by multiplying the wage by either 66.67% or by 100% (see Section 4c).
Exception to using 100% in Sections 4c and 5b: If using 100% in Section 4c exceeds 66.67% of the wages of a full-time employee doing this job, use 66.67% of wages (higher of 1e or 2e) after expanding the hours in Section 1b to full-time.
Exception Note: If this employee's employment situation is unique and you cannot use the computation formulas in Sections 1 and 2, indicate the wage and TTD rate in Section 5, and attach an explanation of how you computed the wage and TTD rate to this request.

WAGE INFORMATION SUPPLEMENT

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

Read instructions on reverse carefully before completing.

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

Employee Name	Employee Social Security Number	Date of Injury
Barry L. Barry	555-55-5555	7/1/2008

Employer Name: Department of Military Affairs

Name of Insurance Company or Self-Insured Employer (do not list adjusting company): Department of Administration, Bureau of State Risk Management

Claims Handling Address (number, city, state, zip code): PO Box 77008 Madison, WI 53703-1008

Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)

1. Hourly Wage — Multiply — Equals — Add — Equals

a. Hourly rate at time of injury:	x	b. Hours per week: (fill in "usual scheduled hours," check the box you use to set the wages)	=	c. Base weekly rate: (See reverse for computing rates for time and a half employees)	+	d. Additional weekly compensation from Section 3 below: (exclude tips)	=	e. Average weekly earnings: (hourly)
☒ Standard Base ☐ Piece Rate (if higher than the standard rate) ☐ Standard base rate plus tips Tip Rate only: $18.35		☒ **Normal scheduled hours:** 56 Includes those hours paid at time-and-a-half: **(See Instructions)** ☐ Actually Worked: (use with piece rate, or tips in Section 1a.) ☐ Expand to: (See Section 4) 24 ☐ Expand to Normal Full-time: ☐ Seasonal: (See instructions) 44		$1,027.60				$1,027.60

2. Gross Wage — Divide — Equals — Add — Equals

a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips)	÷	b. Number of weeks worked in 52-week period prior to injury:	=	c. Base Gross Wage:	+	d. Additional weekly compensation from Section 3 below:	=	e. Actual average weekly earnings:
$58,297.77		52		$1,121.11				$1,121.11

3. Additions to Cash Wage Received by Employee Per Week (Mark any that apply)

☐ Free meals (Number/week): Weekly Amount: ☐ Fuel Weekly Amount:
☐ Room (Number of days/wk: Weekly Amount: ☐ Lights Weekly :
☐ Tips Amount/Week: (Add only to Section 2d., not 1d.) ☐ Other Weekly Amount:
☐ House or Apartment Weekly Amt: ☐ Check if this is continued during disability **Total Weekly Value:**

4. Part-Time Employment (Worked less than 35 hrs/wk) — Divide — Equals

Part of Class Determination	1. Normal number of hours scheduled per week:	2. Number of other part-time employees doing same work on same schedule:	÷	3. Number of full-time employees doing the same type of work:	=	4. ____% ☐ Yes, part of class (2 divided by 3 is greater than 10%) ☐ No, not part of class (2 divided by 3 is less than 10%)

(Choose a, b or c that applies)

a ☐ Employee worked **less** than 24 hrs/wk, **is part of a class and does not restrict** availability for work. Check the box listed as "expand to" in Section 1b above with number of scheduled hours shown as 24.

b ☐ Employee worked less than 35 hours/wk, but **is not part of a class and does not restrict** availability for work. Check the box in Section 1b listed as "Expand to Normal full-time" and enter the number of hours which full-time employees normally work for the employer in this occupation.

c ☐ Employee works less than 27 hrs/wk., and **restricts availability** for work. Check the box in Section 1b listed as "Normal Scheduled Hours" and enter the number of normal scheduled hours. If the employee does not have "normal scheduled hours", leave Section 1b blank and complete all parts of Sections 2 and 5 using the 100% option of the result in Section 2e in Section 5b. **Attach the self-restriction statement**. See instructions on reverse for an **exception to using 100% in Section 5b.**

Important: These options are the only circumstances for which you will use a number other than the "normal hours scheduled" to compute weekly hourly wages. Use normal hours scheduled or actual hours worked (piece rate, time and 1/2 or tip rate) in Section 1b unless 4a, 4b or 4c applies.

5. Weekly Wage and TTD Rate Computation — Multiply — Equals

a. Weekly Wage (Greater of #1 or #2 above):	X	**a.** ☒ 66.67% **OR** ☐ 100%(see 4.c)	=	c. Weekly TTD Rate:
$1,121.11				$807.44

Insurance Claim Rep. Name: Phone No.: ( ) -

SUPPLEMENTARY REPORT ON ACCIDENTS AND INDUSTRIAL DISEASES

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin/wc
e-mail: DWDDWC@dwd.wisconsin.gov

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

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

1. Name of Injured Employee			2. Social Security Number
3. Address	City	State	Zip Code
4. Injury Date	5. Last Day Employee Worked	6. Nature of Injury or Illness	
7. Employer Name	8. Address (City, State and Zip)		
9. Insurance Carrier (Not TPA or Adjuster) ☐ Check if employer is self-insured		10. Insurer Claim Number	11. N.A.I.C. Number
12. Insurer's Claim Handling Address	City	State	Zip Code

13. Date & Type of First Compensation Payment Type: ☐ TTD ☐ TPD ☐ Salary Cont'd ☐ Other Date:	14. Amount of 1st payment $	15. Weekly Wage Used to Set TTD Rate: $ ☐ Rate below max. - WKC-13-A attached ☐ WKC-13-A not attached - Estimated date it will be sent is:	16. TTD Rate: $

17. If 1st Payment Was Late, (more than 14 days after injury date) State Reason:

18. Remarks: ☐ Denied ☐ Being Investigated (Attach Copy of Denial Letter) ☐ Suspended -- Lack of Medical Information ☐ Suspended -- Other Reason (Attach Copy of Suspension Letter)

Date Final Medical Report required under DWD 80.02(2)(e) 4 is anticipated:

☐ Other Remarks (Specify):

	Payment Period						
19. Type of Payment	20. Last Day of Work	21. Date of Return to Work or End of Healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer Paid Holidays	23. No. of Weeks and/or Days Paid	24. Rate	25. Amount of Comp. Paid	26. Accumulated Total Amount Paid
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							

27. Amount of Permanent Partial Disability due:
(Attach supporting medical report if not previously submitted.)
Wks. @ $ = $

Indicate amount of PPD paid to date:
$

28. Final Indemnity Payment Date Type of Payment: Date of Payment:	29. Has the worker returned to work with wages at 90% or more of wages at the time of injury? ☐ Yes ☐ No

30. Report Prepared By	31. Work Phone No. ( ) -	32. Position	33. Date Signed

Under DWD 80.02(2), for injuries which require the first report of injury, self-insured employers and insurance companies shall submit:

- A supplementary report on a form WKC-13 on or before 30 days following that on which the injury occurred.
- Make a report within 7 days from the date that payments are stopped for any reason. If any payments are stopped for a reason other than the employee's return to work, provide an explanation to the department and the employee. The insurer shall advise the employee as to the reason for stopping payments, what the employee must do to reinstate payments, and the worker's rights to a hearing.
- Make a report on form WKC-13 with a copy to the employee when payment of compensation is changed from temporary total disability or temporary partial disability to a permanent disability.
- Include a copy of the WKC-13-A with the WKC-13 for claims where the wage is less than maximum, or provide an estimated date if the wage information is not available at the time the WKC-13 is submitted.
- Make a final report on a form WKC-13 within 30 days of when final payment of any type of compensation has been made. A practitioner's report is due if temporary disability exceeds 3 weeks or if permanent disability has resulted. The final medical report showing the extent of permanent disability and the end of healing is due within 30 days after the date that payment of final compensation is made. If you are unable to obtain one, you must submit a notice explaining why you are unable to obtain one or the date you anticipate submitting one. If the original medical report was not that of the treating practitioner, a treating practitioner's report is necessary if temporary disability exceeds 3 weeks or if permanent disability has resulted. A copy of information contained in the final WKC-13 report and the final practitioner's report must be sent to the employee.

INSTRUCTIONS ON HOW TO COMPLETE THIS FORM:

Items 1 thru 11. Fill in all blanks completely.

Item 12. Fill in the mailing address of the office or adjusting company that makes the payments. All correspondence regarding this injury will be mailed to the insurer's designated claims handling address.

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

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

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

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

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

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

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

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

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

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

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

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

Sample of Items 19 – 26

	Payment Period						
19. Type of Payment	22. Last Day of Work	23. Date of Return to Work or End of Healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer Paid Holidays	23. No. of Weeks and/or Days Paid	24. Rate	26. Amount of Comp. Paid	26. Accumulated Total Amount Paid
☒ TTD ☐ TPD ☐ Other:	2/1/99	6/6//99	3	17+2 days	$ 538.00	$ 9,325.32	$ 9,325.32
☐ TTD ☒ TPD ☐ Other:	6/6/99	8/8/99	0	9	$ 220.00	$ 1,980.00	$ 11,305.32
☐ TTD ☐ TPD ☒ Other: Salary Cont'd	8/8/99	9/6/99	0	4	$ 538.00	$ 2,152.00	$ 13,457.32
☐ TTD ☐ TPD ☒Other: Vocational Rehab	9/6/99	12/21/99	0	15	$ 538.00	$ 8,070.00	$ 21,527.32

SUPPLEMENTARY REPORT ON ACCIDENTS AND INDUSTRIAL DISEASES

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

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

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. (Please read the instructions on reverse for completing this form.)

1. Name of Injured Employee	2. Social Security Number
Barry L. Barry	555-55-5555

3. Address	City	State	Zip Code
32 South 3rd Street	Milwaukee	WI	53207

4. Injury Date	5. Last Day Employee Worked	6. Nature of Injury or Illness
7/1/2008	7/1/2008	Ankle Sprain

7. Employer Name	8. Address (City, State and Zip)
Department of Military Affairs	PO Box 14587 Madison WI 53708-0587

9. Insurance Carrier (Not TPA or Adjuster) ☒ Check if employer is self-insured	10. Insurer Claim Number	11. N.A.I.C. Number
Department of Administration, Bureau of State Risk Management	081-012884	

12. Insurer's Claim Handling Address	City	State	Zip Code
PO Box 77008	Madison	WI	53703-1008

13. Date & Type of First Compensation Payment	14. Amount of 1st payment	15. Weekly Wage Used to Set TTD Rate:	16. TTD Rate:
Type: ☒ TTD ☐ TPD ☐ Salary Cont'd ☐ Other Date: 7/31/2008	$ 403.71	$ 1121.11 ☒ Rate below max. - WKC-13-A attached ☐ WKC-13-A not attached - Estimated date it will be sent is:	$ 807.44

17. If 1st Payment Was Late, (more than 14 days after injury date) State Reason:
Didn't receive medical documentation initially

18. Remarks: ☐ Denied ☐ Being Investigated (Attach Copy of Denial Letter) ☐ Suspended -- Lack of Medical Information ☐ Suspended -- Other Reason (Attach Copy of Suspension Letter)

Date Final Medical Report required under DWD 80.02(2)(e) 4 is anticipated:

☐ Other Remarks (Specify):

	Payment Period						
19. Type of Payment	20. Last Day of Work	21. Date of Return to Work or End of Healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer Paid Holidays	23. No. of Weeks and/or Days Paid	24. Rate	25. Amount of Comp. Paid	26. Accumulated Total Amount Paid
☒ TTD ☐ TPD ☐ Other:	7/1/2008	7/9/2008		3 days			
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							

27. Amount of Permanent Partial Disability due:
(Attach supporting medical report if not previously submitted.)
Wks. @ $ = $

Indicate amount of PPD paid to date:
$

28. Final Indemnity Payment Date Type of Payment: Date of Payment:	29. Has the worker returned to work with wages at 90% or more of wages at the time of injury? ☐ Yes ☐ No

30. Report Prepared By	31. Work Phone No.	32. Position	33. Date Signed
Julie White	(608) 242 - 3157	Risk Manager	7/14/2008

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-6026 (R03/2016)
S. 102.08 WIS. STATS.

WORKER'S COMPENSATION
Temporary Total or Temporary Partial Disability Benefits for Job Related Injuries

Division of Enterprise Operations
Bureau of State Risk Management

Employee Name	Agency Name	
Dates absent from work (mm/dd/yyyy); (for TTD use inclusive dates) ☐ TTD (Temporary Total Disability) From: _____ ☐ TPD (Temporary Partial Disability) To: _____	Claim No.	Date of Injury (mm/dd/yyyy)
	Claim Examiner / Rep.	

WAGE INFORMATION FOR CALCULATING DISABILITY

$ _____ Maximum weekly wage in effect at time of injury **(from WKC-9572)**

$ _____ Weekly wage (from box 5a on **WKC-13A**)

☐ Less than maximum ☐ More than maximum ☐ Renewed disability – s. 102.43(7)

$ _____ **Weekly Temporary Total Disability Rate (Weekly Wage x 66.67%)**
(Weekly TTD Rate found in box 5c on WKC13-A)
(If more than maximum wage, use Maximum Weekly Rate on WKC-9572 chart).

TEMPORARY TOTAL DISABILITY TO BE PAID

$ _____ per week x _____ weeks . . . . . $ _____

$ _____ per day (1/6 of weekly rate) x _____ days . . . . . $ _____

TOTAL TTD BENEFITS DUE $ _____

TEMPORARY PARTIAL DISABILITY TO BE PAID

(% FROM **WKC-7359** (List each week separately.)

_____ % wage loss X $ _____ TTD rate for week of _____ (Sunday) to _____ (Sunday) = _____

_____ % wage loss X $ _____ TTD rate for week of _____ (Sunday) to _____ (Sunday) = _____

TOTAL TPD BENEFITS DUE $ _____

TOTAL BENEFITS DUE (if combined) $ _____

Report prepared by (name)	Date (mm/dd/yyyy)

This document can be made available in alternate formats to individuals with disabilities upon request.

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-6026 (R05/2007)
S. 102.08 WIS. STATS.

WORKER'S COMPENSATION
Temporary or Permanent Disability Benefits for Job Related Injuries

Division of Enterprise Operations
Bureau of State Risk Management

Employee Name	Agency Name
Barry L. Barry	Department of Military Affairs

Dates absent from work (mm/dd/yyyy): (for TTD use inclusive dates)

☒ TTD (Temporary Total Disability) From: 07/02/2008

☐ TPD (Temporary Partial Disability) To: 78/20/08

Claim No.	Date of Injury (mm/dd/yyyy)
081-012884	07/01/2008

Claim Examiner / Rep.
Amy Salzberg

TEMPORARY DISABILITY

$ 1,207.50 Maximum weekly wage in effect at time of injury

$ 1,121.11 Weekly wage (from WC-13A)

☒ Less than maximum ☐ More than maximum ☐ Renewed disability – s. 102.43(7)

$ 807.44 Weekly temporary total disability rate (weekly wage x 66.67%)
(If more than maximum wage, use Weekly Rate on chart)

TEMPORARY TOTAL DISABILITY CALCULATION

$ _____ per week x _____ weeks . . . . . $ _____

$ 134.57 per day (1/6 of weekly rate) x 3 days . . . . . $ 403.71

TOTAL TTD BENEFITS DUE $ 403.71

TEMPORARY PARTIAL DISABILITY CALCULATION - % FROM WKC-7359 (WC-13b) List each week separately.

_____ % wage loss X $ _____ TPD rate for week of _____ (Sunday) to _____ (Sunday) = _____

_____ % wage loss X $ _____ TPD rate for week of _____ (Sunday) to _____ (Sunday) = _____

TOTAL TPD BENEFITS DUE $ _____

TOTAL BENEFITS DUE (if combined) $ _____

Total amount previously paid	Date payment due (mm/dd/yyyy)
$0.00	73/12/008

Concede or Final

Report prepared by (name)	Date (mm/dd/yyyy)
Julie White	71/62/008

Worker's Compensation

Determining Temporary Partial Disability Benefits

TPD is due whenever a worker who is otherwise eligible for compensation suffers a wage loss due to medical circumstances related to the injury that cause either:

- a reduction in the number of hours of work that the employee would otherwise be scheduled to work, or
- a reduction in hourly wages due to being placed on "light duty"

Eligibility for TPD will change to TTD if the offer of restricted work is unreasonable.

Examples of unreasonable work offers: Work offered was one-half a day and the employee would have to come in several times during the day. The employee would be required to travel an unreasonable distance. Work within medical restrictions is not available.

TPD may be denied or suspended if the employee refuses to follow the Doctor's orders or fails to attend a medical examination that is reasonable or refuses to accept an offer of light duty work

TPD is computed using a wage-loss formula. Use the formula and examples in the TPD worksheet, in the WKC-7359-1-E form to compute the amount of TPD due for any given week.

Worker's Compensation - General Guidelines for Temporary Partial Disability Computations

- **Part-time employees** --Use actual wage at the time of the injury, NOT THE EXPANDED WAGES, to compute the wage loss. There is an exception when there are two jobs involved. Call us at (608) 266-1340.
- **TTD & TPD** in the same week -- Figure the entire week as a week of TPD.
- **Time off without pay** by employee's choice, holiday or sick leave during the week of TPD should be added to the amount earned before calculating wage loss.

- **Plant (employer) shutdown** in accordance with a collective bargaining agreement (reference s.102.43 (8) (b). e.g. vacation, model changeover etc. – If no work is available to the employee, TPD continues as it did before the plant shutdown. If the shutdown is not in accordance with a union contract or there is a general layoff situation, TTD is paid for the weeks of the shutdown or layoff.

- **Escalation per 102.43(7)** -- If there is a renewed period of TTD or TPD more than 2 years after the injury date, the escalated rate should be used in column 8 on the TPD supplement form. If there is continuous TTD & TPD there is no escalation.

Completing the "TPD worksheet" (WKC-7359)

1. Week ending is the Sunday date following the week of TPD.
2. Hours the injured worked.
3. Hourly rate the employee was earning for the week of TPD.
4. Earned -- The injured employee obtains a job after the injury, the wage earned is from the other employer and the injured employee needs to report their taxable earnings to the insurance carrier, so the carrier can determine what TPD is due for each week the employee is on temporary restrictions.
5. Weekly wage at time of injury -- This is the actual wages for employees that have had their TTD wage expanded or if the employee was full-time at the time of the injury it is the TTD wage.
6. Wage loss -- Subtract the amount earned from the wage at the time of the injury.
7. % -- divide the wage loss by the wage at the time of the injury.
8. TTD rate -- This is the same rate that the temporary total disability was paid at. It does not lower to 2/3rd's of the actual wage.

   (Use the escalated rate if there is a renewed period of disability more than 2 years after the date of injury.)
9. TPD rate -- Multiply the TTD rate by the % of wage loss.

See the next page for an example of a TPD Worksheet

TEMPORARY PARTIAL DISABILITY

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Avenue, Rm. 161
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-3264
Fax: (608) 267-0394

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

WC Claim Number	Employe Name
STARSWEB CLAIM NO	**Jane Q Employee**
Employe Social Security Number	Employer Name
987-65-4321	**Your Agency's Name**
Injury Date	Insurance Company Name (not adjusting company)
01/08/08	**State of WI, Dept of Administration**

- Each period of Temporary Partial Disability (TPD) is to be entered as a line of compensation on the WKC-13. Use this form only to verify the TPD rate.
- Figure TPD on a weekly basis, Sunday to Saturday.
- **Attach this form as a part of the WKC-13 showing Temporary Partial Disability paid.**

- Read instructions on reverse side before calculating Temporary Partial Disability below.

1	2	3	4	5	6	7	8	9
Week Ending	**Hours Emp. Worked**	**@**	**Earned**	**Weekly Wage at Time of Injury**	**Wage Loss**	**%**	**TTD Rate**	**TPD Rate**
02/03/08	**20**	**17.78**	**355.60**	**711.28**	**355.68**	**.50**	**479.19**	**239.60**
Calculation								
02/10/08	**30**	**17.78**	**533.40**	**711.28**	**177.88**	**.25**	**479.19**	**119.83**
Calculation								
Calculation								
Calculation								
Calculation								
Calculation								
Calculation								
Calculation								
Calculation								

Permanent Partial Disability Benefits (PPD)

- **Compensates for loss of permanent function**
- **Based on percentage of loss per area**
- **Determined by medical provider**
- **Not all injuries warrant PPD**

Permanent Partial Disability, or PPD. PPD is to compensate an employee for the loss of permanent functionality. For example, an employee has shoulder surgery resulting in permanent difficulties raising the arm over the shoulder. This is a permanent loss of function which would warrant PPD. The injured employee's doctor would provide Workers Compensation with a "permanency rating." For example, this aforementioned shoulder injury may result in a 5% PPD rating to the shoulder.

Workers compensation would take this 5%, compute it into statutory weeks, 25 weeks in this case and multiply the weeks times the statutory PPD weekly rate. The current PPD weekly rate is $362.00.

So, $362.00 times 25 = $9050.00.

The injured employee would receive $9050.00, after his/her injury recovery has reached a plateau.

The above process may be a bit complicated for you to grasp in this short training session; however, the goal here is to provide you the basics of understanding. You will not be expected to calculate PPD.

It is also important to note that not all injuries warrant PPD.

There are two different classifications of permanent injuries.

1. Scheduled
2. Un-scheduled

For the purpose of this training manual, PPD will not be covered in full. 102.52 and 102.53 of the Workers Compensation Act will outline greater detail, but there are additional sections of the act as well. The basics of what a new examiner should know about PPD is:

Non-Scheduled injuries include: Back, Neck, Head, Psychological/ or mental. There are others, but these are the most common. All non scheduled injuries are worth 1000 weeks.

For these examples, we assumed the injury took place in 2001 and the employee was entitled to the maximum rate of $184.00. The PPD rate is either the maximum rate for year of injury or employee's TTD rate, whichever is lower. (Maximum Weekly PPD Rates for other dates of injury)

PPD rating by doctor: 10% to the right knee:

10% X 425 weeks (per schedule) = 42.5 weeks

Multiply 42.5 weeks by PPD rate

Therefore:

42.5 weeks X $184.00=$7820.00*

PPD rating by doctor: 25% loss of use to distal joint of left little finger:

25% X 6 weeks (per schedule) =1.5 weeks

Multiply 1.5 weeks by PPD rate

1.5 weeks X $184.00=$276.00

PPD rating by doctor: 2% loss of use to left wrist:

2% X 400 weeks (per schedule) = 8 weeks

Multiply 8 weeks by PPD rate

8 weeks X $184.00=$1472.00

PPD rating by the doctor: 5% to the body as a whole

5% multiplied by 1000 weeks (for nonscheduled injury) = 50 weeks

Multiply 50 weeks by PPD rate

50 multiplied by $184.00=$9200.00*

***PPD is to be paid at a rate of $797.33 a month until sum of it has been paid.

Permanent Partial Disability Schedule

- **The PPD Schedule is authorized in section 102.52 of the Wisconsin state statutes.**

Loss of Body Part	Weeks of Compensation			
Finger	**Distal**	**2nd Joint**	**Proximal**	**Metacarpal & metacarpal bone**
Thumb	50 weeks		120 weeks	160 weeks
Index	12 weeks	30 weeks	50 weeks	60 weeks
Middle	8 weeks	20 weeks	35 weeks	45 weeks
Ring	6 weeks	15 weeks	20 weeks	26 weeks
Little	6 weeks	16 weeks	22 weeks	28 weeks

Loss of Body Part	Weeks of Compensation
Arm at the shoulder	500 weeks
Arm at the elbow	450 weeks
Hand/at wrist	400 weeks
Palm where thumb remains	325 weeks
Of all fingers on one hand at their proximal joints	225 weeks

Loss of Body Part	Weeks of Compensation
Leg at the hip joint	500 weeks
Leg at the knee	425 weeks
Foot at the ankle	250 weeks

Palm where thumb remains	325 weeks

Toes	Distal	2nd Joint	Proximal	Metacarpal & Metacarpal Bone
Great	12 weeks		25 weeks	83 weeks
Second	4 weeks	6 weeks	8 weeks	25 weeks
Third	4 weeks	4 weeks	6 weeks	20 weeks
Fourth	4 weeks	4 weeks	6 weeks	20 weeks
Little	4 weeks	4 weeks	6 weeks	20 weeks

Loss of Body Part	Weeks of Compensation
One Eye, by enucleation or evisceration	275 weeks
One Eye for industrial use	250 weeks
Total Deafness by accident or sudden trauma	330 weeks
Total deafness, one ear from accident or sudden trauma	55 weeks

If an employee had a surgical procedure, it is important to indicate the number and types of procedures, and if related to the spine, the level operated upon (for example, L4-S1, C2-C3, etc.)

If DWD Administrative Code 80.32 sets disability based on loss of motion (for instance, shoulders, wrists, fingers), please give range of motion measurements. It is recommended that a WKC-16 form be completed.

If an employee suffers a finger amputation, include a statement as to whether the amputation involved less than one-third, between one-third and two-thirds, or more than two-thirds of the distal phalanx. If the amputation involved more than two-thirds of the distal phalanx, comparative x-rays will need to be taken so that the exact amount of bone loss may be determined. And, it should be noted on the report which hand is the employee's dominant hand.

In cases of vision loss, it must be emphasized that a proper permanent partial disability calculation cannot be done without a thoroughly completed WKC-16-A form.

Additional rules regulating when a final exam for determining vision loss may be conducted as defined in DWD Administrative Code, 80.26

For the purposes of calculating permanent partial disability for occupational deafness, obtain for each ear the average hearing level in decibels at these four frequencies: 500, 1000, 2000, and 3000 Hz.

**WKC - 16 example next page.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

MEDICAL REPORT ON INDUSTRIAL INJURY

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

PATIENT	WC Claim Number	Employee Name	
	Employee Social Security Number	Employee Address	
Injury	Date	Employer Name	Insurance Company
HISTORY	History as described by patient		
DIAGNOSIS (Please be as detailed as possible)			
PERMANENT DISABILITY (Describe permanent elements of disability, such as limitation of motion, pain, weakness, etc., and describe effect on working ability.)	What amputation present?	Comparative x-rays taken? ☐ Yes ☐ No	Stump: ☐ hardy or ☐ tender
	Has permanent disability resulted? ☐ Yes ☐ No	Date of Last Exam	Has healing period ended? ☐ Yes ☐ No / Patient discharged? ☐ Yes ☐ No
	Description of permanent disability (Record finger motion losses on reverse.)		
	Was surgery performed as a result of accident? ☐ Yes ☐ No If Yes, state type of surgery:		
	If healing has not ended, what is minimum permanent disability expected?		
PRIOR DISABILITY	What previous disability?		
PROGNOSIS	Prognosis:		
	Date injured was or will be able to return to a limited type of work: State any limitations:		
	Date injured was or will be able to return to full-time work subject only to permanent limitations:		
	What further treatment should be given?		
Additional comments, if any:			
Date	City	Physician or Chiropractor Signature (in own writing)	
	Phone Number ( ) -	Typed or Printed Name 73	

Employee Name	Employee Social Security Number

Instructions for finger injuries

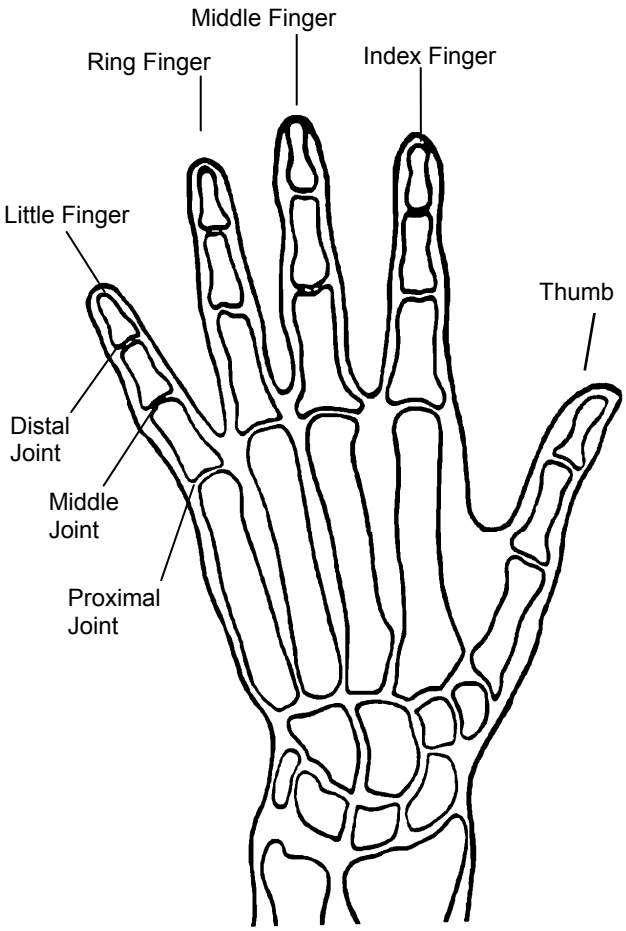
Please use statutory terms in referring to fingers, such as thumbs, index, middle, ring, and little fingers, and distal, middle, and proximal joints. Where there is limitation of motion, list separately the normal range of motion in degrees, the "degrees" loss of flexion, and the "degrees" loss of extension for each joint of each finger. The Worker's Compensation Division will evaluate the loss of use due to loss of motion of the fingers.

Where there are other elements of disability of the fingers, such as deformity, weakness, pain, or lack of endurance, give your opinion on the percentage loss of use as compared to amputation for such elements of disability and specify the joint at which such loss is estimated.

Digit	**Joint**	**Angle Ext./Flex**	**Normal Range of Motion**	**Degrees Loss Extension**	**Degrees Loss Flexion**	**Estimate** % loss of use for additional factors at joint involved and reason for additional allowance
Thumb	Dist					
	Prox					
Index	Dist					
	Mid					
	Prox					
Mid	Dist					
	Mid					
	Prox					
Ring	Dist					
	Mid					
	Prox					
Little	Dist					
	Mid					
	Prox					

CIRCLE HAND INVOLVED: Right Left

DOMINANT HAND: Right Left



See DWD 80.32 & 80.33 for guides to evaluation for amputations, restrictions of motion, ankylosis, sensory loss, and surgical results for disability to the hip, knee, ankle, toes, shoulder, elbow, wrist, fingers and back.

If fingertip amputation is present, submit comparative x-rays or a statement indicating whether the bone loss was less than one-third, between one-third and two-thirds, or more than two-thirds of the distal phalanx.

If amputation is below the distal joint, submit comparative x-rays.

Permanent Total Disability, or PTD

PTD is awarded to an injured employee whose injury has left them unable to return to **any type of work.** PTD would be paid to the injured employee for the rest of his/her life. PTD claims are not easily accepted by Workers Compensation, as the belief is that most people can do some type of work.

PTD rates are computed using the injured employee's wages at the time of injury and again, there is a statutory maximum. The PTD benefit is paid out monthly to the employee. Lastly, as always, a doctor has to provide the PTD determination.

PTD -

- ✓ Compensates for loss of wages when unable to return to any type of work
- ✓ Computed based on wages at time of injury
- ✓ Determined by medical provider
- ✓ Very few PTD cases - Most people can return to some kind of work.

PTD Benefits are determined by taking the injured employee's average weekly wage at the time of the injury and multiplying it by 4.333. This will provide the examiner a monthly rate.

To estimate the exposure of a PTD claim, the examiner would then take the monthly rate times the injured employee's life expectancy. The following page provides you with a life expectancy chart.

Table A. Expectation of life, by age, race, Hispanic origin, race for the non-Hispanic population, and sex: United States, 2011

Age	All races and origins			White			Black			Hispanic[1]			Non-Hispanic white[1]			Non-Hispanic black[1]		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
0	78.7	76.3	81.1	79.0	76.6	81.3	75.3	72.2	78.2	81.6	79.0	83.8	78.8	76.4	81.1	74.9	71.7	77.9
1	78.2	75.8	80.5	78.4	76.0	80.6	75.2	72.1	78.0	81.0	78.5	83.2	78.2	75.9	80.4	74.8	71.6	77.7
5	74.3	71.9	76.6	74.4	72.1	76.7	71.3	68.2	74.1	77.1	74.5	79.3	74.2	71.9	76.5	70.9	67.8	73.8
10	69.3	66.9	71.6	69.5	67.1	71.8	66.4	63.3	69.1	72.1	69.6	74.3	69.3	67.0	71.5	66.0	62.8	68.8
15	64.4	62.0	66.7	64.5	62.2	66.8	61.4	58.4	64.2	67.1	64.6	69.3	64.3	62.0	66.6	61.1	57.9	63.9
20	59.5	57.2	61.7	59.7	57.4	61.9	56.6	53.6	59.3	62.3	59.8	64.4	59.5	57.2	61.7	56.3	53.2	59.0
25	54.8	52.5	56.9	54.9	52.7	57.0	52.0	49.1	54.4	57.5	55.1	59.5	54.7	52.6	56.8	51.6	48.7	54.2
30	50.0	47.9	52.0	50.1	48.0	52.2	47.3	44.6	49.6	52.6	50.3	54.6	50.0	47.9	52.0	47.0	44.2	49.4
35	45.3	43.2	47.2	45.4	43.4	47.3	42.7	40.1	44.9	47.8	45.6	49.7	45.3	43.3	47.2	42.4	39.7	44.7
40	40.6	38.6	42.4	40.7	38.7	42.6	38.1	35.5	40.3	43.0	40.9	44.8	40.6	38.6	42.4	37.8	35.2	40.0
45	36.0	34.0	37.8	36.1	34.2	37.9	33.6	31.1	35.7	38.3	36.2	40.0	36.0	34.1	37.7	33.3	30.8	35.5
50	31.5	29.7	33.2	31.6	29.8	33.3	29.3	26.9	31.3	33.7	31.7	35.3	31.5	29.7	33.2	29.1	26.6	31.1
55	27.2	25.5	28.8	27.3	25.6	28.8	25.3	23.0	27.1	29.3	27.4	30.8	27.2	25.6	28.8	25.1	22.8	26.9
60	23.1	21.6	24.5	23.2	21.6	24.5	21.5	19.4	23.2	25.0	23.3	26.3	23.1	21.6	24.5	21.3	19.3	23.0
65	19.2	17.8	20.3	19.2	17.8	20.3	18.0	16.2	19.4	20.9	19.3	22.0	19.1	17.8	20.3	17.9	16.1	19.2
70	15.5	14.3	16.5	15.5	14.3	16.4	14.7	13.2	15.8	17.0	15.7	17.9	15.4	14.3	16.4	14.6	13.1	15.7
75	12.1	11.1	12.9	12.1	11.0	12.8	11.7	10.4	12.5	13.4	12.3	14.1	12.0	11.0	12.8	11.7	10.4	12.5
80	9.1	8.2	9.6	9.0	8.2	9.6	9.1	8.0	9.6	10.2	9.2	10.6	9.0	8.2	9.6	9.0	8.0	9.6
85	6.5	5.9	6.9	6.5	5.8	6.8	6.8	6.0	7.2	7.4	6.6	7.6	6.5	5.8	6.8	6.8	6.0	7.2
90	4.6	4.1	4.8	4.5	4.0	4.7	5.1	4.5	5.3	5.2	4.6	5.2	4.5	4.0	4.7	5.1	4.5	5.3
95	3.2	2.9	3.3	3.1	2.8	3.2	3.8	3.4	3.9	3.6	3.2	3.5	3.1	2.8	3.2	3.8	3.4	3.9
100	2.3	2.1	2.3	2.2	2.0	2.2	2.8	2.6	2.9	2.5	2.3	2.4	2.2	2.0	2.2	2.9	2.6	2.9

[1]Life tables by Hispanic origin are based on death rates that have been adjusted for race and ethnicity misclassification on death certificates.
SOURCE: CDC/NCHS, National Vital Statistics System.

Loss of Earning Capacity, or LOEC

Loss of Earning Capacity is a benefit paid to an employee if an injury results in permanent loss of wages.

If Workers Compensation is unable to find the employee a job within 90% of his/her previous earnings, they may owe a **Loss of Earning Capacity (LOEC**). Take for example this same employee who was earning 20.00 per hour. Let's say Workers Compensation is only able to find this employee a job making 14.00 per hour. LOEC would pay the difference.

The injured employee may choose to be assessed by a private Vocational expert who will determine what percentage of LOEC the injured employee has sustained. In this case, the Examiner should in turn schedule a Vocational assessment with a Vocational Expert of their choosing to obtain another opinion as to the LOEC. The new examiner will be provided a list of current Vocational Experts upon their training.

Once a LOEC percentage has been determine and agreed upon it is converted to dollars.

Take for example a 40% LOEC

40% x 1000 weeks = 400 weeks x the PPD rate at the time of the injury.

There is a rebuttable presumption that a retraining program of 80 weeks or less is reasonable. A retraining program more than 80 weeks may be reasonable, but there is no presumption. A retraining program more than 80 weeks may not be authorized if the primary purpose is to improve upon pre-injury earning capacity rather than restoring the earning capacity.

Very rarely will DOA/the examiner agree to a training program greater then 80 weeks. Claims in which the employee is demanding more training will usually lead to a litigated dispute. (take for example the injured employee demanding DOA pay for a college degree)

DEATH BENEFITS

PAID TO SPOUSE AND DEPENDENTS AND BURIAL EXPENSES PROVIDED

If a work-related accident or occupational disease causes death, or if a worker dies while entitled to PTD benefits, the law provides for the payment of compensation to a spouse, parent or a relative. Extra benefits are paid to dependent children.

Benefits To The Surviving Spouse

If there is a surviving wife or husband, benefits are paid to the spouse, and all other relatives are excluded (except children who get additional benefits). Compensation varies according to the employee's wage up to the maximum wage in effect at the time of injury. The maximum death benefit is four times the average annual earnings. The benefits are payable monthly. If there is a spouse and dependent children, the division may reassign death benefits to the children if the spouse remarries.

Extra Benefits

Dependent children under 18 years of age living with the employee at the time of injury may receive additional benefits. If the child is mentally or physically incapacitated, benefits may be paid past age 18. The amount of benefits varies with the age of each child. The younger the child, the greater the total benefit.

Death Benefits Other Than To Spouse Or Children

If there is no surviving spouse or child and the employee was totally supporting a parent or other relatives, such parent or relatives are entitled to the full death benefit. If parents are not dependent, but have maintained friendly relations with the deceased, they are allowed $6,500 if the injury occurred on or after January 1, 1990. If the employee contributed $500 to the support of parents in the year before death, the parents may be awarded additional death benefits up to the greater of four times the contributions in the preceding year or one-half of the normal death benefit.

Burial Expenses

In all cases where death results from a work-related accident or disease, the employer or the insurance company must pay burial expenses up to the limits in the law.

Mileage Reimbursement

The employer must reimburse the employee, at the rate set by DWD, for the expense of travel to obtain reasonable and necessary medical treatment.

The rate can be escalated. DWD link for current mileage rate: https://dwd.wisconsin.gov/wc/workers/mileage-rates.htm

MENTAL/PSYCHOLOGICAL CLAIMS

Dealing with claims involving metal stress can be challenging and often times very costly.

There are three different categories of mental claims:

- ✓ Mental/Mental (Non-traumatic Mental Injury)
- ✓ Mental/Physical
- ✓ Physical/Mental

Mental/Mental claims involve no physical injury. The employee alleges their injury is exclusively mental. For example, the employee alleges that the direct threat of a terrorist attach on their building caused extreme mental stress.

Mental/Physical claims involve an employee alleging a mental issue has caused physical symptoms. For example, an employee who is stuck in an elevator for an hour + now suffers great anxiety and mental stress. Within a few hours of being freed from the elevator, the employee develops blistering lesions all over their body, allegedly cause bye the traumatic stressful event.

Physical/Mental claims involve an actual physical injury which in turn caused mental issues. For example, a correctional officer is beat up by an inmate, causing a broken nose and wrist. The physical injury heals, but the correctional officer now is afraid, mentally, to return to work as a correctional officer.

The Wisconsin Supreme Court decided in 1974 that although a non traumatic mental injury may be clearly work related, workers compensation liability will only exist if the injury resulted from extraordinary stress - "a situation of greater dimension**," than " **the countless emotional strains and differences that an employee encounters daily without serious mental injury**." This case is referred to as *the School Dist. Case.*

The following pages include a copy of this case for the new examiner's reference. You will quote and use this case to determine if the mental/mental claims handled are compensable.

Supreme Court of Wisconsin.

SCHOOL DISTRICT #1, VILLAGE OF BROWN DEER, et al., Appellants,
v.
DEPARTMENT OF INDUSTRY, LABOR & HUMAN RELATIONS and Mary R. Tauscher, Respondents.
No. 222.

March 5, 1974.

Claimant, a high school counselor, brought claim for workmen's compensation claiming a compensable injury in the nature of anxiety reaction caused by accident arising out of her employment. The Department of Industry, Labor & Human Relations affirmed findings of an examiner that claimant had sustained a compensable injury and the employer and its insurer appealed. The Circuit Court for Dane County, George R. Currie, Reserved Circuit Judge, affirmed and an appeal was taken. The Supreme Court, Hanley, J., held that the counselor's receipt of a list of suggestions from high school student council which, among things, called for her dismissal was not deemed to be so out of the ordinary from the countless emotional strains and differences that employee encountered daily without serious mental injury to justify an award of compensation.

School counselor's receipt of a partially blacked out list of suggestions prepared by student council which, among other things, asked for her dismissal could not be deemed so out of the ordinary from the countless emotional strains and differences that employees encounter daily without serious mental injury to authorize an award for mental injury under Workmen's Compensation Act.

This is a Workmen's Compensation case. The Department of Industry, Labor & Human Relations (hereinafter, department) affirmed the findings of an examiner that the claimant, Mary R. Tauscher, sustained a compensable injury in the nature of an acute anxiety reaction caused by accident arising out of her employment and awarded statutory benefits for temporary total disability and directed payment of medical expenses. The employer and its insurer appeal from that part of the judgment.

The respondent, Mary R. Tauscher, was employed as a guidance counselor by the appellant school district and assigned to the Brown Deer High School Commencing her employment in September of 1968.

On February 16, 1971 the respondent found a list of recommendations in her school mail box. The recommendations were submitted by the students of Brown Deer High School and asked for the removal of several staff members and numerous other changes. The copy which the respondent received had been blacked out such that it was extremely difficult to discern the recommendation to 'remove Miss Tauscher from the staff.'Miss Tauscher received this list at 3:30 P.M. and left school returning to her home.

The following day, Miss Tauscher returned to school and questioned several students concerning the recommendations. She testified that she became emotionally upset during such questioning and again returned home. During the next several days the respondent stated she was unable to sleep or eat, was nauseated, had severe headaches and acute anxiety.

On February 18, 1971 the respondent telephoned Dr. William C. Miller of Wausau who prescribed medication. Miss Tauscher remained in bed for several days thereafter and took the medication. In March, 1971 the respondent personally visited Dr. Miller who diagnosed her condition as a 'severe neurosis tension state with gastro intestinal signs and symptoms.'

After visiting Dr. Miller, Miss Tauscher returned to the Milwaukee area and on May 28, 1971 visited Dr. Bernard Schaeffer. The respondent told Dr. Schaeffer of the above-described incident and of the recurring medical problems she had since then. Dr. Schaeffer diagnosed said problems as a severe depressive reaction with anxiety and that she would recover from this reaction sufficiently so as to be able to return to work in September.

Dr. Francis J. Miller examined respondent on June 3, 1971. In his opinion she appeared mentally clear, coherent, relevant, oriented, pleasant, co-operative and alert and did not appear particularly anxious or tense or depressed. Dr. Millen was of the further opinion that it was plausible that the posting of the recommendations of the student council precipitated an acute anxiety reaction and that it was of a temporary nature.

Miss Tauscher did not return to Brown Deer High School during 1971. She was, however, compensated for a period of time up to and including March 18, 1971. In July of 1971 the respondent testified she had recovered sufficiently so as to chaperone some students on a trip to Europe. Additionally, the respondent testified, she had procured future employment as a guidance counselor at the University of Wisconsin, Milwaukee, for the fall term of 1971.

The Department made the following findings:
'. . . that on February 16, 1971 the applicant sustained an injury in the nature of an acute anxiety reaction caused by an accident arising out of the applicant's employment by the respondent; that at the time of the injury, the applicant was performing services incidental to her employment by the respondent; that as a result of the injury of February 16, 1971, the applicant sustained temporary total disability from February 16, 1971 to June 18, 1971; . . . that the extent of the permanent partial disability applicant sustained as a result of the injury of February 16, 1971 cannot now be determined; that, therefore, jurisdiction is reserved to issue such further orders concerning disability and medical expense as may be warranted; . . . that as a result of the injury of February 16, 1971, the applicant incurred reasonable and necessary medical expense as follows: to Dr. W. C. Miller, $26.00; to Dr. B. S. Schaeffer, $50.00.'

This was not to be the end of this case though. The Supreme Court overturned the decision and decided in 1974 that although a non-traumatic mental injury may be clearly work related, workers compensation liability will only exist if the injury resulted from extraordinary stress "situation of greater dimensions" then the countless emotional strains and differences that employees encounter daily.. The Supreme Court ruled against Ms. Tauscher.

In reaching its decision, the court sought to avoid: opening the floodgates to numerous fraudulent claims of mental injury:

The next page provides you with a copy of a denial letter for a mental stress claim. Note the denial letter sites the above case.

August 27, 2007

John John
555 Melody Lane
Madison, WI 53704

Re: Worker's Comp Claim No: 00-1010000
Date of Loss: 07-05/09
Employer: Mendota Mental Health Institute

Dear Mr. John:

The State of Wisconsin is self-insured for Worker's Compensation through the Department of Administration.

We recently received your claim, in which you are claiming mental stress due to a situation at work.

For a **mental stress** claim to be considered compensable, the following **must be shown**, based on the case, "School District No. 1 v. DIHLR Department," 62 WIS§2d 370, 377-78(1974):
'…th*at the mental injury non traumatically caused must have resulted from a situation of greater dimensions*
than the day to day emotional strain and tension which all employees must experience. Only if the fortuitous event unexpected and unforeseen can be said to be so out of the ordinary from the countless emotional strain and differences that employees must encounter daily without serious mental injury will liability under the Worker's Compensation Act be found."

There is lack of supporting evidence that indicates the situation in which you were involved in meets the above criteria. Therefore, the Department of Administration is denying this claim at this time.

If you disagree with this position, you have the right to file an application for hearing with the Department of Workforce Development (DWD), Worker's Compensation Division, 201 E Washington Avenue, PO Box 7901, Madison, WI 53707. You may call DWD at (608) 266-1340 for more information.

Sincerely,

Sue Graf
Worker's Comp Claims Examiner
Bureau of State Risk Management

CC:
DWD/WC Division 2000-000000
File

Unique Claim Situations requiring "special claim handling"

There are a few claim situations which require "special," handling procedures, so DOA has developed guidelines for these unique situations. The Special handling involves claims of:

- ✓ Tick Bites, Lymes Disease
- ✓ TB/Turboculosis
- ✓ MRSA
- ✓ HIV
- ✓ Hepatitis
- ✓ Hearing Loss

The following pages will provide guidelines for these situations:

WORKERS COMPENSATION GUIDELINES FOR HEARING LOSS CLAIMS

Workers compensation claims reporting occupational hearing loss are, for the most part, automatically suspended. There is a standard suspension letter to the claimant (*ENTERPRISE Claim Mgr, Hearing Loss, H3*) requesting a HIPAA, provider list, and a hearing loss questionnaire (*ENTERPRISE Claim Mgr, Hearing Loss, H2*).

The suspension letters states that the claimant is responsible for obtaining a hearing test and for providing workers compensation with the results of that hearing test.

When a copy of the audiogram is received, it should be forwarded to DWD for PPD calculations (*ENTERPRISE Claim Mgr, PPD Request to DWD, H1*). If there is a significant hearing loss, we would then investigate further to determine a cause.

Before requesting prior medical records and deciding on plan of action, it is important to review the treating doctor's medical notes for causation, and to determine our likely financial exposure. Should significant monetary exposure be involved, and the claim appears questionable (*red flags might be prior military service, prior work in a profession with high noise levels, recreational use of guns, age, etc.*) obtain certified medical records and schedule an IME.

WORKERS COMPENSATION GUIDELINES FOR TICK BITES (LYME DISEASE EXPOSURE)

If a claimant is alleging a tick bite and in fact reports to have removed one from his body, workers compensation will concede liability for the initial doctor's visit and any prophylactic that may be prescribed.

If there is a follow-up office visit associated with the initial visit, workers compensation will concede this visit also.

Should the claimant return for a follow-up Lyme disease titer, and the results are negative, workers compensation will now deny this office visit and lab test, as it would appear the claimant's symptoms are not the result of this tick bite or Lyme disease.

Should the claimant report to a doctor "several" months after a reported bite "suspecting" Lyme disease because of that tick bite, workers compensation will obtain the results of the Lyme titer to determine compensability. If there is a negative Lyme titer, the claimant's symptoms are not the result of Lyme disease or the tick bite, and treatment would be denied.

Should a claimant test positive for Lyme disease, but cannot recall an attached tick, or did not report an attached tick within a reasonable time, workers compensation would most likely deny the charges for the office visit and test. This type of situation would have to be decided on a case by case basis.

WORKERS COMPENSATION GUIDELINES FOR TUBERCULOSIS (TB) EXPOSURE

Some state health institutions provide TB testing upon initial employment and annually to their employees. DOC does not do annual TB testing. DOC testing is done upon initial employment, positive risk factors, or upon request. The preferred test is a blood test, but a skin test is also accepted.

If a claimant has been employed at a state correctional facility or DHFS institution and the claimant's TB test is positive, the employee may have been exposed to TB at the facility.

The employee is required to see a medical provider for evaluation and to obtain documentation that they are free of communicable TB disease. Worker's Comp will pay for that initial office visit charge and testing (i.e. TB test, chest x-ray, scan, etc.) done at provider's discretion.

If the employee's TB test is positive, and the medical provider recommends treatment, Worker's Compensation will pay for all reasonable and necessary treatment recommended by the provider.

* All employees with a positive TB test must obtain documentation from a medical provider that they are free of active TB disease.

*Employees without symptoms may remain in work status.

*Employees with symptoms must leave work immediately and may not return until documentation is received

* *Note: There are many different TB treatments available. Treatment recommended is at the provider's discretion. This is all addressed above.*

1. The claim handler should find out whether there were any known active TB cases within the past few years at the state facility where the claimant is employed.

2. The claim handler will investigate whether there was an exposure to tuberculosis prior to employment with the state or to a source outside of his/her employment.

3. If the exposure is confirmed to be from the workplace, workers compensation will pay for all reasonable and necessary treatment, including office visits, drugs, lab tests, etc. recommended by the physician.

Worker's Comp is not responsible for pre-employment or pre-service employees' treatment, or evaluations as they have not yet been exposed to the prison population.

The Dept of Health Services can be contacted at 608-261-6319 for questions about TB

MRSA

WORKERS COMPENSATION GUIDELINES FOR MRSA (METHICILLIN RESISTANT STAPHYLOCOCCUS AREUS) EXPOSURE

Compensability of MRSA or CA MRSA under Workers Compensation. Our policy is that an employee suspecting MRSA should contact his/her physician and seek diagnosis and treatment. In order to become eligible for workers compensation, there would have to be a proven physical interaction with an infected inmate and medical documentation from the claimant's treating physician relating the MRSA to the infected inmate. If these two criteria are present, we may consider paying reasonable and necessary treatment. We will not pay for the testing if these two criteria are not present, of if the employee's test comes up negative for MRSA. Even though an institution or agency may have clients/inmates/patients with MRSA within the agency, that does not necessarily support a "physical interaction" and therefore, would probably not be found to be compensable. As always, each case will be investigated on an individual basis, taking all factors into consideration.

Note 1: Facilities generally do not pay for the "core antigen" test which would determine whether the strain of MRSA present in the claimant and an inmate/patient are the same.

Note 2: CDC and Wisconsin Dept of Corrections provide regular statistics on RMSA.

ADDITIONAL INFORMATION

DEPT OF CORRECTIONS GUIDELINES FOR REPORTING MRSA to employer (January 2005)….

1. If you believe you have contracted MRSA, contact your healthcare provider for an examination and diagnosis
2. If MRSA is diagnosed by the healthcare professional and you believe that your infection was caused by interaction with an inmate, then request documentation from the healthcare professional relating the MRSA to the infected inmate exposure.
3. If the healthcare professional relates the MRSA to an infected inmate exposure, then file Workers Compensation claim by completing the Workers Compensation forms (DOA6058, WKC12, DOA6437) and submitting them to your Workers compensation coordination immediately.
4. The Workers Compensation Coordinator will enter the claim into the Workers Compensation database (Enterprise) and send the claim electronically to the Dept of Administration (DOA) Worker's Compensation in Madison.

What is MRSA? MRSA (Methicillin Resistant *Staphylococcus aureus*) is a type of staphylococcus bacterium that has developed resistance to the antibiotics usually used to treat the infection including methicillin, ampicillin and other penicillins.

There are two kinds of MRSA, HA MRSA (hospital acquired) and CA MRSA (community acquired). HA MRSA and CA MRSA strains are genetically different.

How do individuals get MRSA? …primarily by contact (direct or indirect) with a person who either has a wound infection, an infection of the respiratory tract or who is colonized with the bacteria. MRSA is primarily spread among hospital patients, nursing home residents and chronically ill persons. CA (community acquired) MRSA can infect healthy persons with no history of health care contact. Close contact of sports team members, prisoners, and military recruits make them especially susceptible to CA MRSA.

Factors that increase chance of acquiring CA MRSA. Skin to skin contact, cuts, cracks or abrasions in the skin, crowded living conditions, sharing towels and razors, rolling on wrestling mats or football fields with open scrapes or unbandaged cuts, and poor hygiene. Obese individuals have been found to be more susceptible to CA MRSA.

Does everyone who is exposed to MRSA become infected? No. Some who are exposed to MRSA become "colonized" (bacteria are present, growing and multiplying without observable signs of disease). Colonization occurs on skin surface, nasal passage, in sputum or in urine. Other individuals who are exposed to MRSA never become colonized. MRSA colonization may precede or lead to infection in persons with weakened immune systems. However, persons who get MRS infections are usually already very ill from other medical conditions.

Treatment. Effective antibiotics may include bactrim, vancomycine and teicoplanin.
Only patients with symptoms of MRSA infection should be treated. MRSA colonization should usually not be treated.

How long does MRSA last? Length of illness caused by MRSA infection depends upon severity of infection, response to antibiotics and individual's overall health. After infection has resolved, the individual may remain intermittently or persistently colonized with MRSA and may or may not develop future infection(s). Per Gwen Borlaug at DPH, recurrence with no new exposure is common.

Precautions. Hand washing for 15 seconds. Anyone caring for MRSA patient should wear gloves when handling body fluids (urine, wound drainage, etc), or contacting surfaces contaminated by body fluids. Good cleaning with soap and water followed by
household disinfectant (such as bleach) is adequate to disinfect surfaces contaminated with MRSA. Laundry can be done w/standard detergent. Dishes and utensils can be washed as usual.

Capital Times article of 11/8/07. "…'This isn't something just floating around in the air', Julie Gerberding, head of DCD & P told members of Congress.." "It takes close contact ..like sharing towels and razors, or rolling on the wrestling mat or football field with open scrapes or not bandaging cuts- to become infected with the staph germ called MRSA outside of a hospital…" "…MRSA is preventable largely by commonsense hygiene…"

Dept of Public Health Contact: Gwen Borlaug 7-7711
[BorlaGM@dhfs.state.wi.us]
Back up Tom Haupt 6-5326

HIV, HEP-B, HEP-C SIGNIFICANT EXPOSURE GUIDELINES

Blood Borne Pathogens are HIV, Hepatitis B, Hepatitis C and others.

Infectious Body Fluids are: blood, semen, vaginal secretions, cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluid, or other body fluid that is visibly contaminated with blood. Saliva, urine, feces, sputum, vomit, sweat, tears and nasal secretions are not considered potentially infectious unless they contain blood….risk for infection from these fluids is extremely low.

A "Significant" Exposure is defined as a sustained contact with a potentially infectious body fluid which carries a potential for transmission of a blood borne pathogen by one or more of the following:

- Transmission into a body orifice or into a mucous membrane
- Exchange during the accidental or intentional infection of a penetrating wound (needle stick, cut w/sharp object, human bite, etc).
- Exchange into an eye, open wound, oozing lesion or where a significant breakdown in the epidermal barrier has occurred.

Only a licensed health care practitioner can determine if an exposure was significant.

Compensable "exposure" treatment under workers compensation:

1. All office visits, medical treatment, and testing, whether or not "recommended and prescribed" by a doctor, if the patient/inmate/offender tests positive and there is evidence of a "significant" exposure or a "low risk" exposure.
2. Prophylactic medicine that are "not recommended and prescribed" by a doctor , but there is mention in the medical note of an exposure even if low risk exposure.
3. All office visits, medical treatment, and testing, whether or not "recommended and prescribed" by a doctor, if there was a evidence of a significant exposure.
4. All office visits, medical treatment, and testing, whether or not "recommended and prescribed" by a doctor, if there was evidence of a significant exposure, even if offender tests negative.
5. All office visits, medical treatment, and testing, whether or not "recommended and prescribed" by a doctor, if there was a evidence of a low risk or non-significant exposure.

When a "significant" blood/body fluid exposure is confirmed by medical documentation to have arisen out of or due to a hazard of employment, Workers Compensation will pay for the initial ER or office visit, the initial lab testing, a reasonable number of follow-up tests if prescribed by the treating doctor and a course of prophylactic treatment if prescribed by the treating doctor. Workers Compensation will also pay for follow up office visits necessitated by compensable lab testing and/or follow up related to a compensable course of prophylactic treatment.

If the treating doctor determines the exposure was not significant, yet the patient requests testing and/or follow up treatment (i.e. personal preference), workers compensation would not be liable for any office visits or testing not recommended by the treating doctor.

Lab tests and follow up: Usually lab tests are recommended at the initial visit after significant exposure, again at three (3) months, six (6) months and at one year post exposure. Agencies may have their own protocols for re-testing (i.e. Veterans Home Union Grove protocol is to have employees who have had an exposure tested at 3 and 6 months). State of Wisconsin Workers Compensation pays for all testing recommended by the treating doctor. In order to release HIV/HEP lab results, most medical providers and laboratories will require a signed HIPAA authorization (be sure to check the "Physical and Other" box). A letter to the claimant requesting a signed HIPAA and and medical provider list (*ENTERPRISE Claim Mgr, M2, F7, F11*)

Source person (a person whose potentially infectious blood or body fluid was in contact with another person). When the source person of a blood/body fluid exposure is an inmate, patient or member of a state institution, the claim handler will make an effort to obtain the laboratory test results for the source person. (Try to obtain inmate or patient test results through the agency coordinator or health nurse.) Inmates or patients will be asked to voluntarily be tested and provide their test results, if they refuse, the institution can obtain a court order to have the source person tested and to release the test results.

If the claimant's test result is positive, the claim handler will need to determine whether the claimant had an exposure to the disease prior to state employment or to a source outside of his/her employment (this may mean obtaining 10-20 years of prior medical records) (tattoo, IV drug use, etc would be red flags). (*ENTERPRISE Claim Mgr, P9, F7, F11*)

If the claim handler finds that the claimant has a diagnosed disease resulting from the work exposure, workers compensation will pay for all initial and follow up treatment to end of healing or maximum medical improvement.

ADDENDUM - Hep A, B, C and HIV Testing of Inmates

Hepatitis A

- Transmission fecal/oral contamination
- Immunization available
- No chronic (long term) infection
- Once you have had HEP A you cannot get it again
- 15% of people infect will have prolonged or relapsing sx over 6-9 month.

Hepatitis B

- Test for antibody post immunization
- Training
- PPE
- Exposure follow up
  Acute phase is 3-6 months after infection

Hepatitis C

- There is no vaccine
- Currently no established exposure drug prophylaxis
- Most HEP C positive people do not know they are positive for years
- Needle sticks, transfusion, shared drug paraphernalia (needles, syringes, straws)
  Number one reason for liver transplants in USA

HEP B Vaccinations/Boosters. HEP B vaccinations and/or booster shots may be provided by certain state agencies. It may be possible to get the HEP B status of a state employee if they were vaccinated at the institution.

HIV testing of inmates at State Correctional Institutions.
Per 9/11/07 email from Al Munn (Corrections): HIV testing is voluntary on the part of the inmates. Corrections has about 90% acceptance rate upon entry of inmates to the institution.
If/when a DOC employee is potentially exposed to a blood borne pathogen, the inmate can refuse to be HIV tested and/or release his test results. If the inmate refuses, the institution would get a court order.
The institution can either get the inmate to sign a release form to provide workers compensation with their test result, or a court order can be obtained.
The inmate result may be sent to the medical provider and become a part of the claimant's medical record.

Reserving

Claim Reserves are establishes separately for indemnity, medical and expense values. The case reserve represents the best current estimate of probable or expected claim/settlement cost associated with a claim.

Medical case reserve is that part of a case value associated with curative and/or therapeutic medical costs necessary to treat employment related injuries or disease. When establishing medical reserves, keep in mind, severity of injury, age of injured employee, hospital charges, physician charges, prescription charges, physical therapy charges….. With the onset of each new claim, a different medical scenario will develop and with more experience the more accurate the claim handler will become with reserving.

Indemnity case reserve is that part of a case value associated with Statutory benefits as follows:

_ Permanent Total Disability
_ Permanent Partial Disability
_ Temporary Total Disability
_ Temporary Partial Disability
_ Fatalities
_ Retraining (Occupational Vocational rehabilitation Services)

When establishing Indemnity reserves, again, keep in mind age, severity of injury, probably PPD based on part of body injured and TTD rates.

Expense case reserve is that part of a case value associated with claim and litigation management such as legal expenses, independent adjuster/experts, special investigation reports, independent medical examinations, medical bill audits, copy charges, and case management services. Expense reserves do not include general claim management expenses not specifically allocated to individual claims.

Evaluate Initial Claims info

1. First aid claims will not carry a medical case reserve. These claims either do not involve medical treatment by a medical provider or the medical treatment is limited to a one-time visit to a medical provider.

   Medical-only claims will carry a “standard” or formula medical case reserve of $2500.00 and a “standard” expense case reserve of$500, however reserves can increase if treatment continues for an extended period of time.

   Indemnity claims will carry case reserves that properly and adequately reflect statutory wage loss or restraining values in addition to medical and expense claim values.

Document reserves in the RMIS

3. The claims adjuster will enter the determined amount of reserves on to the RMIS along with entering notes in the RMIS as to why the given reserve values were chosen.

Periodic Review and update of reserves

4. Case reserves should be revised as soon as possible after a change in circumstances is brought to light. All information placed in a claim file, especially medical reports, investigative reports, etc., should be evaluated to determine its potential effect on the current case reserve levels. As the case develops from an investigative standpoint, it is equally essential that it be frequently reviewed to determine if case reserves are adequate in terms of reflecting the investigative developments on the case. In making such revisions, it is essential that a review be made of the total payments to date,
in order to project a reasonable evaluation of future payments to be incurred, all of which are valuable indications of required reserve levels.

In setting the case reserve, it is essential to take into account the following factors:

- The nature and extent of the injury and the medical treatment required.
- The type of injury. Back sprains and strains are especially difficult problems, which require careful investigation, evaluation and reserving.
- The maximum period of temporary total, temporary partial, permanent total and permanent partial disability benefits.
- The maximum period of disfigurement benefits and schedule of specific loss benefits payments.
- Whether permanent partial disability benefits are based on wage loss or on loss of earning capacity consideration.
- Whether disability benefits are deducted from death benefits, or paid in addition to them.
- The maximum period and amount of hospital and medical treatment payments.
- Whether a lump sum settlement is anticipated.
- Whether a return-to-work program is in place in the agency and whether one has been initiated for this case.
- Whether the injured employee has been referred to the “Injured State Employees Reemployment Program”.
- Whether the case is subject to another state’s compensation act.
- The manner in which the act is administered by the Department of Workforce Development (DWD).
- The nature of past experiences with DWD on this type of case.
- The amount of disability likely to be awarded by DWD.
- The likelihood of DWD approval of a compromise settlement.
- Case reserving of very serious injuries, such as brain damage, spinal cord injuries, double amputations, etc. Should take into consideration the effect of the injury on the claimant’s normal life
  expectancy and long-term implication of the required medical care rehabilitation efforts, etc.

- Care should be taken to avoid under reserving serious injury cases
- The claimant's age, family (income) needs, continued (transitional duty) work or return-to-work capabilities, and general injury recovery attitude.
- The conduct and potential cost of medical treatment by the individual physician. What does the physician believe the claim requires in the way of treatment, prosthetic devices and the like? What is the physician's reputation with the commission? Is the treating physician willing to confer and cooperate with other physicians of the same specialty?
- The attitude of the employee. In particular, the employee's attitude of cooperating with the claim handler in providing an appropriate return-to-work environment is very important.
- If the injured employee retained an attorney, who the attorney is and the attorney's attitude regarding case dispositions.
- Worker's Compensation case reserves should be revised (revalued up or down) whenever the investigation of the relevant factors indicates a change in circumstances and case value. Worker's Compensation case reserves should not be "discounted" because of anticipated subrogation recoveries.

RESERVES GUIDELINES

INITIAL RESERVE GUIDELINES

Injury Type	Medical	Indemnity	Expense	Permanency
Ankle Strain[1]	$4,000	4 weeks	$25	0%
Brain Concussion/Traumatic [2] 6	$85,000	52 weeks	$10,000	20%
Mild[1]	$5,000	4 weeks	$25	0%
Burns(s)				
w/LT [2]	$10,000	8 weeks	$1,500	0%
>1st Degree [2]	$30,000	12 weeks	$5,000	0%
w/potential disfigurement				$5,000
Carpal Tunnel Syn [3] 4 5				
One (1) wrist	$10,000	2 weeks	$2,000	2% (8wks)
Bilateral	$20,000	4 weeks	$2,000	2% ea wrist + multi
Cervical Strain	$5,000	4 weeks	$25	0%
Cervical Fusion [3] 4	$65,000	30 weeks	$5,000	10% per level
Epicondylitis 5 6	$5,000	2 weeks	$2,500	0%
Finger Amputation	$10,000	2 weeks	$25	Yes
Fracture				
w/out surgery	$5,500	4 weeks	$25	0%
w/reduction[2]	$30,000	6 weeks	$3,500	Yes
Hearing Loss 6	$3,000	N/A	$1,500	yes
Hernia 6	$30,000	4 weeks	$2,000	0%
Hip Sprain	$5,000	4 weeks	$25	0%
w/Replacement [3] 4	$90,000	24 weeks	$5,000	40%(200wks)
Knee Sprain[1]	$5,000	4 weeks	$25	0%
Knee Surgery [3] 4				
w/Menisectomy[2]	$50,000	8 weeks	$5,000	5% (21.25wks)
w/ACL repair[2]	$65,000	12 weeks	$7,000	10% (42.5wks)
w/Replacement[2]	$95,000	30 weeks	$10,000	50% (212.5wks)
Lumbar Sprain[1]4	$15,000	4 weeks	$2,500	0%
Lumbar Laminectomy [3] 4	$65,000	15 weeks	$3,500	5% per level
Lumbar Fusion [3] 4	$85,000	30 weeks	$10,000	10% per level
Non-traumatic Stress 6	$20,000	12 weeks	$5,000	0%
Occupational Respiratory 6	$15,000	6 weeks	$2,500	0%
Rotator Cuff Repair [3] 4	$50,000	24 weeks	$3,500	5% (25wks)
Shoulder Sprain[1]	$5,000	4 weeks	$25	0%
Tendon Tears [3] 4	$55,000	20 weeks	$5,000	Yes

FOOTNOTES

[1] Assumes conservative treatment, alternate duty, x-rays, ER visit and some PT

[2] MCM

[3] Assumes IME and surgery with good results

4 IME and MCM

5 Includes worksite evaluation

6 IME

7 Adjust lower for sedentary jobs

Claims Management Services
Outside sources to assist with the control and costs of claims

Claims Management services consists of Telephonic Case management (TCM), Medical Case Management (MCM), Loss of Earning Capacity Evaluations (LOEC), Independent Medical Evaluations (IME), and Claims Investigations. Contracted vendors provide these services.

Determining when to order claims management services

When handling a claim, a determination must be made as to whether or not services are required to manage a claim efficiently. Consulting a list of criterion for using each service makes this determination.

1. Use **Medical Case Management (MCM)** if/when
   - ✓ A claimant has numerous prior claims.
   - ✓ The injury is serious.
   - ✓ Treatment appears to be excessive.
   - ✓ The treating physician is not cooperating with the adjuster.
   - ✓ Claimant has significant underlying problems.

2. Obtain an **Independent Medical Evaluation (IME)** to:

   - ✓ Determine if the condition diagnosed is causally related to the work injury.
   - ✓ Determine if treatment is reasonable and necessary (ex-surgical procedures, pain clinics).
   - ✓ Determine temporary or permanent work restrictions (determining return to work date).
   - ✓ Determine a Permanent Partial Disability (PPD) rating.
   - ✓ Determine End of Healing (EOH).
   - ✓ Distinguish between pre-existing conditions.
     Mental Illness
   - ✓ Determine if there are enough criteria for meeting psychological diagnosis for DCM-IV (e.g., PTSD).
   - ✓ Determine if there is extraordinary stress per School District No. 1 vs. DILHR.

Obtain a **Loss of Earning Capacity Evaluation (LOEC)** if/when:

- ✓ Attorney names a vocational expert.
- ✓ Claimant has an unscheduled injury and can not return to the same job.
- ✓ Claimant's physician contends claimant has permanent total disability.

Use **Claims Investigations** if/when:

- ✓ There is an identifiable or anonymous tip that the employee may be

exaggerating the injury and able to perform beyond capabilities identified by the treating physician.

- ✓ There is the indication the employee is working at another job even though medically excused from work. Examples: employee is never home, doesn't return phone calls, or doesn't answer correspondence.
- ✓ The employment includes work that exceeds medical restrictions. Documents the employee was earning wages while collecting indemnity payments at the same time.
- ✓ An Independent Medical Exam (IME) or attending physician's report indicates few objective findings to support the disability.
- ✓ The employee's complaints far outweigh the objective medical findings.
- ✓ The Claimant appears to be exaggerating or falsifying information.

***Please be aware that the above criteria are simply guidelines. Claims experience intuition and common sense will be the most valuable guide when assessing treatment and the need for claims management services.

Referring a claim to a Vendor

Upon determining if claims management services are needed, the claims examiner will refer the claim to the proper vendor. A list of vendors can be obtained from the Worker's Compensation Manager or the Claims Supervisor and is also listed on the G drive, G/Risk Management/Workers Compensation/ Vendors. With more experience, the claim examiner will come to know which Vendors provide the best outcome at a reasonable price.

For all of the above claims management services, permission from the Claims Manager is not needed, but surveillance should be discussed.

When referring a claim to a vendor always send a WKC-12, First Report of Injury, along with other documentation specific to the service.

For MCM include medical records and treatment notes. Setting up IME is much more involved: you must select a physician and arrange the appointment; see the section on IME's in the Worker's Compensation Manual which can be viewed on the World Wide Web.

Reports from Vendors

The vendor will send the claims adjuster a report providing the information requested. Sometimes there will be several reports until the file is closed with the vendor. The claims adjuster will review this information and keep the file updated.

Invoices from Vendors

Invoices will be received from the vendor via e-mail or mail for services rendered. The claims examier reviews the invoice for accuracy and appropriate charges. If there is an error the invoice should be forwarded with a note to the Worker's Compensation Manager (WCM). The WCM will contact the vendor for corrections and/or send a disputed charges notice.

For MCM, LOEC, and IME's the claims adjuster pays the invoice using the RMIS following the Bill Payment process outlined on the next page.

DISPUTED CLAIMS and LITIGATION

Many situations throughout the life time of a claim can trigger litigation. Some examples of situation in which litigation will begin are IME results, termination of benefits, suspension or denial. Any, or all, or none of these may start the litigation process. So what happens?

The injured employee, or the injured employee's attorney will file an application for hearing with DWD.

DWD will then in turn mail a copy of the Application for Hearing to DOA, to the employing agency, with a copy back to the employee or Attorney. Attached, DWD will send an "Answer to the Application. The Answer is to be completed and filed within 20 days of the receipt of the Application for hearing. By "filing," it is meant that the Answer is posted to OWCH, the employing Agency and the injured employee, or Attorney.

**It is important to note that once an injured employee is represented by an Attorney, the Claim Examiner should not legally communicate with the injured employee. All communications must go through the Attorney.

The following is the DOA litigation procedure for both Claim Examiners.:

LITIGATION PROCEDURE

<u>Examiners:</u> When an application for hearing arrives examiners should:

1. Scan the entire file -the file should always include a 13, 13a form so this may need to be obtained from the WCC. Do not sit on the file waiting for these forms though. DOJ has 20 days to file an answer.
2. complete a litigation summary
3. Both the scanned file and litigation summary will be uploaded into DOJ sharepoint
4. These tasks should be completed within 48 hours of receiving the Application for hearing.

The examiner will be solely responsible for managing their own litigated files. All additional information received (reports, medical records.....) should be sent the assigned DOJ AAG assigned as received.

Examiner will handle all negotiating with Petitioners Attorneys and DOJ. If they feel a round table is necessary, or the exposure exceeds their authority, $25,000.00, they should schedule the roundtable with the claims supervisor. At the roundtable, they should have exposures and a brief history of the file prepared for discussions. They should also come with their recommendations for settlement.

Upon settlement, it will be the claims examiner's responsibility to pay the order, promptly. The Examiner should then provide a copy of the compromise, or order to the designated Examiner to updated the "litigation," page in the RMIS.

Injured Worker Files Application for a Hearing (Approximately 7,000 annually) 		An injured worker has 6 or 12 years from the date of injury or the date of last payment to file an application for a formal hearing before an ALJ. The Division may attempt to resolve some of these disputes through informal mediation conducted by its paralegal staff. For disputes involving an applicant who is not represented by an attorney, the Division usually conducts a pre-hearing conference with an ALJ to narrow the issues and explain the hearing process
Hearings are Scheduled (Approximately 6000 hearings are scheduled annually) 		Workers' compensation applications for hearings are normally assigned to the ALJ on a first-in, first-out basis. Hearings are generally held in the municipality requested by the applicant. Once assigned, all parties involved in the case are notified in writing as to the date, time and place of hearing
WC Hearing Held (Approximately 1,200 hearings are held annually) 		An ALJ hears evidence presented by both the defendant and claimant at one or more hearings. Most disputes are resolved with one hearing. About two-thirds of all requests for a hearing are settled without an actual hearing. Many are compromised or stipulated.
Decision Rendered 		The ALJ issues a decision within 90 days after the close of the record. This usually means 90 days after the hearing. The typical decision is issued in less than 45 days.
Appeal to Labor Industry Review Commission (LIRC) (Approximately 500 are reviewed annually) 		Either party may file a petition for review with the Labor and Industry Review Commission (LIRC) within 21 days after the ALJ issues a decision.
Appeal made to Circuit Court (Approximately 125 annually) 		Either party may start an action in the circuit court of the county in which he or she resides within 30 days after the LIRC decision.
Court of Appeals (Approximately 5 annually) (Approximately 5 annually) 		Either party may appeal to the Court of Appeals within 45 or 90 days depending on when the notice of entry of judgment is served.
Wisconsin Supreme Court (Approximately 5 annually)		Either party may file a petition for review with the Supreme Court within 30 days of the date of the Court of Appeals decision.

ADMISSION TO SERVICE AND ANSWER TO APPLICATION

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

You are the **RESPONDENT** in this matter.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name
Employee Social Security Number	Employer Name
Date of Alleged Injury	Employer Mailing Address
Insurance Company Name	Insurance Company Mailing Address
Respondent Attorney Name	Respondent Attorney Mailing Address

The enclosed hearing application must be answered within 20 days by mailing a copy of the answer to the Worker's Compensation Division and to applicant's attorney or applicant if unrepresented. Provide such responses as are now known and amend your responses later as necessary. The worker's compensation insurer has a duty to defend and submit an answer on behalf of the employer except that the employer must defend and submit its own answer as to the following claims: (I) 15% increased compensation for safety violation, Wis. Stat. 102.57; (II) refusal to rehire, Wis. Stat. 102.35 (3); (III) penalty for late payment against employer, Wis. Stat. 102.22; (IV) penalty for illegal employment of minor, Wis. Stat. 102.60; and (V) bad faith against employer, Wis. Stat. 102.18 (1) (bp). **Failure by the employer or insurer to file a timely answer may result in liability by default order.**

In answer to the application, using reverse side if additional space is necessary, the respondent states as follows:

1. The accident or occupational exposure occurred as alleged ☐ Admit ☐ Deny
2. The relationship of employer and employee existed ☐ Admit ☐ Deny
3. The parties were subject to the worker's compensation act ☐ Admit ☐ Deny
4. At the time of alleged injury, the employee was performing service growing out of and incidental to employment ☐ Admit ☐ Deny
5. The accident or disease causing injury arose out of the alleged employment ☐ Admit ☐ Deny
6. Notice of injury was given to employer within 30 days/2 years of alleged injury ☐ Admit ☐ Deny
7. Applicant was temporarily disabled for the period claimed ☐ Admit ☐ Deny
   If denied, state disability admitted:
8. Applicant is permanently disabled to the extent claimed ☐ Admit ☐ Deny
   If denied, state disability admitted:
9. The rate of wage claimed is correct ☐ Admit ☐ Deny
   If denied, state wage admitted: and attach a fully updated WKC-13-A
10. The alleged employer was insured or self-insured under the Worker's Compensation Act ☐ Admit ☐ Deny
11. Do you contend that additional parties must be joined for a complete resolution of applicant's claim? If "yes," attach expert opinions supporting joinder and explain who should be joined and why. ☐ Admit ☐ Deny

12. Describe any matters in dispute not already noted above and state all reasons for denying liability not already noted above.

Insurance Carriers & Self-Insured Employers must attach an up-to-date WKC-13 and if wage is disputed, an up-to-date WKC-13-A.

Respondent Signature: Date Signed:

Printed Name: Title: Phone Number: **( ) -**

Representing: ☐ Insurance carrier and the insured interests of employer ☐ Insurance Carrier ☐ Employer

Subrogation

Worker's Compensation subrogation is a process where the State "subrogates," or asserts its rights as a creditor in a third party lawsuit. The goal is to get the money back paid on a claim.

The State's claim is based on past and future benefits to be paid to the injured employee. The claim is against a portion of proceeds from the lawsuit.

The subrogation procedure is provided in Section 102.29, Wis. Stats. "third party" is usually a manufacturer of faulty products or an individual causing damage to the employee though their negligence, resulting in the worker's compensation claim. Examples might be a poorly manufactured ladder or an automobile accident. The employee brings the suit with the aid of a private attorney. Another example and one that applies more often to State injured employees is a car accident involving a state employee and a third party driver.

Determine if criteria for subrogation are met

1. Determining if the criteria for subrogation are met can be done by referring to the Subrogation potential checklist on page.

Collect all information needed to purse subrogation

2. Contact the Workers Compensation coordinator to get the motor vehicle accident report, police report, and safety officer report. Review these reports to obtain third party information including insurance company name, address, and telephone number. Also, contact the employee to determine if an attorney has been secured. Obtain the name, address, and phone number of the attorney.

Send letters to claimant and third party

3. The claimant must be notified that the state has an interest in any settlement that is made. Also, the claimant should be sent a copy of Statutes 102.29 (attached to this procedure) explaining their subrogation rights under Workers Compensation Law. If the claimant has an attorney, the attorney must also be notified. In addition, the third party/parties should be put on notice (via letter) as well as the third party carrier. If the claimant and/or the third party have obtained an attorney they must also receive a copy of the notification letter. These letters can be easily located in the ENTERPRISE letter module.

Assure that evidence has been secured

4. Contact the Workers Compensation Coordinator and any other parties involved to make sure all evidence necessary to pursue out interest has been secured.

Determine if a lawsuit has been initiated

5. If a lawsuit has been initiated you must notify the Department of Justice, subrogation unit. Also, obtain an accounting of all benefits paid out on the claim.

Keep TPA and attorney informed

6. Send follow up notices of all benefits paid out on the claim to the attorney and the TPA periodically as the claim matures.

Determine End of Healing

7. Continue step six until end of healing has been reached. Once end of healing has been reached the claimant will negotiate a settlement.

Prepare settlement papers and send to DWD

8. Prepare the Third Party Proceeds Distribution Agreement, attached, WKC-170 after the settlement has been made and send it to DWD for approval.

Once payment is received the subrogation process has ended.

Distribution of Proceeds

Once the lawsuit is tried, or settled, Section 102.29 (1) provides for distribution of the proceeds as follows:

1. Attorney's fees
2. One-third of the remainder to the employee
3. Two-thirds of the remainder to the insurer (state)

The State is only entitled to an amount equal to benefits paid out; if that amount is less than the 2/3 share, the rest goes to the employee in addition to the employee's 1/3 share. However, the State is entitled to a "cushion," where the extra amount that went to the employee is considered a credit for the State against future worker's compensation benefits.

The following page provides a copy of the WKC-170, or the Third Party Distribution Form necessary for Subrogation and settlement purposes.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

THIRD PARTY PROCEEDS DISTRIBUTION AGREEMENT

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name
Social Security Number	Employee Mailing Address (number, street, city, state, zip code)
Injury Date	Employer Name
Insurance Claim Number	Employer Mailing Address (number, street, city, state, zip code)
Worker's Compensation Insurance Carrier	
Submitted By	Mailing Address (number, street, city, state, zip code)

_____, insurer of

_____ third party, and the above parties have

agreed to settle the liability of the tort-feasor for injury sustained on _____

The proceeds will be distributed according to the provisions of 102.29, Wisconsin Statutes, as follows:

1. $_____ total amount of third party settlement
2. $_____ to employee's attorney as cost of collection (fee & costs)
3. $_____ one-third of balance to employee
4. $_____ to worker's compensation insurance carrier or self-insured employer as reimbursement for payment of

   $_____ in compensation, and

   $_____ in medical expense
5. $_____ balance to employee which shall constitute a cushion or credit against any additional claim under worker's compensation

PLEASE NOTE: APPROVAL VOID IF PROCEEDS RESULT FROM UNINSURED MOTORIST PROVISION	Employee Signature
	Attorney Signature
Agreement Date	Worker's Compensation Insurance Carrier or Self-Insured Employer Signature

SETTLEMENT AND DISTRIBUTION OF PROCEEDS AS STATED ABOVE ARE APPROVED.

_____ _____

Date Signed Administrative Law Judge, Worker's Compensation Division

Subrogation Potential Checklist

Product Liability

- ✓ Attempt to identify the product by brand name, model, serial number, and name and address of manufacturer and its liability insurer.
- ✓ Suggest that the employee locate and save all materials concerning the product such as receipts, instructions, etc.
- ✓ Try to determine if the employee was using the product properly at the time of the injury.
- ✓ Suggest that the employee retain the product in its present condition.
- ✓ Determine whether there have been prior problems with the product. If it was repaired, determine when and obtain the name and address of the party making the repair and its liability insurer.
- ✓ Suggest that the employee locate and save all materials concerning the repair of the product.
- ✓ Determine whether the product was altered by the employee, the employer or a coworker.
- ✓ Attempt to get statements from the employee and witnesses.

Faulty Repairs

- ✓ Review product liability questions above as applicable. In addition,...
- ✓ Determine why repairs were needed.
- ✓ Determine what repairs were made, when they were made, and by whom.
- ✓ Attempt to get statements from the employee and witnesses.

Automobile or vehicular accidents

- ✓ Determine the identity of the driver, owner and insurer of all vehicles involved.
- ✓ Determine whether the other drivers were within the scope of their employment, i.e., what were the purposes of the other drivers' trips.
- ✓ Get a copy of any police reports and accident reports regarding the accident as well as any photos taken of the accident scene.
- ✓ Attempt to get statements from the employee and witnesses.

Accident which occurred on another party's premises such as a slip and fall

- ✓ Determine the name and address of the owner of the premises and its liability insurer.
- ✓ If the property is leased, determine the name and address of the lessee and its liability insurer.
- ✓ Determine whether any third party was responsible for maintenance of the premises and if so, determine its name and address and the name and address of its liability insurer.

- ✓ If an individual was apparently responsible for the injury, identify the individual and his/her relationship to the owner, lessee or maintenance company.
- ✓ Attempt to get statements from the employee and witnesses.

Intentional tort such as an assault

- ✓ Obtain the name and address of the assailant and the name and address of his or her liability insurance company. Usually this will be a renter's or homeowner's policy. While these policies generally contain exclusions for intentional acts, there are times when the insurer will pay all or part of a claim where the conduct could be considered intentional.
- ✓ Obtain the names and addresses of any persons who were with the assailant and the names and addresses of their liability insurance companies.
- ✓ If the assault occurred on privately owned premises, determine whether similar assaults had occurred there in the past.
- ✓ Obtain the name and address of the owner and, if applicable, the lessee of the premises and their liability insurance companies.
- ✓ Obtain copies of all police reports and of any photos taken concerning the incident. Often there will be photos of the injured party showing the extent of the injuries.
- ✓ Attempt to get statements from the employee and witnesses.
- ✓ Contact the Crime Victim Compensation Program at the Department of Justice to coordinate payments and subrogation information. Generally Crime Victim Compensation will not pay benefits for items covered by WC.

DWD Website for Reporting Purposes

The Department of Workforce Development (DWD) is the regulatory agency for Statewide Workers Compensation. This means all Self Insured Employers, TPA's and Insurance Carriers have to report to DWD and abide by their rules and regulations set forth by Chapter 102 and Rules 80.20.

Years back, all information was sent to DWD via paper copies. This was quite cumbersome and time consuming. Today, DWD has an electronic reporting website and requires all of the above to report information through this web. http://www.dwd.state.wi.us/WC/insurance. Examiners and Claim Reps should create a short cut to this link, or add it to their ENTERPRISE page for easy access.

Upon entering this site you will read:

Insurers and Self-Insurers

Insurance carriers and self-insured employers are key stakeholders in the worker's compensation program. They have the primary responsible for the administration of worker's compensation claims for injured workers. This includes the responsibility to make payments that are due to workers promptly and accurately. Further, the responsibilities include interfacing with the Worker's Compensation Division by sending required reports and by replying promptly to all correspondence. The information contained on these web pages is intended to assist insurers, employers and claims administrators to properly insure workers and administer the worker's compensation claims.

Once you enter this website, you will note there are multiple requirements set forth by DWD, thus, a lot of information to update on the site. If an Examiner, or Claim Reps fails to comply with their requests, a fine will be assessed. Over the years, DOA has shown significant improvement in their reporting time and currently, has one person within the claim unit, the Litigation Specialist, who is responsible for updating the DWD site. This has helped DOA to streamline their efforts and been a huge factor in reducing fines from DWD.

Upon entering into the site and the requirements the Claim Examiner will see multiple tabs. The tab to hit each and every day is:

"Pending Reports" then go to

"Insurer's Pending Reports using DWD/WI Logon Management System"
Logon ID and Password ="riskmanagement" "1stateclaims"

The Examiner will then click on the drop down box which will show:

Waiting for First Supplemental Report
Waiting for results of Insurers Investigation
Waiting for Las Supplemental Report WKC-13
Waiting for Final Medical
Expecting Wage Information
Fatal and Perm Total

Upon clicking on one of the above, the Examiner will see a list of all claims, handled by DOA, in need of update information. Information can then be entered directly into the website and sent. Once sent, the claim will drop from the list and the Examiner will no longer see it listed.

It is important for this website and all tabs to be checked daily, as claims are indeed added daily. Often times, the information requested is due by the next day, or even the same day, so it is crucial to keep up with this list. As mentioned above, DOA has a dedicated person to maintain the Site and enter the information, however, in their absence; the Examiner must complete this mission on their own.

The next page provides an example of a fine/forfeiture letter from DWD, in the event an examiner misses a deadline for reporting.

Jim Doyle
Governor

Roberta Gassman
Secretary

Frances Huntley-Cooper
Division Administrator

State of Wisconsin
Department of Workforce Development

WORKER'S COMPENSATION
201 East Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Imaging Server Fax: (608) 260-2503
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: dwddwc@dwd.state.wi.us

March 31, 2003

TEST INSURER 1
ONE MAIN ST
MADISON WI 53703

WC CLAIM NO:	9999-999999	IF YOU CALL OR WRITE US
INJURY DATE:	05/01/98	PLEASE USE WC CLAIM NO.
EMPLOYEE:	SIMPLE, SAMPLE	
EMPLOYER:	SAMPLE EMPLOYER INC	
INSURER NO:	094CBD6S8646	

The first report of injury on this claim was not filed timely as provided for by administrative rule.

DWD 80.02(2) (a) requires that self-insured employers and insurance companies submit a first report of injury on or before the 14th day after an accident or the beginning of a disability from occupational disease. If an employer does not notify the insurance carrier of the injury until after the 14th day, the insurance carrier shall submit the WKC-12 to the Department within 7 days of receiving notice of the injury from any source.

For failing to file this required report in a timely manner, the Department is assessing you a $100 forfeiture, payable to the State of Wisconsin pursuant to s.102.35(1), Wis. Stats. ***Please do not pay now***. The Department will record the forfeiture and invoice you annually for the total amount due on all forfeitures assessed.

Failure to file required reports may also result in sanctions by the Worker's Compensation Division under ss. 102.28(2)(c) or 102.31(3), Wis. Stats. or by the Office of the Commissioner of Insurance, under s. 601.64 Wis. Stats., or both.

To find out what other reports are overdue and avoid forfeitures in the future, go to the Worker's Compensation web site's Insurer's Pending Reports at:
http://www.dwd.state.wi.us/wc/insurance/pending_rpts.htm

Department of Workforce Development
Worker's Compensation Division

FWC12 (N. 03/2003)

Main requirements and deadlines to meet set forth by DWD and rule 80 within the Worker's Compensation Act

Self-insurance and Insurance Company Reporting Requirements

Self-insured employers and insurance companies are legally required to submit (via EDI, Internet or paper forms) all of the following reports to the Worker's Compensation Division:

1. A first report of injury, with the information required by form WKC-12 on or before the 14th day after an accident or the beginning of a disability from occupational disease. If an employer does not notify the insurance carrier of the injury until after the 14th day, the insurance carrier shall submit the WKC-12 to the department within 7 days of receiving notice of the injury from any source.

2. A supplementary report, with information required by form WKC-13 on or before the 30th day following the day on which the injury occurred.

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

4. If applicable, a signed statement from the employee to verify that the employee restricts his/her availability on the labor market to part-time employment, and is not actively employed elsewhere. The employee's statement shall accompany the WKC-13-A. No statement is required if the employee is under the age of 16.

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

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

   B. Temporary disability benefits are reinstated.

   C. Temporary partial disability is paid. The insurance carrier or self-insured employer shall also include the information required by form WKC-7359-1-E. Final payment of compensation is made. If there are more than 3 weeks of temporary disability or any permanent disability, the insurance carrier or self-insured employers shall submit a final treating practitioner's report together with the final WKC-13 or shall explain why the report is not being submitted and shall estimate when the final practitioner's report will be submitted.

6. When submitting a stipulation or compromise and at the time of hearing, a current form WKC-13 indicating all worker's compensation payments to date and the periods of time which these payments were made.

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

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

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

   C. Amputation will require an artificial member appliance.

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

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

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

    Please include the Worker's Compensation Division's claim number or the Social Security number of the worker on all correspondence, compensation reports and medical reports.

6 OR 12-YEAR STATUTE OF LIMITATIONS

When an employee has stopped receiving weekly compensation benefits for temporary or permanent disability after an accidental injury, the claim may be reopened at any time within 6 or 12 years from the date compensation was last paid. This 6 or 12-year period does not apply, however, where a compromise agreement has been made and approved by the department or where a final award has been issued after a hearing.

A final award closes the claim after the time allowed for appeal unless the award is set aside on an appeal. A compromise closes the claim. Within one year after the department's approval of the compromise, any party to the compromise may ask the department to set aside or modify the compromise. The department may or may not grant the request. Few are ever reopened.

When medical treatment will be required beyond the 6 or 12-year period and there has not been a compromise or final award, the employee may file an application for hearing to keep the claim open until a hearing is held and a final order issued. For injuries that occurred before May 13, 1980, the statute of limitations was shorter. Information about the statute of limitations on a specific date of injury before May 13, 1980 can be obtained by contacting the division.

In cases of occupational disease and some serious traumatic injuries there is no statute of limitations. The employee may make a claim against the employer or its insurance company within 6 or 12 years from the date of injury or the date on which compensation was last paid. If this 6 or 12-year period has expired, the employee may make a claim against

FRAUD!!

Fraud as it applies to Workers Compensation can be defined as: The Intentional misrepresentation of an employee to obtain benefits which they are not entitled. May include deliberate misrepresentations of need or eligibility; or providing false information concerning their disability, or condition.

Not many people are tolerant of fraud, so on occasion, a neighbor, family member, friend, or co-worker may learn of a fraudulent Workers Compensation individual. DWD provides a Fraud hotline, to report such situations. The process follows below?

How to Report Fraud

Reporting worker's compensation fraud is easy. Call (608) 261-8486, write or e-mail the Division.; A pre-taped message will ask you to leave the following information:

1. The name of person committing fraud;
2. The person's address (at least the municipality);
3. A description of the alleged fraudulent activity in as much detail as you can provide; and
4. The employer at the time of the injury (if you know who it is).

You may also provide the same information by writing to:

State of Wisconsin
Worker's Compensation Division
P.O. Box 7901
Madison, WI 53707

Callers can remain anonymous. However, you will be asked to leave your name and phone number if you are willing to speak further with an insurance company investigator about the information you have.

If you do leave your name, the Department will not use it in its public reports. However, you should assume that at some point your name could become part of a legal record which -- even though it is not open to the general public -- might be available to the injured worker, the employers and the insurance carriers who are parties to the alleged worker's compensation injury.

Generally, the Department will refer the matter to an insurance carrier for investigation. The carrier will be required to report back to the Department the results of its investigation. However, by law (See section 102.125 of the Wisconsin Statutes), an insurer is not required to report back until it is satisfied that making the results of investigation known to the Department will not hurt their ability to handle the worker's compensation claim.

Based on the results of the insurer's investigation, the Department will make a decision about whether there is a reasonable basis to believe fraud has occurred. If so, the Department will refer the case to the local district attorney for prosecution. The district attorney must then decide whether to start criminal proceedings under the insurance fraud statute. (See section 943.395 of the Wisconsin Statutes.)

Fraud is a criminal offense and here is what the Examiner should know:

II. CRIMINAL STATUTES

A. Wisconsin Statute 943.395 -Fraudulent insurance and employee benefit program claims.

1. Whoever, **knowing** it to be false or fraudulent, does any of the following may be penalized as provided in sub. (2):

> a. Presents or causes to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance; or
>
> b. Prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing,

with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance.

2. Whoever violates this section:

> a. Is guilty of a Class A misdemeanor if the value of the claim or benefit does not exceed $1,000.
>
> b. Is guilty ofa Class E **felony** if the value of the claim or benefit exceeds $1,000.

3. Penalty

> a. Class A misdemeanor = a fine of not to exceed $10,000 or imprisonment not to exceed 9 months, or both.
>
> b. Class E felony = a fine not to exceed $10,000 or imprisonment not to exceed 2 years, or both.

4. Criminal Intent Required

Wisconsin Statute 939.23 -Criminal Intent

> When criminal intent is an element of a crime in chs. 939-951, such intent is indicated by the term "intentionally ," the phrase "with intent to," the phrase "with intent that," or some form of the verbs "know" or "believe."

B. Federal Criminal Actions.

Racketeer Influenced and Corrupt Organizations (RICO):
Mail Fraud -mailing by an insured to an insurer of a false insurance claim constitutes a violation of the mail fraud statute and thus is a violation of the requirements of RICO. (Provides for up to $1000 fine and/or 5 years in prison.)

III. PROSECUTION OF WORKER'S COMPENSATION FRAUD.

A. Department of Workforce Development Responsibility.
Under Wis. Stats. § 102.125*, if an insurer or self-insured employer has evidence that a claim isfalse or fraudulent in violation of §943.395 and ifthe insurer or self-insured employer is satisfied that reporting the claim to the department will not impede its ability to defend the claim, the insurer or self-insured employer shall report the claim to the department.* The Worker's Compensation Division

will review the allegations and may refer the results to the appropriate district attorney for prosecution if there is reasonable basis to believe fraud occurred.

B. Employer Responsibility

The Worker's Compensation Division acts as a clearinghouse for claims of fraud and has no resources to perform a thorough investigation of the claim. The employer and/or its insurance carrier must provide complete and detailed documentation to the Division so that the evidence of fraud is clear and easily understood.

C. Standard of Proof

Because criminal prosecution requires proof of guilt beyond a reasonable doubt, only claims in which there is clear evidence of misrepresentation and intent to obtain worker's compensation benefits through that misrepresentation, will be accepted for prosecution.

D. Fraud Hotline.

The Worker' s Compensation Division has established a fraud hotline to report fraudulent claims. The employer and insurance carrier should work together to prepare evidence ofworker's compensation fraud and contact the Worker's Compensation Division at:

Worker's Compensation Division
Department of Workforce Development
201 E. Washington Ave
P .0. Box 7901
Madison, WI 53707-7901
Fraud Hotline: (608) 261-8486

IV. EMPLOYER FRAUD PREVENTION TECHNIQUES.

A. Generally. In addition to criminal prosecution; injury prevention, investigation, communication, and discipline are the key elements to a successful fraud prevention program.

B. Injury Prevention.

1. Preventing injuries is the best method for avoiding abusive claims and manipulation of the employer's worker's compensation program, because an injury must occur before worker's compensation benefits can be paid.

2. While prevention programs may not eliminate claims which are entirely fabricated (i.e. no injury occurred), preventive measures avoid the fraudulent claims that may arise where an employee, who is legitimately injured, attempts to manipulate his/her claim in order to enhance benefits, due to anger that the

employer allowed the injury to occur, or fear that worker's compensation may not provide enough compensation for loss of job opportunity caused by the injury .

3. Preventive measures establishing safety rules and discipline for violation, provide disincentives to false claims of injury , due to fear of discipline.

4. Where an injury does occur, prevention techniques should also include minimizing the extent of the claim's impact, by assuring immediate and quality medical care, and prompt payment for that care, as well as return of the employee to gainful employment as soon as possible.

5. Prompt payment and return to work, reduces the costs of the injury to the employee, and the uncertainty that arises from being out of work and receiving notices of increasing unpaid bills.

6. These measures also assist the employer in identifying potential suspicious claims, where the employee is overly resistant to seeking medical care or allowing the employer to work with his/her health care provider, or resists employer efforts to return the employee to available work that fits the employee's restrictions.

C. Investigation.

Thorough investigation and follow-up communicates to honest employees that the employer cares about them and wishes to prevent further injury , and communicates to those who are tempted to engage in fraud that it will not be as simple as filing a claim, and that they will need to develop a consistent and substantiated story of the injury occurrence and that they will need to constantly need to look over their shoulder if they are not being honest about the claim. The front line defense against fraudulent claims is thorough investigation of every injury , so that employees are aware that the employer:

1. Investigates injury claims immediately to verify accuracy of employee's statements and interview witnesses.

2. Questions employee regarding cause of alleged injury and assesses credibility and demeanor immediately after incident.

3. Requires employee to walk through injury event with other witnesses present to explain its occurrence.

4. Requires employee to complete and sign Employer's Accident Report. (See Appendix B).

5. Follows up to verify statements of employee and witnesses and consistency with insurance carrier reports and health care reports.

6. Requires regular contact to evaluate employee status and any changes in employee's condition.

7. Hires private investigators where a claim is suspicious and responds quickly and severely to misrepresentation.

D. Communicate to Employees What is Unacceptable.

1. The employer should communicate to its employees that it takes worker's compensation fraud seriously. A notice and poster regarding worker's compensation fraud, has also been issued by the Worker's Compensation Division and is available by contacting the Division at (608) 266-1340.

2. Inform employees that fraud includes:

a. claiming a non-work related injury under worker's compensation;
b. claiming to have suffered an injury that did not occur;
c. remaining absent on worker's compensation longer than necessary; and/or
d. misrepresentation to the doctor, the insurance carrier, or the employer as to the nature or extent of an injury to secure greater benefits or time off.

E. Discipline.

1. Most cases of abuse in the worker's compensation system are not prosecutable as criminal fraud.

2. In order to combat fraud, employers must establish their own rules and punishment for misrepresenting a claim to obtain worker's compensation benefits.

3. These rules should include the actions which the employer considers to be fraud such as those set forth above.

4. Employees should be informed in writing of the consequences of violating the rules through an employee handbook, labor contract or other notice.

5. Where there is clear evidence of violation of the employer rules or other worker's compensation fraud, the employer should immediately investigate to determine what discipline is appropriate.

6. Often there is a tendency in worker's compensation to wait to present evidence of fraud until a hearing on the claim is held in the Worker's Compensation Division. Hearings are often long after the evidence of fraud becomes available, and such delay may undermine the employers decision to discipline or terminate the employee, as well as the ability to prosecute a fraud claim. If the employer and insurance administrator continue worker's compensation benefits and do not discipline the employee for misrepresentation, this will give rise to doubt as to whether they truly believed that the employee misrepresented the claim.

7. If the employer is convinced that misrepresentation on the part of the employee has occurred, the employee should be questioned about the events by the employer to establish the employee's explanation, or to establish that misrepresentation has occurred. Employers should contact competent legal counsel before taking such action to address the appropriate strategy and discipline.

8. Where an employee is disciplined for misrepresentation, the employer should make this known to its other employees in order to deter similar acts. However, because of the potential for legal liability , competent legal counsel should be contacted to develop appropriate communications.

CUSTOM LETTERS WITHIN THE RMIS

Within the RMIS, the claim examiner has the capability to utilize "Custom Letters." These letters include the "most commonly used letters." The RMIS enables the examiner to select a specific letter directly from the claim. The RMIS will also auto fill: The address, the claim number, the date of loss and the Employing Agency. Utilizing Custom Letters will save the examiner a lot of time. Below are examples of custom letters:

D2-WCK16B
D3-WKC16 (7/01)
D4- 3RD Party Distribution
D5-Notice of Inability to obtain final
D6 - WKC13
D7-Answer Revised Oct 2006
D8-WKC16A (8/04)
D9-WKC16B (2/07)
F1-Dean Request
F2-Verity PT or Chrio. Review
F3-Genix IME Referral
F4-Genix Request for Service
F5-DOA 6125
F6-Mileage Reimbursement
F7-Med Provider List
F8-Encore Referral
F9-Pharmacy List
F10-CTS Questionnaire
F11-Hipaa Release Form
F12-Suspend/Deny Form
F13-Verity IME or Rec. Review
F14-Settlement Authority
F15-Dental Provider List
F16-DOA Lost Time Confirmation
F17-WKC16 (7/01)
F18-WKC16A (8/04)
F19-WKC16B (2/07)
H1-PPD Request
H2-Questionnaire
H3-Request Loss Audiogram
I1-X-Ray Request
I2-Notify Employee

I3-Notify Attorney
I4-Results-Employee Deny
L1-PPD Award
L2-Hipaa 2nd Request
L3-Not Following Tx Plan
L4-Denial-No Medical
L5-Denial-Inconsistencies
L6-Denial-Idopathic
L7-Denial-Causaly Related
L8-Hipaa Suspend-Stress
L9-Hipaa Suspend- No Medical
L10-Hipaa Suspend- CTS
L11-Deny-Stress
L12-Hipaa Suspend-Investigating
L13-Hipaa Provider Request
L14-Final
L15-Deny-No Hazard
L16-EE Not Using RX Card
L17-Accepted Claim
M1-PPD Award
M2-Hipaa Request- HIV_HEP
M3-Deny- Prophylactics
M4-Hipaa- 2nd Request
M5-Not following TX Plan
M6-Deny-No Medical
M7-Deny-Inconsistencies
M8-Deny-Idopathic
M9-Deny-Causally Related
M10-Hipaa Suspend-CTS
M11-Denial-Stress
M12-Hipaa Suspend-Stress
M13-Hipaa Suspend-No Medical
M14-Hipaa Suspend-Investigating
M15-Hipaa Provider Request
M16-Deny-No Hazard
M17-Final
M18-Deny-Bee Sting
M19-Accept Claim
P1-Narritive Report Request

	P2-RTW Light Duty Letter & Form
	P3-Request for Refund
	P4-Physicians Cert
	P5-Deny Necessity of Treatment
	P6-Records Request-No Auth
	P7-WKC16 Request
	P8-WKC16 2nd Request
	P9-Records Request Hipaa
	S1-3rd Party to DWD
	S2-Other Driver
	S3-Lien Update
	S4-Insurer
	S5-Attorney
	S6-Claimant
	S7-Cushion

DEFINITIONS OF TERMS ASSOCIATED WITH WORKERS COMPENSATION

Accepted claim: A claim in which the insurance company agrees your injury or illness is covered by workers' compensation. Even if your claim is accepted there may be delays or other problems.

Accident - An unplanned, undesired event that may result in personal injury, illness, property damage, and environmental harm and/or causes an interruption in a process or normal activities.

Accident Analysis - The investigation and analysis and written account of a near miss, incident or an injury or illness based on information gathered by a thorough examination of all factors involved. An accident analysis includes the objective evaluation of all facts, opinions, and physical evidence and statements taken from the affected employee and witnesses. A thorough accident analysis will also identify the primary and secondary causes of the accident and possible deficiencies in the management system so that corrective action(s) can be determined and taken to prevent recurrence.

Administrative Law Judge (ALJ) - an official who presides at an administrative trial-type hearing. He/she is the initial Trier of fact and a decision maker. The designation is also known as "hearing examiner," "hearing officer" or "trial examiner," Under the powers vested in him/her he/she can administer oaths, take testimony and make factual and legal determinations.

Alternative work: A temporary new job with an injured employee's employer. The doctor must say the injured employee will not be able to return to his/her regular job at the time of injury. Employers are strongly encouraged to offer alternative work.

AOE/COE (Arising out of and occurring in the course of employment): Your injury must arise out of employment (happen on the job and happen while in the course of employment (be caused by).

Applicant: The party, the injured worker, files an Application for hearing with the Department.

Appeal - The Petitioner Attorney, or the Insurance Carrier can file an Appeal in the case when a decision may be unfavorable to either party.

Applicants' attorney: A lawyer that can represent the injured worker in reference to their workers' compensation case. Applicant refers to the injured worker.

Application for Hearing: A form completed by the injured worker to pursue additional benefits under workers compensation.

Apportionment: A way of figuring out how much of your permanent disability is due to an injured worker when the injury involves multiple parts of the body.

Average weekly wage: Wages taken from 52 weeks preceding the injury and then averages. This AWW is used to compute TTD.

Causal Connection - Relationship between the event/accident/illness to have caused the injury.

Claim form, or WKC-12: The statutory form used to report a work injury or illness to your employer.

Claims adjuster: The term for insurance companies and others that handle your workers' compensation claim. DOA refers to claim handlers as Claims Examiners, or Claim Representatives.

Claim Examiner: Handles Lost Time, Litigated and Hazardous Duty claims.

Claim Representative: Handles Medical Only Claims**.**

Compromise Agreement**:** A type of settlement in which an injured employee receives a portion of the total claim exposure in exchange for a release. This type of agreement/settlement must be approved by an ALJ.

Compensability: Injury arose in the course of and out of employment. The claim is accepted.

Cumulative injury (CT): An injury that was caused by repeated events or repeated exposures at work. For example, hurting a wrist doing the same motion over and over or losing hearing because of constant loud noise.

Date of injury: When an injured employee gets hurt, or ill. If the injury was caused by one event, the date it happened is the date of injury. If the injury or illness is caused by repeated exposures (a cumulative injury), the date of injury is the date the injured employee knew or should have known the injury was caused by work.

Death benefits: Benefits paid to surviving dependents when a work injury or illness results in death.

Declaration of readiness : A box checked on the application for hearing declaring that the Petitioners Attorney is read for hearing.

Defendant: The party -- usually the employer or its insurance company -- opposing the injured employee in a dispute over benefits or services.

Denied claim: A claim in which the insurance company believes the injury or illness is not covered by workers' compensation.

Description of employee's job duties/job description: A written analysis of an employees job duties.

Disability: A physical or mental impairment that limits injured employee's life activities. A condition that makes engaging in physical, social and work activities difficult.

Disability rating: A rating provided by a doctor declaring percentage of permanent partial disability

Dispute: A disagreement about your right to payments, services or other benefits.

Department of Workforce Development (DWD): Otherwise referred to as the "Department," is the governing agency for workers compensation in the State of Wisconsin.

Employee: A person whose work activities are under the control of an individual or entity. The term employee includes undocumented workers and minors.

Employer: The person or entity with control over your work activities.

Ergonomics: The study of how to improve the fit between the physical demands of the workplace and the employees who perform the work. That means considering the variability in human capabilities when selecting, designing or modifying equipment, tools, work tasks and the work environment.

Essential functions: *Duties considered crucial to the job. When being considered for alternative work, an injured employee must have both the physical and mental qualifications to fulfill* the job's essential functions.

Filing: Sending or delivering a claim document to the Petitioners Attorney and DWD. When the injured employee is Pro Se (see definition) the documents must be sent to the employee.

Final order: Any order, decision or award made by a workers' compensation judge that has not been appealed.

Findings & award: A written decision by a workers' compensation administrative law judge about case, including payments and future medical. The award becomes a final order unless appealed.

First Aid - Any one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require medical care. Such treatment and observation are considered first aid even though provided by a physician or registered nurse.

Fraud: Any knowingly false or fraudulent statement for the purpose of obtaining or denying workers' compensation benefits.

Future medical: On-going right to medical treatment for a work-related injury.

Hazardous Condition - Any condition that may result in, or contribute to, an accident.

Hearings: Legal proceedings in which a workers' compensation judge discusses the issues in a case or receives information in order to make a decision about a dispute or a proposed settlement.

Incident - An unplanned, undesired event that did not immediately result in an injury or illness but may result in an injury or illness at some point in the future.

Independent contractor: There is no set definition of this term. Labor law enforcement agencies and the courts look at several factors when deciding if someone is an employee or an independent contractor. Some employers misclassify employees as an independent contractor to avoid workers' compensation and other payroll responsibilities. Just because an employer says you are an independent contractor and doesn't need to cover you under a workers' compensation policy doesn't make it true. A true independent contractor has control over how their work is done. You probably are not an independent contractor when the person paying you:

- Controls the details or manner of your work
- Has the right to terminate you
- Pays you an hourly wage or salary
- Makes deductions for unemployment or Social Security
- Supplies materials or tools
- Requires you to work specific days or hours

Investigation - A systematic search to determine how and why an accident, incident or near miss occurred.

Lien: A right or claim for payment recovery against a third party against a workers' compensation case.

Material Handling Injury - An injury that involves the lifting, handling and/or moving of an object or person.

Maximal medical improvement (MMI): The injured employee's condition is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Once an employee reaches MMI, a doctor can assess how much, if any, permanent disability resulted from the work injury.

Medical Bill Auditing (MBA) Outside vendor contracted to audit and reduce medical bills in line with the DWD approved data bases.

Medical Case Management (MCM) Private vendor nurses assigned to a Workers Compensation claim to assist with medical care, return to work and end of healing.

Medical Treatment - Treatment of injuries and illness administered by Physicians, registered professional personnel, or lay persons. Medical treatment does not include first aid treatment (one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require medical care) even though provided by a physician or registered professional personnel.

***Medical-legal report*:** A report written by a doctor that describes your medical condition. These reports are written to help clarify disputed medical issues.

Medical treatment: Treatment reasonably required to cure or relieve the effects of a work-related injury or illness. Also called medical care.

Modified work: An old job, with some changes that allow the injured employee to do the job.

Near Miss - An unplanned, undesired event that nearly resulted in a personal injury/illness or property damage.

Notice: an announcement containing information about an event. For example, DOA may receive "Notice of Hearing," meaning, a date and time has been scheduled for a litigated claim.

Objective findings: Measurements, direct observations and test results a treating physician, or IME doctor says contribute to the injury, or permanent disability.

Occupational Illness - Any acute or chronic condition or disorder caused by exposure to environmental factors associated with employment. They include conditions or diseases that are caused by inhalation, absorption, ingestion or direct contact with toxic materials such as hazardous chemicals, silica dead asbestos, etc.. Occupational illnesses also include disorders associated with repeated trauma or motion such as carpal tunnel syndrome.

Occupational Injury - Any injury such as a cut, fracture, sprain, amputation, etc., which results from a work accident or from a single instantaneous exposure in the work environment.

OSHA Lost Workday Case - A work-related injury or illness causing an employee to be unable to perform any available work for one or more workdays.

OSHA Restricted Workday Case - A work-related injury or illness that causes an employee to be unable to perform his or her regular job without restriction.

OSHA Recordable Cases - All work-related deaths and illnesses and work-related injuries that results in loss of consciousness, restriction of work or motion, transfer to another job, or requires medical treatment beyond first aid.

Party: Normally this includes the insurance company, the employer, attorneys and any other person with an interest in the claim (doctors or hospitals that have not been paid).

Permanent Partial Disability (PPD): Any lasting disability that results in a loss of function to the injured employee.

Permanent disability rating A percentage that can be provided only by a doctor which estimates how much an injury permanently limits the injured employee.

Permanent disability rating schedule A DWD publication containing detailed information used to rate permanent disabilities. These schedules are used to convert percentage of loss into dollars.

***Permanent disability benefits*:** Payments the injured employee receives when the work injury permanently limits functionality.

Permanent disability payments: A mandatory monthly, or bi-weekly payment based on the undisputed portion of permanent disability received before and/or after a rating.

***Permanent partial disability award*:** A final award of permanent partial disability made by a workers' compensation judge or the Workers' Compensation Appeals Board.

***Permanent total disability (PTD) benefits*:** Payments an injured employee receives when they can no longer return to any type of gainful employment.

Penalty: An amount of money assessed to the insurance company because something wasn't done correctly regarding a claim. This money is usually paid to the injured employee.

Pro Se: An injured worker not represented by an attorney.

***Treating physician*:** A doctor of the injured employees choosing.

Rating: The percentage of permanency provided to an injured employee by a doctor.

***Re-employment Specialist*:** An employee within the DOA/Risk Management Workers Compensation Unit who works to place injured employees within other employment, suitable to their permanent restrictions.

Repetitive Motion Injury - An injury that is caused by the repetitive use the wrists, hands, arms, shoulders and/or neck.

Risk Management Information System (RMIS) Electronic claim system utilized to capture data, make payments and manage a claim.

Settlement: An agreement between the injured employee and the insurance company about your workers' compensation payments and future medical care. Settlements must be approved by an ALJ.

Social Security Offset: Reduction of Workers Compensation Benefits when an employee is receiving Social Security benefits, according to a formula.

ENTERPRISE: Statistical Tracking and Reporting System: The Computer Program used to manage an maintain State Claims

Stipulated: Formal agreement from a petitioner's attorney, or plaintiff's attorney regarding facts presented pertaining to litigation.

Stipulation with award: Parties agree on the terms of an award. This is the document the ALJ signs to make the award final.

Subjective Complaints: The amount of pain and other symptoms described by an injured worker that a doctor reports as contributing to a worker's permanent disability. Subjective factors are given very little weight as there are no physical/ concrete signs to support the complaint. Example: An employee complains of severe knee pain, but shows no swelling, or signs of limp.

Subpoena: A document that requires a witness to appear at a hearing.

Temporary Total Disability (TTD): Payments an injured work will receive, in place of wages, when their claim is compensable and they are taken completely off of work by a doctor.

Temporary partial disability (TPD) benefits: Payments an injured worker will receive when they can only return to work a portion of the time they worked pre-injury. Example: An employee usually works 40 hours/week, but due to the temporary work restrictions, can only work 20 hours/week.

Travel expenses: Reimbursement for mileage while traveling to and from doctor appointments.

Uninsured Employers Fund **(UEF):** A fund, run by DWD, through which an injured worker can receive benefits even if their employer is illegally uninsured for workers' compensation.

Unsafe Act - A behavioral departure from an accepted, normal, safe, or correct procedure or practice which, in the past, has produced injury, illness or property damage or which has the potential for doing so in the future.

Utilization review **(UR):** The process used by insurance companies to decide whether to authorize and pay for treatment recommended by your treating physician or another doctor.

Vocational Temporary Disability**:** A benefits paid to the injured employee while vocational retraining is taking place. For example, while an employee attends 8 weeks of computer training, Workers Compensation will pay VTD Benefits. These benefits are paid at the same rate as TTD.

Witness - An individual who personally observes the occurrence of a particular even or who is familiar with the circumstances involved in the incident.

Work Environment - Consists of the employer's premises and other locations where employees are engaged in work-related activities or are present as a condition of their employment. The work environment includes not only physical location, but also the equipment or materials used by the employee during the course of work.

***Workers' Compensation Insurance Rating Bureau* (WCIRB):** An agent of the state Department of Insurance and funded by the insurance industry, this private entity provides statistical and rating information for workers' compensation insurance and employer's liability insurance, and collects and tabulates information to develop pure premium rates.

***Work restrictions*:** A doctor's description of the work you can and cannot do. Work restrictions help protect you from further injury.

Workers' compensation administrative law judge: A DWD employee who makes decisions about workers' compensation disputes and approves settlements. Judges hold hearings at local Workers' Compensation Appeals Board (WCAB) offices, and their decisions may be reviewed and reconsidered by the Reconsideration Unit of the WCAB. Also called workers' compensation judge.