WEST VIRGINIA CODE CHAPTER 23 ARTICLE 4

WV Legislature

§23-4-1. To whom compensation fund disbursed; occupational pneumoconiosis and other occupational diseases included in "injury" and "personal injury"; definition of occupational pneumoconiosis and other occupational diseases; rebuttable presumption for cardiovascular injury and disease or pulmonary disease for firefighters.

(a) Subject to the provisions and limitations elsewhere in this chapter, workers' compensation benefits shall be paid to the employees of employers subject to this chapter who have received personal injuries in the course of and resulting from their covered employment or to the dependents, if any, of the employees in case death has ensued, according to the provisions hereinafter made: *Provided*, That in the case of any employees of the state and its political subdivisions, including: Counties; municipalities; cities; towns; any separate corporation or instrumentality established by one or more counties, cities or towns as permitted by law; any corporation or instrumentality supported in most part by counties, cities or towns; any public corporation charged by law with the performance of a governmental function and whose jurisdiction is coextensive with one or more counties, cities or towns; any agency or organization established by the Department of Mental Health, or its successor agencies, for the provision of community health or intellectual and developmental disability services and which is supported, in whole or in part, by state, county, or municipal funds; board, agency, commission, department, or spending unit, including any agency created by rule of the Supreme Court of Appeals, who have received personal injuries in the course of, and resulting from, their covered employment, the employees are ineligible to receive compensation while the employees are at the same time, and for the same reason, drawing sick leave benefits. The state employees may only use sick leave for nonjob-related absences consistent with sick leave use and may draw workers' compensation benefits only where there is a job-related injury. This proviso does not apply to permanent benefits: *Provided, however*, That the employees may collect sick leave benefits until receiving temporary total disability benefits. The Division of Personnel shall propose rules for legislative approval pursuant to §29A-3-1 *et seq*. of this code relating to use of sick leave benefits by employees receiving personal injuries in the course of, and resulting from, covered employment: *Provided further*, That if an employee is injured in the course of and resulting from covered employment and the injury results in lost time from work and the employee, for whatever reason, uses or obtains sick leave benefits and subsequently receives temporary total disability benefits for the same time period, the employee may be restored sick leave time taken by him or her as a result of the compensable injury by paying to his or her employer the temporary total disability benefits received or an amount equal to the temporary total disability benefits received. The employee shall be restored sick leave time on a day-for-day basis which corresponds to temporary total disability benefits paid to the employer: *And provided further*, That since the intent of this subsection is to prevent an employee of the state or any of its political subdivisions from collecting both temporary total disability benefits and sick leave benefits for the same time period, nothing in this subsection prevents an employee of the state or any of its political subdivisions from electing to receive either sick leave benefits or temporary total disability benefits, but not both.

WV Legislature

(b) For the purposes of this chapter, the terms "injury" and "personal injury" include occupational pneumoconiosis and any other occupational disease, as hereinafter defined, and workers' compensation benefits shall be paid to the employees of the employers in whose employment the employees have been exposed to the hazards of occupational pneumoconiosis or other occupational disease and have contracted occupational pneumoconiosis or other occupational disease, or have suffered a perceptible aggravation of an existing pneumoconiosis or other occupational disease, or to the dependents, if any, of the employees, in case death has ensued, according to the provisions hereinafter made: *Provided*, That compensation is not payable for the disease of occupational pneumoconiosis, or death resulting from the disease, unless the employee has been exposed to the hazards of occupational pneumoconiosis in the State of West Virginia over a continuous period of not less than two years during the 10 years immediately preceding the date of his or her last exposure to such hazards, or for any five of the 15 years immediately preceding the date of his or her last exposure. An application for benefits on account of occupational pneumoconiosis shall set forth the name of the employer or employers and the time worked for each. The commission may allocate to and divide any charges resulting from such claim among the employers by whom the claimant was employed for as much as 60 days during the period of three years immediately preceding the date of last exposure to the hazards of occupational pneumoconiosis. The allocation shall be based upon the time and degree of exposure withemployer.

(c) For the purposes of this chapter, disability or death resulting from occupational pneumoconiosis, as defined in subsection (d) of this section, shall be treated and compensated as an injury by accident.

(d) Occupational pneumoconiosis is a disease of the lungs caused by the inhalation of minute particles of dust over a period of time due to causes and conditions arising out of, and in the course of, the employment. The term "occupational pneumoconiosis" includes, but is not limited to, such diseases as silicosis, anthracosilicosis, coal worker’s pneumoconiosis, commonly known as black lung or miner's asthma, silicotuberculosis (silicosis accompanied by active tuberculosis of the lungs), coal worker's pneumoconiosis accompanied by active tuberculosis of the lungs, asbestosis, siderosis, anthrax, and any and all other dust diseases of the lungs and conditions and diseases caused by occupational pneumoconiosis which are not specifically designated in this section meeting the definition of occupational pneumoconiosis set forth in this subsection.

(e) In determining the presence of occupational pneumoconiosis, x-ray evidence may be considered, but may not be accorded greater weight than any other type of evidence demonstrating occupational pneumoconiosis.

(f) For the purposes of this chapter, occupational disease means a disease incurred in the course of and resulting from employment. No ordinary disease of life to which the general public is exposed outside of the employment is compensable except when it follows as an incident of occupational disease as defined in this chapter. Except in the case of occupational pneumoconiosis, a disease is considered to have been incurred in the course of,

www.Legislature

or to have resulted from, the employment only if it is apparent to the rational mind, upon consideration of all the circumstances: (1) That there is a direct causal connection between the conditions under which work is performed and the occupational disease; (2) that it can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment; (3) that it can be fairly traced to the employment as the proximate cause; (4) that it does not come from a hazard to which workmen would have been equally exposed outside of the employment; (5) that it is incidental to the character of the business and not independent of the relation of employer and employee; and (6) that it appears to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction: *Provided*, That compensation is not payable for an occupational disease or death resulting from the disease unless the employee has been exposed to the hazards of the disease in the State of West Virginia over a continuous period that is determined to be sufficient, by rule of the Insurance Commissioner and Industrial Council, for the disease to have occurred in the course of and resulting from the employee's employment. An application for benefits on account of an occupational disease shall set forth the name of the employer or employers and the time worked for each. The commission may allocate to and divide any charges resulting from the claim among the employers by whom the claimant was employed. The allocation shall be based upon the time and degree of exposure with each employer.

(g) No award may be made under the provisions of this chapter for any occupational disease contracted prior to July 1, 1949. An employee has contracted an occupational disease within the meaning of this subsection if the disease or condition has developed to such an extent that it can be diagnosed as an occupational disease.

(h) For purposes of this chapter, a rebuttable presumption that a professional firefighter who has developed a cardiovascular or pulmonary disease or sustained a cardiovascular injury or who has developed leukemia, lymphoma, multiple myeloma, bladder cancer, mesothelioma, or testicular cancer arising out of, and in the course of, employment as a firefighter has received an injury or contracted a disease arising out of, and in the course of, his or her employment exists if: (A) The person has been actively employed by a fire department as a professional firefighter for a minimum of two years prior to the cardiovascular injury or onset of a cardiovascular or pulmonary disease or death; (B) the injury or onset of the disease or death occurred within six months of having participated in firefighting or a training or drill exercise which actually involved firefighting; and (C) in the case of the development of leukemia, lymphoma, multiple myeloma, bladder cancer, mesothelioma, or testicular cancer, the person has been actively employed by a fire department as a professional firefighter for a minimum of five years in the state prior to the development of leukemia, lymphoma, multiple myeloma, bladder cancer, mesothelioma, or testicular cancer, has not used tobacco products more than six times in a calendar year for at least 10 years, and is not over the age of 65 years. When the above conditions are met, it shall be presumed that sufficient notice of the injury, disease, or death has been given and that the injury, disease, or death was not self-inflicted. The amendments made to this section during the

WV Legislature

regular session of the Legislature, 2024, to include bladder cancer, mesothelioma or testicular cancer arising out of, and in the course of, employment as a firefighter as a rebuttable presumption expire on July 1, 2027, unless extended by the Legislature.

(i) Claims for occupational disease as defined in §23-4-1(f) of this code, except occupational pneumoconiosis for all workers and pulmonary disease and cardiovascular injury and disease for professional firefighters, shall be processed in like manner as claims for all other personal injuries.

WV Legislature

§23-4-1a. Report of injuries by employee.

Every employee who sustains an injury subject to this chapter, or his or her representative, shall immediately on the occurrence of the injury or as soon thereafter as practicable give or cause to be given to the employer or any of the employer's agents a written notice of the occurrence of the injury stating in ordinary language the name and address of the employer, the name and address of the employee, the time, place, nature, and cause of the injury, and whether temporary total disability has resulted from the injury. The notice shall be given personally to the employer or any of the employer's agents, or may be sent by certified mail addressed to the employer at the employer's last known residence or place of business.

WV Legislature

§23-4-1b. Report of injuries by employers.

It is the duty of every employer to report every injury sustained by any person in his or her employ to its workers' compensation insurance carrier or claims administrator, if applicable. The report shall be on forms prescribed by the Insurance Commissioner and shall be made within five days of the employer's receipt of the employee's notice of injury as required by §23-4-1a of this code. The five-day period may not be extended by the employer's workers' compensation insurance carrier or claims administrator, if applicable, but the employer has the right to file a supplemental report at a later date. The employer's report of injury shall include a statement as to whether, on the basis of the information available, the employer disputes the compensability of the injury or objects to the payment of temporary total disability benefits in connection with the injury. The statements by the employer shall not prejudice the employer's right thereafter to contest the compensability of the injury, or to object to any subsequent finding or award, in accordance with §23-5-1 *et seq*. of this code; but an employer's failure to make timely report of an injury as required in this section, or statements in the report to the effect that the employer does not dispute the compensability of the injury or object to the payment of temporary total disability benefits for the injury, shall be considered to be a waiver of the employer's right to object to any interim payment of temporary total disability benefits with respect to any period from the date of injury to the date of receipt of any objection made to the interim payments by the employer.

WV Legislature

§23-4-1c. Payment of temporary total disability benefits directly to claimant; payment of medical benefits; payments of benefits during protest; right of Insurance Commissioner, private carriers, and self-insured employers to collect payments improperly made.

(a) In any claim for benefits under this chapter, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall determine whether the claimant has sustained a compensable injury within the meaning of §23-4-1 of this code and enter an order giving all parties immediate notice of the decision.

(1) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may enter an order conditionally approving the claimant's application if it finds that obtaining additional medical evidence or evaluations or other evidence related to the issue of compensability would aid the Insurance Commissioner, private carrier, or self-insured employer in making a correct final decision. Benefits shall be paid during the period of conditional approval; however, if the final decision is one that rejects the claim, the payments shall be considered an overpayment. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may only recover the amount of the overpayment as provided for in subsection (h) of this section.

(2) In making a determination regarding the compensability of a newly filed claim or upon a filing for the reopening of a prior claim pursuant to the provisions of §23-4-16 of this code based upon an allegation of recurrence, reinjury, aggravation, or progression of the previous compensable injury, or in the case of a filing of a request for any other benefits under the provisions of this chapter, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall consider the date of the filing of the claim for benefits for a determination of the following:

(A) Whether the claimant had a scheduled shutdown beginning within one week of the date of the filing;

(B) Whether the claimant received notice within 60 days of the filing that his or her employment position was to be eliminated, including, but not limited to, the closure of the claimant's worksite, a layoff, or the elimination of the claimant's employment position;

(C) Whether the claimant is receiving unemployment compensation benefits at the time of the filing; or

(D) Whether the claimant has received unemployment compensation benefits within 60 days of the filing.

In the event of an affirmative finding upon any of these four factors, the finding shall be given probative weight in the overall determination of the compensability of the claim or of the merits of the reopening request.

WV Legislature

(3) Any party may object to the order of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, and obtain an evidentiary hearing as provided in §23-5-1a of this code: *Provided*, That if a private carrier or self-insured employer fails to timely issue a ruling upon any application or motion as provided by law, or if the claimant files a timely protest to the ruling of a private carrier or self-insured employer denying the compensability of the claim, denying temporary total disability benefits, or denying medical authorization, the Board of Review shall provide a hearing on the protest on an expedited basis as determined by rule of the Board of Review.

(b) Where it appears from the employer's report, or from proper medical evidence, that a compensable injury will result in a disability which will last longer than three days as provided in §23-4-5 of this code, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may immediately enter an order commencing the payment of temporary total disability benefits to the claimant in the amounts provided for in §23-4-6 and §23-4-14 of this code, and the payment of the expenses provided for in §23-4-3(a) of this code, relating to the injury, without waiting for the expiration of the 30-day period during which objections may be filed to the findings as provided in §23-5-1a of this code. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall enter an order commencing the payment of temporary total disability or medical benefits within 15 working days of receipt of either the employee's or employer's report of injury, whichever is received sooner, and also upon receipt of either a proper physician's report or any information necessary for a determination. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall give the parties immediate notice of any order granting temporary total disability or medical benefits. When an order granting temporary total disability benefits is made, the claimant's return-to-work potential shall be assessed. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may schedule medical and vocational evaluation of the claimant and assign appropriate personnel to expedite the claimant's return to work as soon as reasonably possible.

(c) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may enter orders granting temporary total disability benefits upon receipt of medical evidence justifying the payment of the benefits. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may not enter an order granting prospective temporary total disability benefits for a period of more than 90 days: *Provided*, That when the Insurance Commissioner, private carrier, or self-insured employer determines that the claimant remains disabled beyond the period specified in the prior order granting temporary total disability benefits, the Insurance Commissioner, private carrier, or self-insured employer shall enter an order continuing the payment of temporary total disability benefits for an additional period not to exceed 90 days and shall give immediate notice to all parties of the decision.

(d) Upon receipt of the first report of injury in a claim, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall request from the employer or employers any wage information necessary for determining the rate of benefits to which the

WV Legislature

employee is entitled. If an employer does not furnish this information within 15 days from the date the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, received the first report of injury in the case, the employee shall be paid temporary total disability benefits for lost time at the rate the Insurance Commissioner obtains from reports made pursuant to §23-2-2(b) of this code. If no wages have been reported, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall make the payments at the rate the Insurance Commissioner, private carrier, or self-insured employer finds would be justified by the usual rate of pay for the occupation of the injured employee. The rate of benefits shall be adjusted both retroactively and prospectively upon receipt of proper wage information. The Insurance Commissioner shall have access to all wage information in the possession of any state agency.

(e) Subject to the limitations set forth in §23-4-16 of this code, upon a finding of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, that a claimant who has sustained a previous compensable injury which has been closed by order, or by the claimant's return to work, suffers further temporary total disability or requires further medical or hospital treatment resulting from the compensable injury, payment of temporary total disability benefits to the claimant in the amount provided for in §23-4-6 and §23-4-14 of this code, including the expenses provided for in §23-4-3(a) of this code, shall immediately commence relating to the disability, without waiting for the expiration of the 30-day period during which objections may be filed. Immediate notice to the parties of the decision shall be given.

(f) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall deliver amounts due for temporary total disability benefits directly to the claimant.

(g) Where the employer has elected to carry its own risk under §23-2-9 of this code, and upon the findings aforesaid, the self-insured employer shall immediately pay the amounts due the claimant for temporary total disability benefits. A copy of the notice shall be sent to the claimant.

(h) In the event that an employer files a timely objection to any order of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, with respect to compensability, or any order denying an application for modification with respect to temporary total disability benefits, or with respect to those expenses outlined in §23-4-3(a) of this code, the Insurance Commissioner, private carrier, or self-insured employer shall continue to pay to the claimant such benefits and expenses during the period of such disability. When the employer has protested the compensability or applied for modification of a temporary total disability benefit award or expenses and the final decision in that case determines that the claimant was not entitled to the benefits or expenses, the disputed amount of benefits or expenses is considered an overpayment. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may recover the overpayment by withholding, in whole or in part, future benefits payable to the individual in the same or other claims and credit the amount against the overpayment until it is repaid in

WV Legislature

full.

(i) In the event that the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, finds that, based upon the employer's report of injury, the claim is not compensable, the Insurance Commissioner, private carrier, or self-insured employer shall provide a copy of the employer's report to the claimant in addition to the order denying the claim.

(j) If a claimant is receiving benefits paid through a wage replacement plan, salary continuation plan, or other benefit plan provided by the employer to which the employee has not contributed, and that plan does not provide an offset for temporary total disability benefits to which the claimant is also entitled under this chapter as a result of the same injury or disease, the employer shall notify the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, of the duplication of the benefits paid to the claimant. Upon receipt of the notice, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall reduce the temporary total disability benefits provided under this chapter by an amount sufficient to ensure that the claimant does not receive monthly benefits in excess of the amount provided by the employer's plan or the temporary total disability benefit, whichever is greater: *Provided*, That this subsection does not apply to benefits being paid under the terms and conditions of a collective bargaining agreement.

WV Legislature

§23-4-1d. Method and time of payments for permanent disability.

(a) If the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, makes an award for permanent partial or permanent total disability, the Insurance Commissioner, private carrier, or self-insured employer shall start payment of benefits by mailing or delivering the amount due directly to the employee within 15 working days from the date of the award: *Provided*, That the Insurance Commissioner, private carrier, or self-insured employer may withhold payment of the portion of the award that is the subject of subsection (b) of this section until 77 days have expired without an objection being filed.

(b) When the Insurance Commissioner, private carrier, self-insured employer, or the Workers' Compensation Board of Review, whichever is applicable, enters an order or provides notice granting the claimant a permanent total disability award and an objection or petition for appeal is filed, payment of monthly permanent total disability benefits shall begin. However, any payment for a back period of benefits from the onset date of total permanent disability to the date of the award shall be limited to a period of 12 months of benefits. If, after all litigation is completed and the time for the filing of any further objections or appeals to the award has expired and the award of permanent total disability benefits is upheld, the claimant shall receive the remainder of benefits due to him or her based upon the onset date of permanent total disability that was finally determined.

(c) If the claimant is owed any additional payment of back permanent total disability benefits, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall not only pay the claimant the sum owed but shall also add thereto interest at the simple rate of six percent per annum from the date of the initial award granting the total permanent disability to the date of the final order upholding the award. In the event that an intermediate order directed an earlier onset date of permanent total disability than was found in the initial award, the interest-earning period for that additional period shall begin upon the date of the intermediate award.

(d) If a timely protest to the award is filed, as provided in §23-5-1a or §23-5-9a of this code, benefits shall continue to be paid to the claimant during the period of the disability unless it is subsequently found that the claimant was not entitled to receive the benefits or any part thereof. If the final decision in any case determines that a claimant was not lawfully entitled to benefits paid to him or her pursuant to a prior decision, the amount of benefits paid shall be considered an overpayment and the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may only recover that amount by withholding, in whole or in part, future benefits payable to the individual in the same or other claims and credit the amount against the overpayment until it is repaid in full.

(e) An award for permanent partial disability shall be made as expeditiously as possible and in accordance with the time frame requirements promulgated by rule of the Insurance Commissioner.

WV Legislature

(f) If a claimant is receiving benefits paid through a retirement plan, wage replacement plan, salary continuation plan, or other benefit plan provided by the employer to which the employee has not contributed, and that plan does not provide an offset for permanent total disability benefits to which the claimant is also entitled under this chapter as a result of the same injury or disease, the employer shall notify the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, of the duplication of the benefits paid to the claimant. Upon receipt of the notice, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall reduce the permanent total disability benefits provided under this chapter by an amount sufficient to ensure that the claimant does not receive monthly benefits in excess of the amount provided by the employer's plan or the permanent total disability benefit, whichever is greater: *Provided*, That this subsection does not apply to benefits being paid under the terms and conditions of a collective bargaining agreement.

WV Legislature

§23-4-1e. Temporary total disability benefits not to be paid for periods of correctional center or jail confinement; denial of workers' compensation benefits for injuries or disease incurred while confined.

(a) Notwithstanding any provision of this code to the contrary, no person shall be jurisdictionally entitled to temporary total disability benefits for that period of time in excess of three days during which that person is confined in a state correctional facility or jail: *Provided*, That confinement shall not affect the claimant's eligibility for payment of expenses: Provided*, however*, That this subsection is applicable only to injuries and diseases incurred prior to any period of confinement. Upon release from confinement, the payment of benefits for the remaining period of temporary total disability shall be made if justified by the evidence and authorized by order of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable.

(b) Notwithstanding any provision of this code to the contrary, no person confined in a state correctional facility or jail who suffers injury or a disease in the course of and resulting from his or her work during the period of confinement which work is imposed by the administration of the state correctional facility or jail and is not suffered during the person's usual employment with his or her usual employer when not confined shall receive benefits under the provisions of this chapter for the injury or disease: Provided, That individuals otherwise confined in a state correctional facility or jail, or at a juvenile services facility, and working in a program authorized by §25-7-14 or §25-7-16 of this code, shall be eligible to receive benefits under the provisions of this chapter while working in an authorized program. The coverage for benefits may be obtained either by the private entity or by agreement with the state agency as specified in §25-7-14(a)(5) and §25-7-16(a)(5) of this code.

WV Legislature

§23-4-1f. Certain psychiatric injuries and diseases not compensable; definitions; legislative findings; terms; report required.

(a) Except as provided by this section, for the purposes of this chapter, no alleged injury or disease may be recognized as a compensable injury or disease which was solely caused by nonphysical means and which did not result in any physical injury or disease to the person claiming benefits. Except as otherwise provided in this section, it is the purpose of this section to clarify that so-called mental-mental claims are not compensable under this chapter.

(b) For the purposes of this section:

(1) "First responder" means a law enforcement officer, firefighter, emergency medical technician, paramedic, and emergency dispatcher;

(2) "Post-traumatic stress disorder" means a disorder that meets the diagnostic criteria for post-traumatic stress disorder specified by the American Psychiatric Association in the Diagnostic

and Statistical Manual of Mental Disorders, fifth edition, or a later edition as adopted by rule of the insurance commissioner; and

(3) "Licensed mental health provider" means a licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed marriage and family therapist, certified mental health nurse practitioner, certified psychiatric physician assistant, or licensed social worker who:

(A) Holds a master's degree or higher;

(B) Holds a terminal license within their profession; and

(C) Is qualified to treat post-traumatic stress disorder.

(4) "Employer" means any entity that controls, consistent with the provisions of West Virginia law relating to an employment relationship, the paid or volunteer employment of a first responder eligible for benefits under this section.

(c) The Legislature finds that post-traumatic stress disorder is a unique medical condition. Although it may manifest itself as a psychiatric condition that would be otherwise precluded from workers' compensation coverage, post-traumatic stress disorder is an occupational hazard for first responders, similar to members of the military serving in combat. The Legislature further finds that because first responders are required to expose themselves to traumatic events during the course of their employment and thus are at a recognized higher risk of developing post-traumatic stress disorder, and because of the severe nature and debilitative effects of post-traumatic stress disorder, it is the moral obligation of the state to permit coverage to this class of individuals for their work-related disease.

WV Legislature

(d)(1) Post-traumatic stress disorder suffered by a first responder may be recognized as a compensable occupational disease under §23-4-1(f) of this code when:

(A) The employer has elected to provide coverage for post-traumatic stress disorder as an occupational disease; and

(B) A diagnosis has been made by a licensed psychiatrist, certified mental health nurse practitioner, or certified psychiatric physician assistant that the first responder suffered from post-traumatic stress disorder due to exposure to an event or events that occurred in the course of and resulting from the first responder's paid or volunteer covered employment: *Provided*, That the provisions of this section shall apply only to a post-traumatic stress disorder diagnosis made on or after July 1, 2021, or the first day of the employer's next workers' compensation insurance policy or self-insurance program term for which post-traumatic stress disorder coverage has been purchased or elected, whichever is later.

(2) While the diagnosis must be made by a licensed psychiatrist, certified mental health nurse practitioner, or certified psychiatric physician assistant, mental health treatment consistent for a post-traumatic stress disorder diagnosis may be offered by a licensed mental health provider other than the diagnosing psychiatrist, certified mental health nurse practitioner, or certified psychiatric physician assistant.

(3) A diagnosis of post-traumatic stress disorder under this section may not include consideration of any layoff, termination, disciplinary action, or any similar personnel-related action taken in good faith by an employer.

(4) Benefits for a post-traumatic stress disorder diagnosis made under this section are contingent upon the employer electing to provide coverage for post-traumatic stress disorder from its workers' compensation insurance carrier or to provide for it through its self-insurance program, whichever is applicable.

(5) The receipt of benefits is contingent on a claim being made within three years from and after a licensed psychiatrist, certified mental health nurse practitioner, or certified psychiatric physician assistant has made the claimant aware of a post-traumatic stress disorder diagnosis in accordance with this section.

WV Legislature

§23-4-1g. Weighing of evidence.

(a) For all awards made on or after the effective date of the amendment and reenactment of this section during the year two thousand three, resolution of any issue raised in administering this chapter shall be based on a weighing of all evidence pertaining to the issue and a finding that a preponderance of the evidence supports the chosen manner of resolution. The process of weighing evidence shall include, but not be limited to, an assessment of the relevance, credibility, materiality and reliability that the evidence possesses in the context of the issue presented. Under no circumstances will an issue be resolved by allowing certain evidence to be dispositive simply because it is reliable and is most favorable to a party's interests or position. If, after weighing all of the evidence regarding an issue in which a claimant has an interest, there is a finding that an equal amount of evidentiary weight exists favoring conflicting matters for resolution, the resolution that is most consistent with the claimant's position will be adopted.

(b) Except as provided in subsection (a) of this section, a claim for compensation filed pursuant to this chapter must be decided on its merit and not according to any principle that requires statutes governing workers' compensation to be liberally construed because they are remedial in nature. No such principle may be used in the application of law to the facts of a case arising out of this chapter or in determining the Constitutionality of this chapter.

WV Legislature

§23-4-2. Disbursement where injury is self-inflicted or intentionally caused by employer; legislative declarations and findings; "deliberate intention" defined.

(a) Notwithstanding anything contained in this chapter, no employee or dependent of any employee is entitled to receive any sum under the provisions of this chapter on account of any personal injury to or death to any employee caused by a self-inflicted injury or the intoxication of the employee. Upon the occurrence of an injury which the employee asserts, or which reasonably appears to have, occurred in the course of and resulting from the employee's employment, the employer may require the employee to undergo a blood test for the purpose of determining the existence or nonexistence of evidence of intoxication: *Provided*, That the employer must have a reasonable and good faith objective suspicion of the employee's intoxication and may only test for the purpose of determining whether the person is intoxicated. If any blood test for intoxication is given following an accident, at the request of the employer or otherwise, and if any of the following are true, the employee is deemed intoxicated and the intoxication is the proximate cause of the injury:

(1) If a blood test is administered within two hours of the accident and evidence that there was, at that time, more than five hundredths of one percent, by weight, of alcohol in the employee's blood; or

(2) If there was, at the time of the blood test, evidence of either on or off the job use of a nonprescribed controlled substance as defined in the West Virginia Uniform Controlled Substances Act, West Virginia Code §60A-2-201, *et seq.*, Schedules I, II, III, IV and V.

(b) For the purpose of this chapter, the commission may cooperate with the Office of Miners' Health, Safety and Training and the State Division of Labor in promoting general safety programs and in formulating rules to govern hazardous employments.

(c) If injury results to any employee from the deliberate intention of his or her employer to produce the injury or death, the employee, or, if the employee has been found to be incompetent, his or her conservator or guardian, may recover under this chapter and bring a cause of action against the employer, as if this chapter had not been enacted, for any excess of damages over the amount received or receivable in a claim for benefits under this chapter. If death results to any employee from the deliberate intention of his or her employer to produce the injury or death, the representative of the estate may recover under this chapter and bring a cause of action, pursuant to section six, article seven of chapter fifty-five of this code, against the employer, as if this chapter had not been enacted, for any excess of damages over the amount received or receivable in a claim for benefits under this chapter. To recover under this section, the employee, the employee's representative or dependent, as defined under this chapter, must, unless good cause is shown, have filed a claim for benefits under this chapter.

(d)(1) It is declared that enactment of this chapter and the establishment of the workers' compensation system in this chapter was and is intended to remove from the common law tort system all disputes between or among employers and employees regarding the

WV Legislature

compensation to be received for injury or death to an employee except as expressly provided in this chapter and to establish a system which compensates even though the injury or death of an employee may be caused by his or her own fault or the fault of a co-employee; that the immunity established in sections six and six-a, article two of this chapter is an essential aspect of this workers' compensation system; that the intent of the Legislature in providing immunity from common lawsuit was and is to protect those immunized from litigation outside the workers' compensation system except as expressly provided in this chapter; that, in enacting the immunity provisions of this chapter, the Legislature intended to create a legislative standard for loss of that immunity of more narrow application and containing more specific mandatory elements than the common law tort system concept and standard of willful, wanton and reckless misconduct; and that it was and is the legislative intent to promote prompt judicial resolution of the question of whether a suit prosecuted under the asserted authority of this section is or is not prohibited by the immunity granted under this chapter.

(2) The immunity from suit provided under this section and under sections six and six-a, article two of this chapter may be lost only if the employer or person against whom liability is asserted acted with "deliberate intention". This requirement may be satisfied only if:

(A) It is proved that the employer or person against whom liability is asserted acted with a consciously, subjectively and deliberately formed intention to produce the specific result of injury or death to an employee. This standard requires a showing of an actual, specific intent and may not be satisfied by allegation or proof of: (i) Conduct which produces a result that was not specifically intended; (ii) conduct which constitutes negligence, no matter how gross or aggravated; or (iii) willful, wanton or reckless misconduct; or

(B) The trier of fact determines, either through specific findings of fact made by the court in a trial without a jury, or through special interrogatories to the jury in a jury trial, that all of the following facts are proven:

(i) That a specific unsafe working condition existed in the workplace which presented a high degree of risk and a strong probability of serious injury or death;

(ii) That the employer, prior to the injury, had actual knowledge of the existence of the specific unsafe working condition and of the high degree of risk and the strong probability of serious injury or death presented by the specific unsafe working condition.

(I) In every case actual knowledge must specifically be proven by the employee or other person(s) seeking to recover under this section, and shall not be deemed or presumed: *Provided*, That actual knowledge may be shown by evidence of intentional and deliberate failure to conduct an inspection, audit or assessment required by state or federal statute or regulation and such inspection, audit or assessment is specifically intended to identify each alleged specific unsafe working condition.

(II) Actual knowledge is not established by proof of what an employee's immediate

WV Legislature

supervisor or management personnel should have known had they exercised reasonable care or been more diligent.

(III) Any proof of the immediate supervisor or management personnel's knowledge of prior accidents, near misses, safety complaints or citations from regulatory agencies must be proven by documentary or other credible evidence.

(iii) That the specific unsafe working condition was a violation of a state or federal safety statute, rule or regulation, whether cited or not, or of a commonly accepted and well-known safety standard within the industry or business of the employer.

(I) If the specific unsafe working condition relates to a violation of a commonly accepted and well-known safety standard within the industry or business of the employer, that safety standard must be a consensus written rule or standard promulgated by the industry or business of the employer, such as an organization comprised of industry members: *Provided*, That the National Fire Protection Association Codes and Standards or any other industry standards for Volunteer Fire Departments shall not be cited as an industry standard for Volunteer Fire Departments, Municipal Fire Departments and Emergency Medical Response Personnel as an unsafe working condition as long as the Volunteer Fire Departments, Municipal Fire Departments and the Emergency Medical Response Personnel have followed the Rules that have been promulgated by the Fire Commission.

(II) If the specific unsafe working condition relates to a violation of a state or federal safety statute, rule or regulation that statute, rule or regulation:

(a) Must be specifically applicable to the work and working condition involved as contrasted with a statute, rule, regulation or standard generally requiring safe workplaces, equipment or working conditions;

(b) Must be intended to address the specific hazard(s) presented by the alleged specific unsafe working condition; and,

(c) The applicability of any such state or federal safety statute, rule or regulation is a matter of law for judicial determination.

(iv) That notwithstanding the existence of the facts set forth in subparagraphs (i) through (iii), inclusive, of this paragraph, the person or persons alleged to have actual knowledge under subparagraph (ii) nevertheless intentionally thereafter exposed an employee to the specific unsafe working condition; and

(v) That the employee exposed suffered serious compensable injury or compensable death as defined in section one, article four, chapter twenty-three as a direct and proximate result of the specific unsafe working condition. For the purposes of this section, serious compensable injury may only be established by one of the following four methods:

(I) It is shown that the injury, independent of any preexisting impairment:

WV Legislature

(a) Results in a permanent physical or combination of physical and psychological injury rated at a total whole person impairment level of at least thirteen percent (13%) as a final award in the employees workers' compensation claim; and

(b) Is a personal injury which causes permanent serious disfigurement, causes permanent loss or significant impairment of function of any bodily organ or system, or results in objectively verifiable bilateral or multi-level dermatomal radiculopathy; and is not a physical injury that has no objective medical evidence to support a diagnosis; or

(II) Written certification by a licensed physician that the employee is suffering from an injury or condition that is caused by the alleged unsafe working condition and is likely to result in death within eighteen (18) months or less from the date of the filing of the complaint. The certifying physician must be engaged or qualified in a medical field in which the employee has been treated, or have training and/or experience in diagnosing or treating injuries or conditions similar to those of the employee and must disclose all evidence upon which the written certification is based, including, but not limited to, all radiographic, pathologic or other diagnostic test results that were reviewed.

(III) If the employee suffers from an injury for which no impairment rating may be determined pursuant to the rule or regulation then in effect which governs impairment evaluations pursuant to this chapter, serious compensable injury may be established if the injury meets the definition in subclause (I)(b).

(IV) If the employee suffers from an occupational pneumoconiosis, the employee must submit written certification by a board certified pulmonologist that the employee is suffering from complicated pneumoconiosis or pulmonary massive fibrosis and that the occupational pneumoconiosis has resulted in pulmonary impairment as measured by the standards or methods utilized by the West Virginia Occupational Pneumoconiosis Board of at least fifteen percent (15%) as confirmed by valid and reproducible ventilatory testing. The certifying pulmonologist must disclose all evidence upon which the written certification is based, including, but not limited to, all radiographic, pathologic or other diagnostic test results that were reviewed: *Provided*, That any cause of action based upon this clause must be filed within one year of the date the employee meets the requirements of the same: *Provided further*, That the employee asserting a cause of action based upon this clause must prove that the employer fraudulently concealed or manipulated dust samples or air quality samples.

(C) In cases alleging liability under the provisions of paragraph (B) of this subdivision:

(i) The employee, the employee's guardian or conservator, or the representative of the employee's estate shall serve with the complaint a verified statement from a person with knowledge and expertise of the workplace safety statutes, rules, regulations and consensus industry safety standards specifically applicable to the industry and workplace involved in the employee's injury, setting forth opinions and information on:

www.Legislature

(I) The person's knowledge and expertise of the applicable workplace safety statutes, rules, regulations and/or written consensus industry safety standards;

(II) The specific unsafe working condition(s) that were the cause of the injury that is the basis of the complaint; and

(III) The specific statutes, rules, regulations or written consensus industry safety standards violated by the employer that are directly related to the specific unsafe working conditions: *Provided, however*, That this verified statement shall not be admissible at the trial of the action and the Court, pursuant to the Rules of Evidence, common law and subclause two-c, subparagraph (iii), paragraph (B), subdivision (2), subsection (d), section two, article four, chapter twenty-three of this code, retains responsibility to determine and interpret the applicable law and admissibility of expert opinions.

(ii) No punitive or exemplary damages shall be awarded to the employee or other plaintiff;

(iii) Notwithstanding any other provision of law or rule to the contrary, and consistent with the legislative findings of intent to promote prompt judicial resolution of issues of immunity from litigation under this chapter, the employer may request and the court shall give due consideration to the bifurcation of discovery in any action brought under the provisions of subparagraphs (i) through (v), of paragraph (B) such that the discovery related to liability issues be completed before discovery related to damage issues. The court shall dismiss the action upon motion for summary judgment if it finds pursuant to rule 56 of the rules of civil procedure that one or more of the facts required to be proved by the provisions of subparagraphs (i) through (v), inclusive, paragraph (B) of this subdivision do not exist, and the court shall dismiss the action upon a timely motion for a directed verdict against the plaintiff if after considering all the evidence and every inference legitimately and reasonably raised thereby most favorably to the plaintiff, the court determines that there is not sufficient evidence to find each and every one of the facts required to be proven by the provisions of subparagraphs (i) through (v), inclusive, paragraph (B) of this subdivision; and

(iv) The provisions of this paragraph and of each subparagraph thereof are severable from the provisions of each other subparagraph, subsection, section, article or chapter of this code so that if any provision of a subparagraph of this paragraph is held void, the remaining provisions of this act and this code remain valid.

(e) Any cause of action brought pursuant to this section shall be brought either in the circuit court of the county in which the alleged injury occurred or the circuit court of the county of the employer's principal place of business. With respect to causes of action arising under this chapter, the venue provisions of this section shall be exclusive of and shall supersede the venue provisions of any other West Virginia statute or rule.

(f) The reenactment of this section in the regular session of the Legislature during the year 2015 does not in any way affect the right of any person to bring an action with respect to or upon any cause of action which arose or accrued prior to the effective date of the

WV Legislature

reenactment.

(g) The amendments to this section enacted during the 2023 session of the Legislature shall apply to all injuries occurring on or after July 1, 2023.

WV Legislature

§23-4-2a. Limit on liability for noneconomic loss.

(a) In any action brought pursuant to this article, the maximum amount recoverable as compensatory damages for noneconomic loss may not exceed the higher of two times the economic damages before offset or $500,000 for each person, regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees.

(b) On January 1, 2024, and in each year thereafter, the limitation for compensatory damages contained in subsection (a) of this section shall increase to account for inflation by an amount equal to the Consumer Price Index published by the United States Department of Labor, not to exceed one hundred fifty percent of the amounts specified in said subsections.

(c) This section shall become effective for causes of action accruing on or after July 1, 2023.

WV Legislature

§23-4-3. Schedule of maximum disbursements for medical, surgical, dental, and hospital treatment; legislative approval; guidelines; preferred provider agreements; charges in excess of scheduled amounts not to be made; required disclosure of financial interest in sale or rental of medically related mechanical appliances or devices; promulgation of rules to enforce requirement; consequences of failure to disclose; contract by employer with hospital, physician, etc., prohibited; criminal penalties for violation; payments to certain providers prohibited; medical cost and care program; payments; interlocutory orders.

(a) The Insurance Commissioner shall establish and alter from time to time, as he or she determines appropriate, a schedule of the maximum reasonable amounts to be paid to health care providers, providers of rehabilitation services, providers of durable medical and other goods, providers of other supplies and medically related items, or other persons, firms, or corporations for the rendering of treatment or services to injured employees under this chapter.

The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall disburse and pay for personal injuries to the employees who are entitled to the benefits under this chapter as follows:

(1) Sums for health care services, rehabilitation services, durable medical and other goods and other supplies, and medically related items as may be reasonably required. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall determine that which is reasonably required within the meaning of this section in accordance with the medical management rule established by the Insurance Commissioner and approved by the Workers' Compensation Industrial Council pursuant to §23-2C-5 of this code. Each health care provider who seeks to provide services or treatment which are not within any guideline set forth in the rule shall submit to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, specific justification for the need for the additional services in the particular case and the Insurance Commissioner, private carrier, or self-insured employer shall have the justification reviewed by a health care professional before authorizing the additional services. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may enter into preferred provider and managed care agreements which provides for fees and other payments which deviate from the schedule set forth in this subsection.

(2) Payment for health care services, rehabilitation services, durable medical and other goods and other supplies, and medically related items authorized under this subsection may be made to the injured employee or to the person, firm, or corporation who or which has rendered the treatment or furnished health care services, rehabilitation services, durable medical or other goods or other supplies and items, or who has advanced payment for them, as the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, considers proper, but no payments shall be made unless duly verified statements have been filed within six months after the rendering of the treatment or the delivery of such goods, supplies, or items or within 90 days of a subsequent compensability ruling if a claim

WV Legislature

is initially rejected: *Provided*, That no payment under this section shall be made unless a verified statement shows a charge for the treatment or with respect to any of the items specified in this subdivision has been or will be made against the injured employee or any other person, firm, or corporation. When an employee covered under the provisions of this chapter is injured in the course of and as a result of his or her employment and is accepted for health care services, rehabilitation services, or the provision of durable medical or other goods or other supplies or medically related items, the person, firm, or corporation rendering the treatment may not make any charge or charges for the treatment or with respect to the treatment against the injured employee or any other person, firm, or corporation which would result in a total charge for the treatment rendered in excess of the maximum amount in the fee schedule set forth in this subsection.

(3) Any pharmacist filling a prescription for medication for a workers' compensation claimant shall dispense a generic brand of the prescribed medication if a generic brand exists. If a generic brand does not exist, the pharmacist may dispense the name brand. In the event that a claimant wishes to receive the name brand medication in lieu of the generic brand, the claimant may receive the name brand medication but, in that event, the claimant is personally liable for the difference in costs between the generic brand medication and the brand name medication.

(4) If a claimant elects to receive health care services for a compensable injury from an out-of-state health care provider, and the out-of-state health care provider refuses to accept the rate of reimbursement set forth in the fee schedule established by the Insurance Commissioner, the claimant is personally liable for the difference between the scheduled fee and the amount demanded by the out-of-state health care provider, except as provided in paragraphs (A) or (B) of this subdivision.

(A) In the event of an emergency where there is an urgent need for immediate medical attention in order to prevent the death of a claimant or to prevent serious and permanent harm to the claimant, if the claimant receives the emergency care from an out-of-state health care provider who refuses to accept as full payment the scheduled amount, the claimant is not personally liable for the difference between the amount scheduled and the amount demanded by the health care provider. Upon the claimant's attaining a stable medical condition and being able to be transferred to either a West Virginia health care provider or an out-of-state health care provider who has agreed to accept the scheduled amount of fees as payment in full, if the claimant refuses to seek the specified alternative health care providers, he or she is personally liable for the difference in costs between the scheduled amount and the amount demanded by the health care provider for services provided after attaining stability and being able to be transferred.

(B) In the event that there is no health care provider reasonably near to the claimant's home who is qualified to provide the claimant's needed medical services who is either located in the State of West Virginia or who has agreed to accept as payment in full the scheduled amounts of fees, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, upon application by the claimant, may authorize the claimant to

www.Legislature

receive medical services from another health care provider. The claimant is not personally liable for the difference in costs between the scheduled amount and the amount demanded by the health care provider.

(b)(1) No employer shall enter into any contracts with any hospital, its physicians, officers, agents, or employees to render medical, dental, or hospital service or to give medical or surgical attention to any employee for injury compensable within the purview of this chapter and no employer shall permit or require any employee to contribute, directly or indirectly, to any fund for the payment of such medical, surgical, dental, or hospital service within such hospital for the compensable injury. Any employer violating this subsection is liable in damages to the employer's employees as provided in §23-2-8 of this code, and any employer or hospital or agent or employee thereof violating the provisions of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not less than $100 nor more than $1,000 or by imprisonment not exceeding one year, or both.

(2) The provisions of this subsection shall not prohibit an employer, private carrier, or self-insured employer from participating in a managed health care plan, including, but not limited to, a preferred provider organization or program or a health maintenance organization or managed care organization or other medical cost containment relationship with the providers of medical, hospital, or other health care. An employer, private carrier, or self-insured employer that provides a managed health care plan approved by the Insurance Commissioner for its employees or the employees of its insured may require an injured employee to use health care providers authorized by the managed health care plan for care and treatment of his or her compensable injuries. If the employer, private carrier, or self-insured employer does not provide a managed health care plan or program, the claimant may select his or her initial health care provider for treatment of a compensable injury or disease. If a claimant wishes to change his or her health care provider and if his or her employer has established and maintains a managed health care plan, the claimant shall select a new health care provider through the managed health care plan. A claimant who has used the providers under the employer's managed health care plan may select a health care provider outside the employer's plan for treatment of the compensable injury or disease if the employee receives written approval from the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, to do so.

(c) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall provide for the replacement of artificial limbs, crutches, hearing aids, eyeglasses, and all other mechanical appliances provided in accordance with this section which later wear out, or which later need to be refitted because of the progression of the injury which caused the devices to be originally furnished, or which are broken in the course of and as a result of the employee's employment. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall pay for these devices, when needed, notwithstanding any time limits provided by law.

(d) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may engage in and contract for medical cost containment programs, pharmacy

WV Legislature

benefits management programs, medical case management programs, and utilization review programs. Payments for these programs shall be made from the Workers' Compensation Old Fund, by the private carrier, or by the self-insured employer, whichever is applicable. Any order issued pursuant to the program shall be interlocutory in nature until an objecting party has exhausted all review processes provided for by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable.

(e) Notwithstanding the provisions of this section, the Insurance Commissioner, private carrier, or self-insured employer may establish fee schedules, make payments, and take other actions required or allowed pursuant to §16-29D-1 *et seq*. of this code.

WV Legislature

§23-4-3a.

Repealed.

Acts, 1999 Reg. Sess., Ch. 294.

WV Legislature

§23-4-3b. Creation of health care advisory panel.

[Repealed.]

WV Legislature

§23-4-3c. Suspension or termination of providers of health care.

[Repealed.]

WV Legislature

§23-4-4. Funeral expenses; wrongfully seeking payment; criminal penalties.

(a) In case the personal injury causes death, reasonable funeral or cemetery expense, in an amount to be fixed, from time to time, by the Insurance Commissioner, shall be paid by the Insurance Commissioner, the private carrier, or self-insured employer, whichever is applicable, to persons who have furnished the services and supplies, or to the persons who have advanced payment for the services and supplies, in addition to any award made to the employee's dependents.

(b) A funeral director or any person who furnished the services and supplies associated with the funeral or cemetery expenses, or a person who has advanced payment for the services and supplies, is prohibited from making any charge or charges against the employee's dependents for funeral expenses which would result in a total charge for funeral expenses in excess of the amount fixed by the Insurance Commissioner, unless:

(1) The person seeking funeral expenses notifies, in writing and prior to the rendering of any service, the employee's dependent as to the exact cost of the service and the exact amount the employee's dependent would be responsible for paying in excess of the amount fixed by the Insurance Commissioner; and

(2) The person seeking funeral expenses secures, in writing and prior to the rendering of any service, consent from the employee's dependent that he or she will be responsible to make payment for the amount in excess of the amount fixed by the Insurance Commissioner.

(c) Any person who knowingly and willfully seeks or receives payment of funeral expenses in excess of the amount fixed by the Insurance Commissioner without satisfying both of the requirements of subsection (b) of this section is guilty of a misdemeanor and, upon conviction thereof, shall be fined $3,000 or confined in jail for a definite term of confinement of 12 months, or both.

WV Legislature

§23-4-5. Benefits for first three days after injury.

If the period of disability does not last longer than three days from the day the employee leaves work as the result of the injury, no award shall be allowed, except the disbursements or payments provided for in §23-4-6 and §23-4-6a of this code, but if the period of disability lasts longer than seven days from the day the employee leaves work as a result of the injury, an award shall be allowed for the first three days of such disability.

WV Legislature

§23-4-6. Classification of and criteria for disability benefits.

Where compensation is due an employee under the provisions of this chapter for personal injury, the compensation shall be as provided in the following schedule:

(a) The terms "average weekly wage earnings, wherever earned, of the injured employee, at the date of injury" and "average weekly wage in West Virginia", as used in this chapter, have the meaning and shall be computed as set forth in §23-4-14 of this code except for the purpose of computing temporary total disability benefits for part-time employees pursuant to the provisions of §23-4-6d of this code.

(b) For all awards made on and after the effective date of the amendment and reenactment of this section during the year 2003, if the injury causes temporary total disability, the employee shall receive during the continuance of the disability a maximum weekly benefit to be computed on the basis of 66 and two-thirds percent of the average weekly wage earnings, wherever earned, of the injured employee, at the date of injury, not to exceed 100 percent of the average weekly wage in West Virginia: *Provided*, That in no event shall an award for temporary total disability be subject to annual adjustments resulting from changes in the average weekly wage in West Virginia: *Provided, however*, That in the case of a claimant whose award was granted prior to the effective date of the amendment and reenactment of this section during the year 2003, the maximum benefit rate shall be the rate applied under the prior enactment of this subsection which was in effect at the time the injury occurred. The minimum weekly benefits paid under this subdivision shall not be less than 33 and one-third percent of the average weekly wage in West Virginia, except as provided in §23-4-6d and §23-4-9 of this code. In no event, however, shall the minimum weekly benefits exceed the level of benefits determined by use of the applicable federal minimum hourly wage: *Provided further*, That any claimant receiving permanent total disability benefits, permanent partial disability benefits, or dependents' benefits prior to July 1, 1994, shall not have his or her benefits reduced based upon the requirement in this subdivision that the minimum weekly benefit shall not exceed the applicable federal minimum hourly wage.

(c) Subdivision (b) of this section is limited as follows: Aggregate award for a single injury causing temporary disability shall be for a period not exceeding 208 weeks; aggregate award for a single injury for which an award of temporary total disability benefits is made on or after the effective date of the amendment and reenactment of this section in the year 2003 shall be for a period not exceeding 104 weeks. Notwithstanding any other provision of this subdivision to the contrary, no person may receive temporary total disability benefits under an award for a single injury for a period exceeding 104 weeks from the effective date of the amendment and reenactment of this section in the year 2003.

(d) For all awards of permanent total disability benefits that are made on or after February 2, 1995, including those claims in which a request for an award was pending before the former workers' compensation division of the Bureau of Employment Programs or which were in litigation but not yet submitted for a decision, then benefits shall be payable until the claimant attains the age necessary to receive federal old age retirement benefits under

WV Legislature

the provisions of the Social Security Act, 42 U.S.C. §§ 401 and 402, in effect on the effective date of this section. The claimant shall be paid benefits so as not to exceed a maximum benefit of 66 and two-thirds percent of the claimant's average weekly wage earnings, wherever earned, at the time of the date of injury not to exceed 100 percent of the average weekly wage in West Virginia. The minimum weekly benefits paid under this section shall be as is provided for in subdivision (b) of this section. In all claims in which an award for permanent total disability benefits was made prior to February 2, 1995, the awards shall continue to be paid at the rate in effect prior to the effective date of the amendment and reenactment of this section in the year 2003. A single or aggregate permanent disability of 85 percent or more entitles the employee to a rebuttable presumption of a permanent total disability for the purpose of paragraph (2), subdivision (n) of this section: *Provided*, That the claimant must also be at least 50 percent medically impaired upon a whole body basis or has sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section. The presumption may be rebutted if the evidence establishes that the claimant is not permanently and totally disabled pursuant to subdivision (n) of this section. Under no circumstances may the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, grant an additional permanent disability award to a claimant receiving a permanent total disability award: *Provided, however*, That if any claimant thereafter sustains another compensable injury and has permanent partial disability resulting from the injury, the total permanent disability award benefit rate shall be computed at the highest benefit rate justified by any of the compensable injuries.

(e)(1) For all awards made on or after the effective date of the amendment and reenactment of this section during the year 2003, if the injury causes permanent disability less than permanent total disability, the percentage of disability to total disability shall be determined and the award computed on the basis of four weeks' compensation for each percent of disability determined at the maximum or minimum benefit rates as follows: 66 and two-thirds percent of the average weekly wage earnings, wherever earned, of the injured employee at the date of injury, not to exceed 70 percent of the average weekly wage in West Virginia: *Provided*, That in no event shall an award for permanent partial disability be subject to annual adjustments resulting from changes in the average weekly wage in West Virginia: *Provided, however*, That in the case of a claimant whose award was granted prior to the effective date of the amendment and reenactment of this section during the year 2003, the maximum benefit rate shall be the rate applied under the prior enactment of this section which was in effect at the time the injury occurred.

(2) If a claimant is released by his or her treating physician to return to work at the job he or she held before the occupational injury occurred and if the claimant's preinjury employer does not offer the preinjury job or a comparable job to the employee when a position is available to be offered, the award for the percentage of partial disability shall be computed on the basis of six weeks of compensation for each percent of disability.

(3) The minimum weekly benefit under this subdivision shall be as provided in subdivision (b) of this section for temporary total disability.

WV Legislature

(f) If the injury results in the total loss by severance of any of the members named in this subdivision, the percentage of disability shall be determined by the percentage of disability, specified in the following table:

The loss of a great toe shall be considered a 10 percent disability.

The loss of a great toe (one phalanx) shall be considered a five percent disability.

The loss of other toes shall be considered a four percent disability.

The loss of other toes (one phalanx) shall be considered a two percent disability.

The loss of all toes shall be considered a 25 percent disability.

The loss of forepart of foot shall be considered a 30 percent disability.

The loss of a foot shall be considered a 35 percent disability.

The loss of a leg shall be considered a 45 percent disability.

The loss of thigh shall be considered a 50 percent disability.

The loss of thigh at hip joint shall be considered a 60 percent disability.

The loss of a little or fourth finger (one phalanx) shall be considered a three percent disability.

The loss of a little or fourth finger shall be considered a five percent disability.

The loss of ring or third finger (one phalanx) shall be considered a three percent disability.

The loss of ring or third finger shall be considered a five percent disability.

The loss of middle or second finger (one phalanx) shall be considered a three percent disability.

The loss of middle or second finger shall be considered a seven percent disability.

The loss of index or first finger (one phalanx) shall be considered a six percent disability.

The loss of index or first finger shall be considered a 10 percent disability.

The loss of thumb (one phalanx) shall be considered a 12 percent disability.

The loss of thumb shall be considered a 20 percent disability.

The loss of thumb and index fingers shall be considered a 32 percent disability.

WV Legislature

The loss of index and middle fingers shall be considered a 20 percent disability.

The loss of middle and ring fingers shall be considered a 15 percent disability.

The loss of ring and little fingers shall be considered a 10 percent disability.

The loss of thumb, index and middle fingers shall be considered a 40 percent disability.

The loss of index, middle and ring fingers shall be considered a 30 percent disability.

The loss of middle, ring and little fingers shall be considered a 20 percent disability.

The loss of four fingers shall be considered a 32 percent disability.

The loss of hand shall be considered a 50 percent disability.

The loss of forearm shall be considered a 55 percent disability.

The loss of arm shall be considered a 60 percent disability.

The total and irrecoverable loss of the sight of one eye shall be considered a 33 percent disability. For the partial loss of vision in one or both eyes, the percentages of disability shall be determined by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, using as a basis the total loss of one eye.

The total and irrecoverable loss of the hearing of one ear shall be considered a 22 and one-half percent disability. The total and irrecoverable loss of hearing of both ears shall be considered a 55 percent disability.

For the partial loss of hearing in one or both ears, the percentage of disability shall be determined by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, using as a basis the total loss of hearing in both ears.

If a claimant sustains a compensable injury which results in the total loss by severance of any of the bodily members named in this subdivision or dies from sickness or noncompensable injury before the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, makes the proper award for the injury, the Insurance Commissioner, private carrier, or self-insured employer shall make the award to the claimant's dependents as defined in this chapter, if any; the payment to be made in the same installments that would have been paid to claimant if living: *Provided*, That no payment shall be made to any surviving spouse of the claimant after his or her remarriage and that this liability shall not accrue to the estate of the claimant and is not subject to any debts of, or charges against, the estate.

(g) If a claimant to whom has been made a permanent partial award dies from sickness or noncompensable injury, the unpaid balance of the award shall be paid to claimant's

WV Legislature

dependents as defined in this chapter, if any; the payment to be made in the same installments that would have been paid to claimant if living: *Provided*, That no payment shall be made to any surviving spouse of the claimant after his or her remarriage, and that this liability shall not accrue to the estate of the claimant and is not subject to any debts of, or charges against, such estate.

(h) For the purposes of this chapter, a finding of the Occupational Pneumoconiosis Board has the force and effect of an award.

(i) For the purposes of this chapter, with the exception of those injuries provided for in subdivision (f) of this section and §23-4-6b of this code, the degree of permanent disability other than permanent total disability shall be determined exclusively by the degree of whole body medical impairment that a claimant has suffered. For those injuries provided for in subdivision (f) of this section and §23-4-6b of this code, the degree of disability shall be determined exclusively by the provisions of said subdivision and said section. The Occupational Pneumoconiosis Board created pursuant to §23-4-8a of this code shall premise its decisions on the degree of pulmonary function impairment that claimants suffer solely upon whole body medical impairment. The Insurance Commissioner shall adopt standards for the evaluation of claimants and the determination of a claimant's degree of whole body medical impairment. Once the degree of medical impairment has been determined, that degree of impairment shall be the degree of permanent partial disability that shall be awarded to the claimant. This subdivision is applicable to all injuries incurred and diseases with a date of last exposure on or after February 2, 1995, to all applications for an award of permanent partial disability made on and after that date and to all applications for an award of permanent partial disability that were pending before the former workers' compensation commission or pending in litigation but not yet submitted for decision on and after that date. The prior provisions of this subdivision remain in effect for all other claims.

(j) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall establish a reviewing body to review applications for permanent total disability. The reviewing bodies shall employ or otherwise engage adequate resources, including medical professionals.

(1) The Insurance Commissioner shall establish requirements for the proper completion and support for an application for permanent total disability benefits, and no issue of permanent total disability may be referred to a reviewing body unless a properly completed and supported application for permanent total disability benefits has been first filed. Prior to a reviewing body's adjudication of a permanent total disability application, the reviewing body shall conduct examinations of the claimant that it finds necessary and obtain all pertinent records concerning the claimant's medical history and reports of examinations. The claimant may furnish all pertinent information to the reviewing body and shall furnish to the reviewing body any information requested. The claimant may submit no more than one report and opinion regarding each issue present in a claim. The reviewing body may request that those persons who have furnished reports and opinions regarding a claimant provide it with additional information considered necessary. The claimant may submit or obtain

WV Legislature

reports from experts challenging or supporting the other reports in the record regardless of whether or not the expert examined the claimant or relied solely upon the evidence of record.

(2) In the event a reviewing body elects to examine a claimant, the reviewing body shall prepare a report stating the tests, examinations, procedures, and other observations that were made, the manner in which each was conducted and the results of each. The report shall state the findings made by the reviewing body and the reasons for the findings. Copies of the reports of all examinations made by the reviewing body shall be served upon the parties. Each shall be given an opportunity to respond in writing to the findings and conclusions stated in the reports.

(3) A reviewing body shall state its initial recommendations in writing with an explanation for each recommendation setting forth the reasons for each. The recommendations shall be served upon the claimant and the claimant shall be afforded a 30-day opportunity to respond in writing to the reviewing body regarding its recommendations. The reviewing body shall review any responses and issue its final recommendations. The final recommendations shall be effectuated by the entry of an appropriate order by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable. For all awards for permanent total disability where the claim was filed on or after the effective date of the amendment and reenactment of this section in the year 2003, the reviewing body shall establish the date of onset of the claimant's permanent total disability as the date when a properly completed and supported application for permanent total disability benefits as prescribed in subdivision (1) of this subsection that results in a finding of permanent total disability was filed: *Provided*, That upon notification to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, by a claimant or his or her representative that the claimant seeks to be evaluated for permanent total disability, the Insurance Commissioner, private carrier, or self-insured employer shall send the claimant or his or her representative the proper application form. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall set time limits for the return of the application. A properly completed and supported application returned within the time limits set by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall be treated as if received on the date the Insurance Commissioner, private carrier, or self-insured employer was notified the claimant was seeking evaluation for permanent total disability: *Provided, however*, That notwithstanding any other provision of this section to the contrary, the onset date may not be sooner than the date upon which the claimant meets the percentage thresholds of prior permanent partial disability that are established by subsection (n) of this section as a prerequisite to the claimant's qualification for consideration for a permanent total disability award.

Any objection filed in regard to a decision on an application for permanent total disability benefits shall be subject to the review provisions of §23-5-1 *et seq*. of this code.(k) Compensation payable under any subdivision of this section shall not exceed the maximum nor be less than the weekly benefits specified in subdivision (b) of this section.

(l) Except as otherwise specifically provided in this chapter, temporary total disability benefits payable under subdivision (b) of this section shall not be deductible from permanent partial disability awards payable under subdivision (e) or (f) of this section. Compensation, either temporary total or permanent partial, under this section shall be payable only to the injured employee and the right to the compensation shall not vest in his or her estate, except that any unpaid compensation which would have been paid or payable to the employee up to the time of his or her death, if he or she had lived, shall be paid to the dependents of the injured employee if there are any dependents at the time of death.

(m) The following permanent disabilities shall be conclusively presumed to be total in character:

Loss of both eyes or the sight thereof.

Loss of both hands or the use thereof.

Loss of both feet or the use thereof.

Loss of one hand and one foot or the use thereof.

(n)(1) Other than for those injuries specified in subdivision (m) of this section, in order to be eligible to apply for an award of permanent total disability benefits for all injuries incurred and all diseases, including occupational pneumoconiosis, regardless of the date of last exposure, on and after the effective date of the amendment and reenactment of this section during the year 2003, a claimant: (A) Must have been awarded the sum of 50 percent in prior permanent partial disability awards; (B) must have suffered a single occupational injury or disease which results in a finding that the claimant has suffered a medical impairment of 50 percent; or (C) has sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section. Upon filing an application, the claim will be reevaluated by the reviewing body pursuant to subdivision (i) of this section to determine if the claimant has suffered a whole body medical impairment of 50 percent or more resulting from either a single occupational injury or occupational disease or a combination of occupational injuries and occupational diseases or has sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section. A claimant whose prior permanent partial disability awards total 85 percent or more shall also be examined by the reviewing body and must be found to have suffered a whole body medical impairment of 50 percent in order for his or her request to be eligible for further review. The reviewing body shall review the claim as provided for in subdivision (j) of this section. If the claimant has not suffered whole body medical impairment of at least 50 percent or has sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section, the request shall be denied. Upon a finding that the claimant has a 50 percent whole body medical impairment or has sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section, the review of the application continues as provided for in the following paragraph of this subdivision. Those claimants whose prior permanent partial disability awards total 85 percent or more and who have been found to have a whole body

WV Legislature

medical impairment of at least 50 percent or have sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section are entitled to the rebuttable presumption created pursuant to subdivision (d) of this section for the remaining issues in the request.

(2) For all awards made on or after the effective date of the amendment and reenactment of this section during the year 2003, disability which renders the injured employee unable to engage in substantial gainful activity requiring skills or abilities which can be acquired or which are comparable to those of any gainful activity in which he or she has previously engaged with some regularity and over a substantial period of time shall be considered in determining the issue of total disability. The comparability of preinjury income to post-disability income will not be a factor in determining permanent total disability. Geographic availability of gainful employment within a driving distance of 75 miles from the residence of the employee or within the distance from the residence of the employee to his or her preinjury employment, whichever is greater, will be a factor in determining permanent total disability. For any permanent total disability award made after the amendment and reenactment of this section in the year 2003, permanent total disability benefits shall cease at the age of 70 years.

(3) In the event that a claimant, who has been found to have at least a 50 percent whole body medical impairment or has sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section is denied an award of permanent total disability benefits pursuant to this subdivision and accepts and continues to work at a lesser paying job than he or she previously held, the claimant is eligible, notwithstanding the provisions of §23-4-9 of this code, to receive temporary partial rehabilitation benefits for a period of four years. The benefits shall be paid at the level necessary to ensure the claimant's receipt of the following percentages of the average weekly wage earnings of the claimant at the time of injury calculated as provided in this section and §23-4-6d and §23-4-14 of this code:

(A) 80 percent for the first year;

(B) 70 percent for the second year;

(C) 60 percent for the third year; and

(D) 50 percent for the fourth year: *Provided*, That in no event shall the benefits exceed 100 percent of the average weekly wage in West Virginia. In no event shall the benefits be subject to the minimum benefit amounts required by the provisions of subdivision (b) of this section.

(4) Notwithstanding any provision of this subsection, subsection (d) of this section, or any other provision of this code to the contrary, on any claim filed on or after the effective date of the amendment and reenactment of this section in the year 2003:

(A) No percent of whole body medical impairment existing as the result of carpal tunnel

syndrome for which a claim has been made under this chapter may be included in the aggregation of permanent disability under the provisions of this subsection or subsection (d) of this section; and

(B) No percent of whole body medical impairment existing as the result of any occupational disease, the diagnosis of which is based solely upon symptoms rather than specific, objective, and measurable medical findings, and for which a claim has been made under this chapter may be included in the aggregation of permanent disability under the provisions of this subsection or subsection (d) of this section.

(o) To confirm the ongoing permanent total disability status of the claimant, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may elect to have any recipient of a permanent total disability award undergo one medical examination during each of the first five years that the permanent total disability award is paid and one medical examination during each three-year period thereafter until the claimant reaches the age of 70 years: *Provided*, That the Insurance Commissioner, private carrier, or self-insured employer may elect to have any recipient of a permanent total disability award under the age of 50 years undergo one medical examination during each year that the permanent total disability award is paid until the recipient reaches the age of 50 years, and thereafter one medical examination during each three-year period thereafter until the claimant reaches the age of 70 years.

WV Legislature

§23-4-6a. Benefits and mode of payment to employees and dependents for occupational pneumoconiosis; further adjustment of claim for occupational pneumoconiosis.

If an employee is found to be permanently disabled due to occupational pneumoconiosis as defined in §23-4-1 of this code, the percentage of permanent disability is determined by the degree of medical impairment that is found by the Occupational Pneumoconiosis Board. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall enter an order setting forth the findings of the Occupational Pneumoconiosis Board with regard to whether the claimant has occupational pneumoconiosis and the degree of medical impairment, if any, resulting therefrom. That order is the final decision of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, for purposes of §23-5-1a of this code. If a decision is objected to, the Board of Review shall affirm the decision of the Occupational Pneumoconiosis Board made following hearing unless the decision is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record. Compensation is paid therefor in the same manner and at the same rate as is provided for permanent disability under the provisions of §23-4-6 of this code: *Provided*, That for any employee who applies for occupational pneumoconiosis benefits whose award was granted on or after the effective date of the amendment and reenactment of this section during the year 2003, there shall be no permanent partial disability awarded based solely upon a diagnosis of occupational pneumoconiosis, it being the intent of the Legislature to eliminate any permanent partial disability awards for occupational pneumoconiosis without a specific finding of measurable impairment.

If the employee dies from occupational pneumoconiosis, the benefits shall be as provided for in §23-4-10 of this code; as to the benefits, §23-4-11 through §23-4-14 of this code, inclusive, of this article apply.

In cases of permanent disability or death due to occupational pneumoconiosis, as defined in §23-4-1 of this code, accompanied by active tuberculosis of the lungs, compensation shall be payable as for disability or death due to occupational pneumoconiosis alone.

The provisions of §23-4-16 of this code and §23-5-2, §23-5-3a, §23-5-4, and §23-5-5a of this code providing for the further adjustment of claims are applicable to the claim of any claimant who receives a permanent partial disability award for occupational pneumoconiosis.

WV Legislature

§23-4-6b. Occupational hearing loss claims.

(a) In all claims for occupational hearing loss caused by either a single incident of trauma or by exposure to hazardous noise in the course of and resulting from employment, the degree of permanent partial disability, if any, shall be determined in accordance with the provisions of this section and awards made in accordance with the provisions of section six of this article.

(b) The percent of permanent partial disability for a monaural hearing loss shall be computed in the following manner:

(1) The measured decibel loss of hearing due to injury at the sound frequencies of five hundred, one thousand, two thousand and three thousand hertz shall be determined for the injured ear and the total shall be divided by four to ascertain the average decibel loss;

(2) The percent of monaural hearing impairment for the injured ear shall be calculated by multiplying by one and six-tenths percent the difference by which the aforementioned average decibel loss exceeds twenty-seven and one-half decibels, up to a maximum of one hundred percent hearing impairment, which maximum is reached at ninety decibels; and

(3) The percent of monaural hearing impairment obtained shall be multiplied by twenty-two and one-half to ascertain the degree of permanent partial disability.

(c) The percent of permanent partial disability for a binaural hearing loss shall be computed in the following manner:

(1) The measured decibel loss of hearing due to injury at the sound frequencies of five hundred, one thousand, two thousand and three thousand hertz is determined for each ear and the total for each ear shall be divided by four to ascertain the average decibel loss for each ear;

(2) The percent of hearing impairment for each ear is calculated by multiplying by one and six-tenths percent the difference by which the aforementioned average decibel loss exceeds twenty-seven and one-half decibels, up to a maximum of one hundred percent hearing impairment, which maximum is reached at ninety decibels;

(3) The percent of binaural hearing impairment shall be calculated by multiplying the smaller percentage (better ear) by five, adding this figure to the larger percentage (poorer ear) and dividing the sum by six; and

(4) The percent of binaural hearing impairment obtained shall be multiplied by fifty-five to ascertain the degree of permanent partial disability.

(d) No permanent partial disability benefits shall be granted for tinnitus, psychogenic hearing loss, recruitment or hearing loss above three thousand hertz.

WV Legislature

(e) An additional amount of permanent partial disability shall be granted for impairment of speech discrimination, if any, to determine the additional amount for binaural impairment, the percentage of speech discrimination in each ear shall be added together and the result divided by two to calculate the average percentage of speech discrimination, and the permanent partial disability shall be ascertained by reference to the percentage of permanent partial disability in the table below on the line with the percentage of speech discrimination obtained. To determine the additional amount for monaural impairment, the permanent partial disability shall be ascertained by reference to the percentage of permanent partial disability in the table below on the line with the percentage of speech discrimination in the injured ear.

TABLE

% of Permanent

% of Speech Discrimination Partial Disability

90% and up to and including 100% 0%

80% and up to but not including 90% 1%

70% and up to but not including 80% 3%

60% and up to but not including 70% 4%

0% and up to but not including 60% 5%

(f) No temporary total disability benefits shall be granted for noise-induced hearing loss.

(g) An application for benefits alleging a noise-induced hearing loss shall set forth the name of the employer or employers and the time worked for each. The Insurance Commissioner may allocate to and divide any charges resulting from the claim among the employers with whom the claimant sustained exposure to hazardous noise for as much as sixty days during the period of three years immediately preceding the date of last exposure. The allocation is based upon the time of exposure with each employer. In determining the allocation, the Insurance Commissioner shall consider all the time of employment by each employer during which the claimant was exposed and not just the time within the three-year period under the same allocation as is applied in occupational pneumoconiosis cases.

(h) The employer against whom the claim is filed shall provide for prompt referral the claims for evaluation, for all medical reimbursement and for prompt authorization of hearing enhancement devices.

WV Legislature

§23-4-6c. Benefits payable to certain sheltered workshop employees; limitations.

Notwithstanding the provisions of section six, six-a or six-b of this article or any other provision of this chapter, the minimum weekly benefit payments under subsection (b), section six of this article shall not apply to employees who work at nonprofit "workshops" as defined in section one, article one, chapter five-a of this code. When compensation is due any such employee, the weekly benefits payable hereunder to such employee may not exceed seventy percent of that employee's actual weekly wages, and in no event may the average weekly wage in West Virginia be the basis upon which to compute the benefits of temporary total disability to employees working for less than the minimum wage.

WV Legislature

§23-4-6d. Benefits payable to part-time employees.

(a) For purposes of this section, a part-time employee means an employee who, at the date of injury, is customarily employed 25 hours per week or less on a regular basis and is classified by the employer as a part-time employee: *Provided*, That the term "part-time employee" shall not include an employee who regularly works more than 25 hours per week for the employer, nor shall it include an employee who regularly works for more than one employer and whose regular combined working hours total more than 25 hours per week when that employee is rendered unable to perform the duties of his or her employment as a result of the injury, nor shall it include any employee in the construction industry who works less than 25 hours per week.

(b) For purposes of establishing temporary total disability weekly benefits pursuant to §23-4-6(b) of this code for part-time employees, the "average weekly wage earnings, wherever earned, of the injured person at the date of injury" shall be computed based upon the best average weekly gross pay, wherever earned, which is received by the employee during the best quarter of wages out of the preceding four quarters of wages as reported to the Insurance Commissioner pursuant to §23-2-2(b) of this code: *Provided*, That for part-time employees who have been employed less than two months but more than one week prior to the date of injury or any employee whose wages have not yet been reported to the Insurance Commissioner, the average weekly wage earnings shall be calculated based upon the average gross earnings in the weeks actually worked: *Provided, however*, That for part-time employees who have been employed one week or less, the average weekly wage earnings shall be calculated based upon the average weekly wage prevailing for the same or similar part-time employment at the time of injury except that when an employer has agreed to pay a certain hourly wage to a part-time employee, the average weekly wage shall be computed by multiplying the hourly wage by the regular numbers of hours contracted to be worked each week: *Provided further*, That notwithstanding any provision of this article to the contrary, no part-time employee shall receive temporary total disability benefits greater than his or her average weekly wage earnings as so calculated.

(c) Notwithstanding any other provisions of this article to the contrary, benefits payable to a part-time injured employee for any permanent disability shall be computed and paid on the same basis as if the injured employee is not a part-time employee within the meaning of this section.

WV Legislature

§23-4-7. Release of medical information to employer; legislative findings; effect of application for benefits; duty of employer.

(a) The Legislature hereby finds and declares that two of the primary objectives of the workers' compensation system established by this chapter are to provide benefits to an injured claimant promptly and to effectuate his or her return to work at the earliest possible time; and that the prompt dissemination of medical information to the employer as to diagnosis, treatment, and recovery is essential if these two objectives are to be achieved.

(b) In view of the foregoing findings, a claimant irrevocably agrees by the filing of his or her application for benefits that any physician may release to and orally discuss with the claimant's employer, or its representative, or with a representative of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, from time to time, the claimant's medical history and any medical reports pertaining to the occupational injury or disease and to any prior injury or disease of the portion of the claimant's body to which a medical impairment is alleged containing detailed information as to the claimant's condition, treatment, prognosis, and anticipated period of disability and dates as to when the claimant will reach or has reached his or her maximum degree of improvement or will be or was released to return to work. For the exclusive purposes of this chapter, the patient-physician privilege of confidentiality is waived with regard to the physician's provision of this medical information pursuant to this section. Whenever a copy of any medical report is obtained by the employer or its representative and the physician has not also forwarded a copy of the medical report to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, the employer shall forward a copy of the medical report to the Insurance Commissioner, private carrier, or self-insured employer within 10 days from the date the employer received the medical report from the physician.

WV Legislature

§23-4-7a. Monitoring of injury claims; legislative findings; review of medical evidence; recommendation of authorized treating physician; medical evaluations; temporary total disability benefits and the termination thereof; mandatory action; additional authority; suspension of benefits.

(a) The Legislature hereby finds and declares that injured claimants should receive the type of treatment needed as promptly as possible; that overpayments of benefits with the resultant hardship created by the requirement of repayment should be minimized; and that to achieve these two objectives it is essential that the Insurance Commissioner, private carriers, and self-insured employers establish and operate a systematic program for the monitoring of injury claims where the disability continues longer than might ordinarily be expected.

(b) In view of the foregoing findings, the Insurance Commissioner shall establish guidelines as to the anticipated period of disability for the various types of injuries. Each injury claim in which temporary total disability continues beyond the anticipated period of disability established for the injury involved shall be reviewed. If satisfied after reviewing the medical evidence that the claimant would not benefit by a medical evaluation, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall mark the claim file accordingly and shall diary the claim file as to the next date for required review which shall not exceed 60 days. If the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, concludes that the claimant might benefit by a medical evaluation, the Insurance Commissioner, private carrier, or self-insured employer shall proceed as specified in subsections (d) and (e) of this section.

(c) When the authorized treating physician concludes that the claimant has either reached his or her maximum degree of improvement or is ready for disability evaluation, or when the claimant has returned to work, the authorized treating physician may recommend a permanent partial disability award for residual impairment relating to and resulting from the compensable injury, and the following provisions govern and control:

(1) If the authorized treating physician recommends a permanent partial disability award of 15 percent or less, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall enter an award of permanent partial disability benefits based upon the recommendation and all other available information. The claimant’s entitlement to temporary total disability benefits ceases upon the entry of the award unless previously terminated under the provisions of subsection (e) of this section.

(2) If, however, the authorized treating physician recommends a permanent partial disability award in excess of 15 percent, or recommends a permanent total disability award, the claimant’s entitlement to temporary total disability benefits ceases upon the receipt by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, of the medical report. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall refer the claimant to a physician or physicians of its selection for evaluation prior to the entry of a permanent disability award: *Provided*, That

WV Legislature

unless the claimant has returned to work, the claimant shall thereupon receive benefits which shall be at the permanent partial disability rate as provided in §23-4-6(e) of this code until the entry of a permanent disability award or until the claimant returns to work. The amount of benefits paid prior to the receipt of the evaluation report shall be considered and determined to be payment of the permanent disability award granted, if any. In the event that benefits actually paid exceed the amount granted by the permanent partial disability award, the claimant is entitled to no further benefits by the award and the excess paid shall be an overpayment. For all awards made or nonawarded partial benefits paid, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may only recover the amount of overpaid benefits or expenses by withholding, in whole or in part, future disability benefits payable to the individual in the same or other claims and credit the amount against the overpayment until it is repaid in full.

(d) When the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, concludes that a medical evaluation is indicated, or that a claimant may be ready for disability evaluation in accordance with other provisions of this chapter, the Insurance Commissioner, private carrier, or self-insured employer shall refer the claimant to a physician or physicians of its selection for examination and evaluation. If the physician or physicians selected recommend continued, additional, or different treatment, the recommendation shall be relayed to the claimant and the claimant's treating physician and the recommended treatment may be authorized by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable.

(e) Notwithstanding any provision in subsection (c) of this section, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall enter a notice suspending the payment of temporary total disability benefits but providing a reasonable period of time during which the claimant may submit evidence justifying the continued payment of temporary total disability benefits:

(1) When the physician or physicians selected by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, conclude that the claimant has reached his or her maximum degree of improvement;

(2) When the authorized treating physician advises the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, that the claimant has reached his or her maximum degree of improvement or that he or she is ready for disability evaluation and when the authorized treating physician has not made any recommendation with respect to a permanent disability award as provided in subsection (c) of this section;

(3) When other evidence submitted to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, justifies a finding that the claimant has reached his or her maximum degree of improvement; or

(4) When other evidence submitted or otherwise obtained justifies a finding that the claimant has engaged or is engaging in abuse, including, but not limited to, physical activities

WV Legislature

inconsistent with his or her compensable workers' compensation injury.

In all cases, a finding by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, that the claimant has reached his or her maximum degree of improvement terminates the claimant's entitlement to temporary total disability benefits regardless of whether the claimant has been released to return to work. Under no circumstances shall a claimant be entitled to receive temporary total disability benefits either beyond the date the claimant is released to return to work or beyond the date he or she actually returns to work.

In the event that the medical or other evidence indicates that claimant has a permanent disability, unless he or she has returned to work, the claimant shall thereupon receive benefits which shall be at the permanent partial disability rate as provided in §23-4-6(e) of this code until entry of a permanent disability award, pursuant to an evaluation by a physician or physicians selected by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, or until the claimant returns to work. The amount of benefits shall be considered and determined to be payment of the permanent disability award granted, if any. In the event that benefits actually paid exceed the amount granted under the permanent disability award, the claimant is entitled to no further benefits by the order.

(f) Notwithstanding the anticipated period of disability established pursuant to the provisions of subsection (b) of this section, whenever in any claim temporary total disability continues longer than 120 days from the date of injury (or from the date of the last preceding examination and evaluation pursuant to the provisions of this subsection or pursuant to the directions of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, under other provisions of this chapter), the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall refer the claimant to a physician or physicians of the Insurance Commissioner's, private carrier's, or self-insured employer's selection for examination and evaluation in accordance with the provisions of §23-4-7a(d) of this code, and the provisions of subsection (e) of this section are fully applicable: *Provided*, That the requirement of mandatory examinations and evaluations pursuant to the provisions of this subsection shall not apply to any claimant who sustained a brain stem or spinal cord injury with resultant paralysis or an injury which resulted in an amputation necessitating a prosthetic appliance.

(g) The provisions of this section are in addition to and in no way in derogation of the power and authority vested in the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, by other provisions of this chapter or vested in the employer to have a claimant examined by a physician or physicians of the employer's selection and at the employer's expense, or vested in the claimant or employer to file a protest, under other provisions of this chapter.

(h) All evaluations and examinations performed by physicians shall be performed in accordance with the protocols and procedures established by rule of the Insurance

WV Legislature

Commissioner: *Provided*, That the physician may exceed these protocols when additional evaluation is medically necessary.

(i) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may suspend benefits being paid to a claimant if the claimant refuses, without good cause, to undergo the examinations or needed treatments provided for in this section until the claimant submits to the examination or needed treatments.

WV Legislature

§23-4-7b. Trial return to work; Insurance Commissioner to develop rules.

(a) The Legislature hereby finds and declares that it is in the interest of employees and employers that injured employees be encouraged to return to work as quickly as possible after an injury and that appropriate protections be afforded to injured employees who return to work on a trial basis.

(b) The Insurance Commissioner shall propose rules, as provided in section five, article two-c of this chapter, establishing criteria for providing employers the option of allowing employees, following an injury, to return to work on a trial basis and for the suspension of temporary total benefits during a period of trial return to work.

WV Legislature

§23-4-8. Physical examination of claimant.

(a) The Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, may, after due notice to the claimant, whenever in its opinion it is necessary, order a claimant of compensation for a personal injury other than occupational pneumoconiosis to appear for examination before a medical examiner or examiners selected by the Insurance Commissioner, other private carrier or self-insured employer, whichever is applicable; and the claimant and employer each may select a physician of the claimant's or the employer's own choosing and at the claimant's or the employer's own expense to participate in the examination. All examinations shall be performed in accordance with the protocols and procedures established by rules of the Insurance Commissioner: Provided, That the physician may exceed these protocols when additional evaluation is medically necessary. The claimant and employer shall be furnished with a copy of the report of examination made by the medical examiner or examiners. The physicians selected by the claimant and employer have the right to submit a separate report to, or concur in any report made by the medical examiner or examiners selected by the Insurance Commissioner, private carrier or self-insured employer, and any separate report shall be considered in passing upon the claim.

(b) If the compensation claimed is for occupational pneumoconiosis, the Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, may, after due notice to the employer, order a claimant to appear for examination before the Occupational Pneumoconiosis Board provided for in section eight-a of this article.

(c) Where the claimant is ordered to appear for an examination by the Occupational Pneumoconiosis Board pursuant to subsection (b) of this section or is required to undergo a medical examination or examinations, pursuant to subsection (a) of this section, the party that referred the claimant to the Occupational Pneumoconiosis Board or required the medical examination shall reimburse the claimant for loss of wages and reasonable traveling expenses as set forth in subsection (e) of this section and other expenses in connection with the examination or examinations.

(d) The claimant shall be reimbursed for reasonable traveling expenses as set forth in subsection (e) of this section incurred in connection with medical examinations, appointments and treatments, including appointments with the claimant's authorized treating physician.

(e) The claimant's traveling expenses include, at a minimum, reimbursement for meals, lodging and milage. Reimbursement for travel in a personal motor vehicle shall be at the milage reimbursement rates contained in the Department of Administration's Purchasing Division Travel Rules as authorized by section eleven, article three, chapter twelve of this code in effect at the time the treatment is authorized.

WV Legislature

§23-4-8a. Occupational Pneumoconiosis Board; composition; term of office; duties; quorum; remuneration.

The Occupational Pneumoconiosis Board shall consist of five licensed physicians who shall be appointed by the Insurance Commissioner. No person shall be appointed as a member of the board, or as a consultant thereto, who has not by special study or experience, or both, acquired special knowledge of pulmonary diseases. All members of the Occupational Pneumoconiosis Board shall be physicians of good professional standing admitted to practice medicine and surgery in this state. Two members shall be roentgenologists. One member of the board shall be designated annually as chairman by the Insurance Commissioner. The term of office of each member of the board shall be six years. Any member of the board may be appointed to any number of terms. The function of the board is to determine all medical questions relating to cases of compensation for occupational pneumoconiosis under the direction and supervision of the Insurance Commissioner. Any three members of the board constitute a quorum for the transaction of its business if at least one of the members present is a roentgenologist. The Insurance Commissioner, shall, from time to time, fix the compensation to be paid each member of the board. Members are also entitled to reasonable and necessary traveling and other expenses incurred while actually engaged in the performance of their duties. In fixing the compensation of board members, the Insurance Commissioner shall take into consideration the number of claimants a member of the board actually examines, the actual time spent by members in discharging their duties, and the recommendation of the Governor as to reasonable reimbursement per unit of time expended based on comparative data for physicians within the state in the same medical specialties.

WV Legislature

§23-4-8b. Occupational Pneumoconiosis Board; procedure; autopsy.

The Occupational Pneumoconiosis Board, upon reference to it by an appropriate party of a case of occupational pneumoconiosis, shall notify the employee, or in case he or she is dead, the claimant, and the employer, as well as the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, to appear before the board at a time and place stated in the notice. If the employee is living, he or she shall appear before the board at the time and place specified and submit to the examination, including clinical and X-ray examinations, required by the board. If a physician licensed to practice medicine in the state makes an affidavit that the employee is physically unable to appear at the time and place designated by the board, the board shall, on notice to the proper parties, change the place and time as may reasonably facilitate the hearing or examination of the employee or may appoint a qualified specialist in the field of respiratory disease to examine the claimant on behalf of the board. The employee, or in case he or she is dead, the claimant, and employer shall also produce as evidence to the board all reports of medical and X-ray examinations which may be in their respective possession or control, showing the past or present condition of the employee. If the employee is dead, the notice of the board shall further require that the claimant produce necessary consents and permits so that an autopsy may be performed, if the board so directs. When in the opinion of the board an autopsy is considered necessary to accurately and scientifically ascertain and determine the cause of death, the autopsy examination shall be ordered by the board, which shall designate a duly licensed physician, a pathologist, or any other specialists determined necessary by the board, to make the examination and tests to determine the cause of death and certify his or her or their written findings, in triplicate, to the board. The findings shall be public records. In the event that a claimant for compensation for the death refuses to consent and permit the autopsy to be made, all rights for compensation are forfeited.

The employee, or if he or she be dead, the claimant, and the employer, shall be entitled to be present at all examinations conducted by the board and to be represented by attorneys and physicians.

WV Legislature

§23-4-8c. Occupational Pneumoconiosis Board; reports and distribution thereof; presumption; findings required of board; objection to findings; procedure thereon; limitations on refilings; consolidation of claims.

(a) The Occupational Pneumoconiosis Board, as soon as practicable after it has completed its investigation, shall make its written report to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, of its findings and conclusions on every medical question in controversy and the board shall send one copy of the report to the employee or claimant and one copy to the employer. The Occupational Pneumoconiosis Board shall also return to and file with the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, all the evidence as well as all statements under oath, if any, of the persons who appeared before it on behalf of the employee or claimant, or employer, and also all medical reports and X-ray examinations produced by or on behalf of the employee or claimant, or employer.

(b) If it can be shown that the claimant or deceased employee has been exposed to the hazard of inhaling minute particles of dust in the course of and resulting from his or her employment for a period of 10 years during the 15 years immediately preceding the date of his or her last exposure to such hazard and that the claimant or deceased employee has sustained a chronic respiratory disability, it shall be presumed that the claimant is suffering or the deceased employee was suffering at the time of his or her death from occupational pneumoconiosis which arose out of and in the course of his or her employment. This presumption is not conclusive.

(c) The findings and conclusions of the Occupational Pneumoconiosis Board shall set forth, among other things, the following:

(1) Whether or not the claimant or the deceased employee has contracted occupational pneumoconiosis and, if so, the percentage of permanent disability resulting therefrom;

(2) Whether or not the exposure in the employment was sufficient to have caused the claimant's or deceased employee's occupational pneumoconiosis or to have perceptibly aggravated an existing occupational pneumoconiosis or other occupational disease; and

(3) What, if any, physician appeared before the board on behalf of the claimant or employer and what, if any, medical evidence was produced by or on behalf of the claimant or employer.

(d) If either party objects to the whole or any part of the findings and conclusions of the Occupational Pneumoconiosis Board, the party shall file with the Board of Review, within 60 days from receipt of the copy to that party, unless for good cause shown the Board of Review extends the time, the party's objections to the findings and conclusions of the Occupational Pneumoconiosis Board in writing, specifying the particular statements of the Occupational Pneumoconiosis Board's findings and conclusions to which such party objects. The filing of an objection within the time specified is a condition of the right to litigate the findings and

WV Legislature

therefore jurisdictional. After the time has expired for the filing of objections to the findings and conclusions of the Occupational Pneumoconiosis Board, the Board of Review shall proceed to act as provided in this chapter. If, after the time has expired for the filing of objections to the findings and conclusions of the Occupational Pneumoconiosis Board, no objections have been filed, the report of a majority of the Occupational Pneumoconiosis Board of its findings and conclusions on any medical question shall be taken to be plenary and conclusive evidence of the findings and conclusions stated in the report. If objection has been filed to the findings and conclusions of the Occupational Pneumoconiosis Board, notice of the objection shall be given to the board. The members of the Occupational Pneumoconiosis Board joining in the findings and conclusions shall appear at the time fixed by the Board of Review for the hearing to submit to examination and cross-examination in respect to the findings and conclusions. At the hearing, evidence to support or controvert the findings and conclusions of the Occupational Pneumoconiosis Board shall be limited to examination and cross-examination of the members of the board and to the taking of testimony of other qualified physicians and roentgenologists.

(e) In the event that a claimant receives a final decision that he or she has no evidence of occupational pneumoconiosis, the claimant is barred for a period of three years from the date of the Occupational Pneumoconiosis Board's decision or until his or her employment with the employer who employed the claimant at the time designated as the claimant's last date of exposure in the denied claim has terminated, whichever is sooner, from filing a new claim or pursuing a previously filed, but unruled upon, claim for occupational pneumoconiosis or requesting a modification of any prior ruling finding him or her not to be suffering from occupational pneumoconiosis. For the purposes of this subsection, a claimant's employment shall be considered to be terminated if, for any reason, he or she has not worked for that employer for a period in excess of 90 days. Any previously filed, but unruled upon, claim shall be consolidated with the claim in which the Occupational Pneumoconiosis Board's decision is made and shall be denied together with the decided claim. The provisions of this subsection shall not be applied in any claim where doing so would, in and of itself, later cause a claimant's claim to be forever barred by the provisions of §23-4-15 of this code.

(f) Effective upon termination of the former workers' compensation commission, the Insurance Commissioner shall assume all administrative powers and responsibilities necessary to administer this section and §23-4-8a and §23-4-8b of this code.

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§23-4-8d. Occupational pneumoconiosis claims never closed for medical benefits with exception of settled claims.

Notwithstanding the provisions of subdivision (4), subsection (a), section sixteen of this article, with the exception of claims settled pursuant to article five, section seven of this chapter, a request for medical services, durable medical goods or other medical supplies in an occupational pneumoconiosis claim may be made at any time.

WV Legislature

§23-4-8e.

Repealed.

Acts, 1971 Reg. Sess., Ch. 177.

WV Legislature

§23-4-8f.

Repealed.

Acts, 1971 Reg. Sess., Ch. 177.

WV Legislature

§23-4-9. Physical and vocational rehabilitation.

(a) The Legislature hereby finds that it is a goal of the workers' compensation program to assist employees to return to suitable gainful employment after an injury. In order to encourage workers to return to employment and to encourage and assist employers in providing suitable employment to injured employees, it is a priority of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, to achieve early identification of individuals likely to need rehabilitation services and to assess the rehabilitation needs of these injured employees. It is the goal of rehabilitation to return injured employees to employment which is comparable in work and pay to that which the individual performed prior to the injury. If a return to comparable work is not possible, the goal of rehabilitation is to return the individual to alternative suitable employment, using all possible alternatives of job modification, restructuring, reassignment, and training, so that the individual will return to productivity with his or her employer or, if necessary, with another employer. The Legislature further finds that it is the shared responsibility of the employer, the employee, the physician, and the Insurance Commissioner or private carrier to cooperate in the development of a rehabilitation process designed to promote reemployment for the injured employee.

(b) In cases where an employee has sustained a permanent disability, or has sustained an injury likely to result in temporary disability as determined by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, the Insurance Commissioner, private carrier, or self-insured employer shall at the earliest possible time determine whether the employee would be assisted in returning to remunerative employment with the provision of rehabilitation services and if it is determined that the employee can be physically and vocationally rehabilitated and returned to remunerative employment by the provision of rehabilitation services including, but not limited to, vocational or on-the-job training, counseling, assistance in obtaining appropriate temporary or permanent work site, work duties, or work hours modification, by the provision of crutches, artificial limbs, or other approved mechanical appliances, or medicines, medical, surgical, dental, or hospital treatment or other services which the Insurance Commissioner, private carrier, or self-insured employer in its sole discretion determines will directly assist the employee's return to employment, the Insurance Commissioner, private carrier, or self-insured employer shall immediately develop a rehabilitation plan for the employee and, after due notice to the employer, expend an amount necessary for that purpose: *Provided*, That the expenditure for vocational rehabilitation shall not exceed $20,000 for any one injured employee: *Provided, however*, That no payment shall be made for such vocational rehabilitation purposes as provided in this section unless authorized by the Insurance Commissioner, private carrier, or self-insured employer prior to the rendering of the physical or vocational rehabilitation, except that payments shall be made for reasonable medical expenses without prior authorization if sufficient evidence exists which would relate the treatment to the injury and the attending physician or physicians have requested authorization prior to the rendering of the treatment: *Provided further*, That payment for physical rehabilitation, including the purchase of prosthetic devices and other equipment

and training in use of the devices and equipment, are considered expenses within the meaning of §23-4-3 of this code and are subject to the provisions of §23-4-3 of this code. The provision of any rehabilitation services may be pursuant to a rehabilitation plan to be developed and monitored by a rehabilitation professional for each injured employee or by such other provider as determined by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable. Notwithstanding any other provision of this section to the contrary, the Insurance Commissioner may determine by rule that a rehabilitation plan or any component thereof is not appropriate for an injured employee.

(c) In every case in which the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, orders physical or vocational rehabilitation of a claimant as provided in this section, the claimant shall, during the time he or she is receiving any vocational rehabilitation or rehabilitative treatment that renders him or her totally disabled during the period of rehabilitation, be compensated on a temporary total disability basis for that period.

(d) In every case in which the claimant returns to gainful employment as part of a rehabilitation plan, and the employee's average weekly wage earnings are less than the average weekly wage earnings earned by the injured employee at the time of the injury, he or she shall receive temporary partial rehabilitation benefits calculated as follows: The temporary partial rehabilitation benefit shall be 70 percent of the difference between the average weekly wage earnings earned at the time of the injury and the average weekly wage earnings earned at the new employment, both to be calculated as provided in §23-4-6, §23-4-6d, and §23-4-14 of this code as the calculation is performed for temporary total disability benefits, subject to the following limitations: In no event are the benefits subject to the minimum benefit amounts required by the provisions of §23-4-6(b) of this code, nor may the benefits exceed the temporary total disability benefits to which the injured employee would be entitled pursuant to §23-4-6, §23-4-6d, and §23-4-14 of this code during any period of temporary total disability resulting from the injury in the claim: *Provided*, That no temporary total disability benefits shall be paid for any period for which temporary partial rehabilitation benefits are paid: *Provided, however*, That the aggregate award of temporary total rehabilitation or temporary partial rehabilitation benefits for a single injury for which an award of temporary total rehabilitation or temporary partial rehabilitation benefits is made on or after the effective date of the amendment and reenactment of this section in the year 2003 shall be for a period not exceeding 52 weeks unless the payment of temporary total rehabilitation disability benefits is in conjunction with an approved vocational rehabilitation plan for retraining, in which event the payment period of temporary total rehabilitation disability benefits may be extended for a period not to exceed a total of 104 weeks. The amount of temporary partial rehabilitation benefits payable under this subsection shall be reviewed every 90 days to determine whether the injured employee's average weekly wage in the new employment has changed and, if the change has occurred, the amount of benefits payable under this subsection shall be adjusted prospectively. Temporary partial rehabilitation benefits shall only be payable when the injured employee is receiving vocational rehabilitation services in accordance with a rehabilitation plan

WV Legislature

developed under this section and no payment of temporary partial rehabilitation benefits shall be made after the claimant has received the vocational training provided under the rehabilitation plan.

(e) The Insurance Commissioner shall propose for promulgation rules for the purpose of developing a comprehensive rehabilitation program which will assist injured workers to return to suitable gainful employment after an injury in a manner consistent with the provisions and findings of this section. The rules shall provide definitions for rehabilitation facilities and rehabilitation services pursuant to this section. Notwithstanding any other provision of this chapter to the contrary, and in addition to the provisions of §23-4-3 of this code authorizing an employer or the employer's representative to participate in a managed health care plan, including a managed health care plan that provides physical and vocational rehabilitation services, an employer or the employer's representative may contract directly with one or more providers of vocational rehabilitation services to be the employer's preferred provider of vocational rehabilitation services for its employees who receive injuries compensable under the provisions of this chapter and the rules promulgated under this section may require those employees to use the preferred providers.

WV Legislature

§23-4-9a

Repealed

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Acts, 1947 Reg. Sess., Ch. 165.

WV Legislature

§23-4-9b. Preexisting impairments not considered in fixing amount of compensation.

Where an employee has a definitely ascertainable impairment resulting from an occupational or a nonoccupational injury, disease or any other cause, whether or not disabling, and the employee thereafter receives an injury in the course of and resulting from his or her employment, unless the subsequent injury results in total permanent disability within the meaning of section one, article three of this chapter, the prior injury, and the effect of the prior injury, and an aggravation, shall not be taken into consideration in fixing the amount of compensation allowed by reason of the subsequent injury. Compensation shall be awarded only in the amount that would have been allowable had the employee not had the preexisting impairment. Nothing in this section requires that the degree of the preexisting impairment be definitely ascertained or rated prior to the injury received in the course of and resulting from the employee's employment or that benefits must have been granted or paid for the preexisting impairment. The degree of the preexisting impairment may be established at any time by competent medical or other evidence. Notwithstanding the foregoing provisions of this section, if the definitely ascertainable preexisting impairment resulted from an injury or disease previously held compensable and the impairment had not been rated, benefits for the impairment shall be payable to the claimant by or charged to the employer in whose employ the injury or disease occurred. The employee shall also receive the difference, if any, in the benefit rate applicable in the more recent claim and the prior claim.

WV Legislature

§23-4-10. Classification of death benefits; "dependent" defined.

In case a personal injury, other than occupational pneumoconiosis or other occupational disease, suffered by an employee in the course of and resulting from his or her employment, causes death, and disability is continuous from the date of the injury until the date of death, or if death results from occupational pneumoconiosis or from any other occupational disease, the benefits shall be in the amounts and to the persons as follows:

(a) If there are no dependents, the disbursements shall be limited to the expense provided for in sections three and four of this article;

(b) If there are dependents as defined in subdivision (d) of this section, the dependents shall be paid for as long as their dependency continues in the same amount that was paid or would have been paid the deceased employee for total disability had he or she lived. The order of preference of payment and length of dependence shall be as follows:

(1) A dependent widow or widower until death or remarriage of the widow or widower, and any child or children dependent upon the decedent until each child reaches eighteen years of age or where the child after reaching eighteen years of age continues as a full-time student in an accredited high school, college, university, business or trade school, until the child reaches the age of twenty-five years, or if an invalid child, to continue as long as the child remains an invalid. All persons are jointly entitled to the amount of benefits payable as a result of employee's death;

(2) A wholly dependent father or mother until death; and

(3) Any other wholly dependent person for a period of six years after the death of the deceased employee;

(c) If the deceased employee leaves no wholly dependent person, but there are partially dependent persons at the time of death, the payment shall be $50 a month to continue for the portion of the period of six years after the death, determined by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, but no partially dependent person shall receive compensation payments as a result of the death of more than one employee.

Compensation under this subdivision and subdivision (b) of this section shall, except as may be specifically provided to the contrary in those subdivisions, cease upon the death of the dependent, and the right to the compensation shall not vest in his or her estate.

(d) "Dependent", as used in this chapter, means a widow, widower, child under eighteen years of age, or under twenty-five years of age when a full-time student as provided in this section, invalid child or posthumous child, who, at the time of the injury causing death, is dependent, in whole or in part, for his or her support upon the earnings of the employee, stepchild under eighteen years of age, or under twenty-five years of age when a full-time

WV Legislature

student as provided in this section, child under eighteen years of age legally adopted prior to the injury causing death, or under twenty-five years of age when a full-time student as provided in this section, father, mother, grandfather or grandmother, who, at the time of the injury causing death, is dependent, in whole or in part, for his or her support upon the earnings of the employee; and invalid brother or sister wholly dependent for his or her support upon the earnings of the employee at the time of the injury causing death; and

(e) If a person receiving permanent total disability benefits dies from a cause other than a disabling injury leaving any dependents as defined in subdivision (d) of this section, an award shall be made to the dependents in an amount equal to one hundred four times the weekly benefit the worker was receiving at the time of his or her death and be paid either as a lump sum or in periodic payments, at the option of the dependent or dependents.

(f) The Insurance Commissioner shall prescribe a form notice to be sent by the commissioner, private carrier or self-insured employer, as applicable, to the dependent with the first payment and six months prior to the last payment of the benefits provided in subsection (e) of this section, that advises the dependent that the benefits will stop as of a date certain. The notice shall also advise the dependent that he or she may be eligible for additional benefits under section fifteen of this article and how to apply for those benefits. The notices shall be written in plain English in a manner that is easily understood by the general public.

WV Legislature

§23-4-11. To whom death benefits paid.

The benefits, in case of death, shall be paid to one or more dependents of the decedent, or to any other persons, for the benefit of all of the dependents, as may be determined by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, who may apportion the benefits among the dependents in the manner as they consider just and equitable. Payment to a dependent subsequent in right may be made if the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, considers proper and it operates to discharge all other claims for the benefits.

WV Legislature

§23-4-12. Application of benefits.

The dependent or person to whom benefits are paid shall apply the benefits to the use of the several beneficiaries of the benefits according to their respective claims upon the decedent for support, in compliance with the finding and direction of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable.

WV Legislature

§23-4-13. Effect of abandonment of spouse.

Notwithstanding anything herein contained, no sum will be paid to a widow or widower who abandoned the employee before the injury causing death. However, the provisions of this section may not be construed to preclude a widow or widower from receiving compensation in accordance with section ten of this article if the widow or widower was abandoned within a period of two years by the employee for any reason except a reason that would have entitled the deceased employee to an annulment or a divorce as provided in articles three or five, chapter forty-eight of this code.

WV Legislature

§23-4-14. Computation of benefits.

(a) The average weekly wage earnings, wherever earned, of the injured person at the date of injury and the average weekly wage in West Virginia as determined by the Insurance Commissioner, in effect at the date of injury, shall be taken as the basis upon which to compute the benefits.

(1) In cases involving occupational pneumoconiosis or other occupational diseases, the "date of injury" is the date of the last exposure to the hazards of occupational pneumoconiosis or other occupational diseases.

(2) In computing benefits payable on account of occupational pneumoconiosis, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall deduct the amount of all prior workers' compensation benefits paid to the same claimant on account of silicosis, but a prior silicosis award shall not, in any event, preclude an award for occupational pneumoconiosis otherwise payable under this article.

(b)(1) Until July 1, 1994, the expression "average weekly wage earnings, wherever earned, of the injured person, at the date of injury", within the meaning of this chapter, shall be computed based upon the daily rate of pay at the time of the injury or upon the average pay received during the two months, six months or 12 months immediately preceding the date of the injury, whichever is most favorable to the injured employee, except for the purpose of computing temporary total disability benefits for part-time employees pursuant to the provisions of §23-4-6d of this code.

(2) On and after July 1, 1994, the expression "average weekly wage earnings, wherever earned, of the injured person, at the date of injury", within the meaning of this chapter, shall be computed based upon the daily rate of pay at the time of the injury or upon the weekly average derived from the best quarter of wages out of the preceding four quarters of wages as reported to the Insurance Commissioner pursuant to §23-2-2(b) of this code, whichever is most favorable to the injured employee, except for the purpose of computing temporary total disability benefits for part-time employees pursuant to the provisions of §23-4-6d of this code.

(c) The expression "average weekly wage in West Virginia", within the meaning of this chapter, is the average weekly wage in West Virginia as determined by the Commissioner of the Bureau of Employment Programs in accordance with the provisions of §21A-6-10 and §21A-6-11 of this code and other applicable provisions of said chapter.

(d) In any claim for injuries, including occupational pneumoconiosis and other occupational diseases, occurring on or after July 1, 1971, any award for temporary total, permanent partial, or permanent total disability benefits or for dependent benefits shall be paid at the weekly rates or in the monthly amount in the case of dependent benefits applicable to the claimant in effect on the date of the injury. In no event shall an award for permanent total disability be subject to annual adjustments resulting from changes in the average weekly

WV Legislature

wage in West Virginia.

WV Legislature

§23-4-15. Application for benefits.

(a) To entitle any employee or dependent of a deceased employee to compensation under this chapter, other than for occupational pneumoconiosis or other occupational disease, the application for compensation shall be made on the form or forms prescribed by the Insurance Commissioner, and filed with the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, within six months from and after the injury or death, as the case may be, and unless filed within the six months period, the right to compensation under this chapter is forever barred, such time limitation being hereby declared to be a condition of the right and hence jurisdictional, and all proofs of dependency in fatal cases must also be filed within six months from and after the death. In case the employee is mentally or physically incapable of filing the application, it may be filed by his or her attorney or by a member of his or her family.

(b) To entitle any employee to compensation for occupational pneumoconiosis under the provisions of this subsection, the application for compensation shall be made on the form or forms prescribed by the Insurance Commissioner, and filed with the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, within three years from and after the last day of the last continuous period of 60 days or more during which the employee was exposed to the hazards of occupational pneumoconiosis or within three years from and after a diagnosed impairment due to occupational pneumoconiosis was made known to the employee by a physician and unless filed within the three-year period, the right to compensation under this chapter is forever barred, such time limitation being hereby declared to be a condition of the right and hence jurisdictional, or, in the case of death, the application shall be filed by the dependent of the employee within two years from and after the employee's death, and such time limitation is a condition of the right and hence jurisdictional.

(c) To entitle any employee to compensation for occupational disease other than occupational pneumoconiosis under the provisions of this section, the application for compensation shall be made on the form or forms prescribed by the Insurance Commissioner, and filed with the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, within three years from and after the day on which the employee was last exposed to the particular occupational hazard involved or within three years from and after the employee's occupational disease was made known to him or her by a physician or which he or she should reasonably have known, whichever last occurs, and unless filed within the three-year period, the right to compensation under this chapter shall be forever barred, such time limitation being hereby declared to be a condition of the right and therefore jurisdictional, or, in case of death, the application shall be filed as aforesaid by the dependent of the employee within one year from and after the employee's death, and such time limitation is a condition of the right and hence jurisdictional.

WV Legislature

§23-4-15a. Nonresident alien beneficiaries.

Notwithstanding any other provisions of this chapter, nonresident alien beneficiaries are entitled to the same benefits as citizens of the United States: Provided, That the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, in its discretion may make, and the beneficiary shall accept, commutation of the benefits into a lump sum settlement and payment. Nonresident alien beneficiaries within the meaning of this section means persons not citizens of the United States residing outside of the territorial limits of the United States at the time of the injury with respect to which benefits are awarded.

WV Legislature

§23-4-15b. Determination of nonmedical questions; claims for occupational pneumoconiosis; hearing.

If a claim for occupational pneumoconiosis benefits is filed by an employee within three years from and after the last day of the last continuous period of 60 days' exposure to the hazards of occupational pneumoconiosis, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall determine whether the claimant was exposed to the hazards of occupational pneumoconiosis for a continuous period of not less than 60 days while in the employ of the employer within three years prior to the filing of his or her claim, whether in the State of West Virginia the claimant was exposed to such hazard over a continuous period of not less than two years during the 10 years immediately preceding the date of his or her last exposure to the hazard and whether the claimant was exposed to the hazard over a period of not less than 10 years during the 15 years immediately preceding the date of his or her last exposure to the hazard. If a claim for occupational pneumoconiosis benefits is filed by an employee within three years from and after the employee's occupational pneumoconiosis was made known to the employee by a physician, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall determine whether the claimant filed his or her application within that period and whether in the State of West Virginia the claimant was exposed to the hazard over a continuous period of not less than two years during the 10 years immediately preceding the date of last exposure to the hazard and whether the claimant was exposed to the hazard over a period of not less than 10 years during the 15 years immediately preceding the date of last exposure to the hazard. If a claim for occupational pneumoconiosis benefits is filed by a dependent of a deceased employee, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall determine whether the deceased employee was exposed to the hazards of occupational pneumoconiosis for a continuous period of not less than 60 days while in the employ of the employer within 10 years prior to the filing of the claim, whether in the State of West Virginia the deceased employee was exposed to the hazard over a continuous period of not less than two years during the 10 years immediately preceding the date of his or her last exposure to the hazard and whether the claimant was exposed to the hazard over a period of not less than 10 years during the 15 years immediately preceding the date of his or her last exposure to the hazard. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall also determine other nonmedical facts that, in the opinion of the Insurance Commissioner, private carrier, or self-insured employer, are pertinent to a decision on the validity of the claim.

The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall enter an order with respect to nonmedical findings within 90 days following receipt by the Insurance Commissioner, private carrier, or self-insured employer of both the claimant's application for occupational pneumoconiosis benefits and the physician's report filed in connection with the claimant's application and shall give each interested party notice in writing of these findings with respect to all the nonmedical facts. The findings and actions of the Insurance Commissioner, private carrier, or self-insured employer, whichever is

applicable, are final unless the employer, employee, claimant, or dependent, within 60 days after receipt of the notice, objects to the findings and, unless an objection is filed within the 60-day period, the findings are forever final, the time limitation is a condition of the right to litigate the findings and therefore jurisdictional. Upon receipt of an objection, the Board of Review shall set a hearing as provided in §23-5-9a of this code. In the event of an objection to the findings by the employer, the claim shall, notwithstanding the fact that one or more hearings may be held with respect to the objection, mature for reference to the Occupational Pneumoconiosis Board with like effect as if the objection had not been filed. If the Board of Review concludes after the objection hearings that the claim should be dismissed, a final order of dismissal shall be entered. The final order is subject to appeal in accordance with the provisions of §23-5-10a and §23-5-12a of this code. If the Board of Review concludes after the objection hearings that the claim should be referred to the Occupational Pneumoconiosis Board for its review, the order entered shall be interlocutory only and may be appealed only in conjunction with an appeal from a final order with respect to the findings of the Occupational Pneumoconiosis Board.

WV Legislature

§23-4-15c.

Repealed.

Acts, 1971 Reg. Sess., Ch. 177.

WV Legislature

§23-4-16. Jurisdiction over case continuous; modification of finding or order; time limitation on awards; reimbursement of claimant for expenses; reopening cases involving permanent total disability; promulgation of rules.

(a) The power and jurisdiction of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, over each case is continuing and the Insurance Commissioner, private carrier, or self-insured employer may, in accordance with the provisions of this section and after due notice to the employer, make modifications or changes with respect to former findings or orders that are justified. The period in which a claimant may request a modification, change, or reopening of a prior award shall be determined by the following subdivisions of this subsection. Any request that is made beyond that period shall be refused.

(1) Except as provided in §23-4-22 of this code, in any claim which was closed without the entry of an order regarding the degree, if any, of permanent disability that a claimant has suffered, or in any case in which no award has been made, any request must be made within five years of the closure. During that time period, only two requests may be filed.

(2) Except as stated below, in any claim in which an award of permanent disability was made, any request must be made within five years of the date of the initial award. During that time period, only two requests may be filed. With regard to those occupational diseases, including occupational pneumoconiosis, which are medically recognized as progressive in nature, if any such request is granted by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, a new five-year period begins upon the date of the subsequent award.

(3) No further award may be made in fatal cases except within two years after the death of the employee.

(4) With the exception of the items set forth in §23-4-3(d) of this code, in any claim in which medical or any type of rehabilitation service has not been rendered or durable medical goods or other supplies have not been received for a period of five years, no request for additional medical or any type of rehabilitation benefits shall be granted nor shall any medical or any type of rehabilitation benefits or any type of goods or supplies be paid for by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, if they were provided without a prior request. For the exclusive purposes of this subdivision, medical services and rehabilitation services shall not include any encounter in which significant treatment was not performed.

(b) In any claim in which an injured employee makes application for a further period of temporary total disability, if the application is in writing and filed within the applicable time limit stated above, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall pass upon the request within 30 days of the receipt of the request. If the decision is to grant the request, the order shall provide for the receipt of temporary total disability benefits. In any case in which an injured employee makes

WV Legislature

application for a further award of permanent partial disability benefits or for an award of permanent total disability benefits, if the application is in writing and filed within the applicable time limit as stated above, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall pass upon the request within 30 days of its receipt and, if the Insurance Commissioner, private carrier, or self-insured employer determines that the claimant may be entitled to an award, the Insurance Commissioner, private carrier, or self-insured employer shall refer the claimant for further examinations that are necessary.

(c) If the application is based on a report of any medical examination made of the claimant and submitted by the claimant to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, in support of his or her application and the claim is opened for further consideration and additional award is later made, the claimant shall be reimbursed for the expenses of the examination. The reimbursement shall be made by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, to the claimant, in addition to all other benefits awarded, upon due proof of the amount thereof being furnished by the claimant, but shall in no case exceed the sum fixed pursuant to the applicable schedule of maximum reasonable fees.

(d) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, has continuing power and jurisdiction over claims in which permanent total disability awards have been made after April 8, 1993.

(1) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall continuously monitor permanent total disability awards and may, from time to time, after due notice to the claimant, reopen a claim for reevaluation of the continuing nature of the disability and possible modification of the award. At such times as the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may determine, the Insurance Commissioner, private carrier, or self-insured employer may require the claimant to provide documents and other information, including, but not limited to, tax returns, financial records, and affidavits demonstrating level of income, recreational activities, work activities, medications used, and physicians or other medical or rehabilitation providers treating or prescribing medication or other services for the claimant; require the claimant to appear under oath and answer questions; and suspend or terminate any benefits of a claimant who willfully fails to provide the information or appear as required. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may reopen a claim for reevaluation when, in its sole discretion, it concludes that there exists good cause to believe that the claimant no longer meets the eligibility requirements under §23-4-6(n) of this code. The eligibility requirements, including any vocational standards, shall be applied as those requirements are stated at the time of a claim’s reopening.

(2) Upon reopening a claim under this subsection, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may take evidence, have the claimant evaluated, make findings of fact and conclusions of law, and shall vacate, modify, or

WV Legislature

affirm the original permanent total disability award as the record requires. In the event the claimant retains his or her award following the reevaluation, the claimant's reasonable attorneys' fees incurred in defending the award shall be paid by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable. In addition, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall reimburse a prevailing claimant for his or her costs in obtaining one evaluation on each issue during the course of the reevaluation.

(3) This subsection shall not be applied to awards made under the provisions of §23-4-6(m) of this code. The claimant may seek review of the final order as otherwise provided in §23-5-1 *et seq*. of this code for review of orders granting or denying permanent disability awards.

(4) The Insurance Commissioner shall establish by rule criteria for review, reopening, and reevaluating a claim under this subsection.

(e) A claimant may have only one active request for a permanent disability award pending in a claim at any one time. Any new request that is made while another is pending shall be consolidated into the former request.

WV Legislature

§23-4-16a. Interest on benefits.

Whenever any award of temporary total, permanent partial, or permanent total disability benefits or dependent benefits is made on or after July 1, 1971, and a protest is filed to the award or an appeal is taken from the award by an employer only and not by the claimant or dependent and the award is not ultimately denied or reduced following the protest or appeal, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall add interest to the award at the simple rate of six percent per annum from the date the award would have been payable had the protest or appeal not been filed or taken, exclusive of any period for which a continuance was granted upon motion of any party other than the protesting or appealing employer.

WV Legislature

§23-4-17. Commutation of periodical benefits.

The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, under special circumstances and when it is considered advisable, may commute periodical benefits to one or more lump-sum payments. Upon the application of any claimant who has received an award of partial or total disability, who is not a citizen of the United States and desires to reside permanently beyond the territorial limits of the United States, or upon the application of an alien dependent of a deceased employee with respect of whose death award of compensation has been made, the dependent residing in the territorial limits of the United States at the time of the decedent's death, and desiring to reside permanently beyond the territorial limits of the United States, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may commute into one lump-sum payment the periodical payments to which the claimant or dependent would be entitled, but at the rate of one-half the amount that would be payable to a citizen of the United States under like circumstances. The lump-sum payment at the rate specified in this section discharges all liability with respect to the award, but in no event shall the award be paid until the claimant or dependent has actually arrived and domiciled himself or herself outside the territorial limits of the United States, except a sufficient portion of the award to pay transportation and other necessary expenses.

WV Legislature

§23-4-18. Mode of paying benefits generally; exemptions of compensation from legal process.

Except as provided by this section, compensation shall be paid only to the employees or their dependents and is exempt from all claims of creditors and from any attachment, execution or assignment other than compensation to counsel for legal services, under the provisions of, and subject to the limitations contained in §23-5-16a of this code, and other than for the enforcement of orders for child or spousal support entered pursuant to the provisions of chapter 48 of this code. Payments may be made in the periodic installments determined by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, in each case, but in no event less frequently than semimonthly for any temporary award and monthly for any permanent award. Payments for permanent disability shall be paid on or before the third day of the month in which they are due. In all cases where compensation is awarded or increased, the amount of compensation shall be calculated and paid from the date of disability.

WV Legislature

§23-4-19.

Repealed.

Acts, 1999 Reg. Sess., Ch. 294.

WV Legislature

§23-4-20. Postmortem examinations.

The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may, after due notice to the claimant, whenever it considers it necessary, order an autopsy and may designate a duly licensed physician to make the postmortem examination or examinations that are necessary to determine the cause of the deceased employee's death. The physician shall file with the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, a written report of his or her findings. The claimant has the right to select a physician of his or her own choosing and, at his or her own expense, to participate in the postmortem examination. The physician selected by the claimant has the right to concur in any report made by the physician selected by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, or may file a separate report. In any case, including silicosis cases, in which a claimant requests that an autopsy be performed, the autopsy shall be directed as provided in this section. In the event that a claimant refuses to consent and permit the autopsy, all rights to compensation shall be forfeited.

WV Legislature

§23-4-21. Severability.

If any provision of this article or the application thereof to any person or circumstance is held unconstitutional or invalid, such unconstitutionality or invalidity shall not affect other provisions or applications of the article, and to this end the provisions of this article are declared to be severable.

WV Legislature

§23-4-22. Permanent disability evaluations; limitations; notice.

[Repealed.]

WV Legislature

§23-4-23. Permanent total disability benefits; reduction of disability benefits; reduction of benefits; application of section; severability.

(a) This section is applicable whenever benefits are being paid for permanent total disability benefits arising under §23-4-6(d), (m), or (n) of this code or under §23-4-8c of this code. This section is not applicable to the receipt of temporary total disability benefits, the receipt of permanent partial disability benefits, the receipt of benefits by partially or wholly dependent persons, or to the receipt of benefits pursuant to the provisions of §23-4-10(e) of this code. This section is not applicable to the receipt of medical benefits or the payment for medical benefits.

(b) Whenever applicable benefits are paid to a beneficiary with respect to the same time period for which payments under a self-insurance plan, a wage continuation plan, or a disability insurance policy provided by an employer are also received or being received by the beneficiary, the applicable benefits shall be reduced by these amounts:

(1) The after-tax amount of the payments received or being received under a self-insurance plan, a wage continuation plan, or under a disability insurance policy provided by an employer if the employee did not contribute directly to the plan or to the payment of premiums regarding the disability insurance policy; or

(2) The proportional amount, based on the ratio of the employer's contributions to the total insurance premiums for the policy period involved, of the after-tax amount of the payments received or being received by the employee pursuant to a disability insurance policy provided by an employer if the employee did contribute directly to the payment of premiums regarding the disability insurance policy: *Provided*, That in no event shall applicable benefits be reduced below the minimum weekly benefits as provided for in §23-4-6(b) and (d) of this code.

(c) This section applies to awards of permanent total disability made after the effective date of this section.

(d) The Insurance Commissioner shall promulgate the appropriate rules for the interpretation, processing, and enforcement of this section.

(e) If any portion of this section or any application of this section is subsequently found to be unconstitutional or in violation of applicable law, it shall not affect the validity of the remainder of this section or the applications of the section that are not unconstitutional or in violation.

WV Legislature

§23-4-24. Permanent total disability awards; retirement age; limitations on eligibility and the introduction of evidence; effects of other types of awards; procedures; requests for awards; jurisdiction.

(a) Notwithstanding any provision of this chapter to the contrary, except as stated below, no claimant shall be awarded permanent total disability benefits arising under §23-4-6(d) or (n) of this code or §23-4-8c of this code who terminates active employment and is receiving full old-age retirement benefits under the Social Security Act, 42 U.S.C. § 401 and 42 U.S.C. § 402. Any claimant shall be evaluated only for the purposes of receiving a permanent partial disability award premised solely upon the claimant's impairments. This subsection is not applicable in any claim in which the claimant has completed the submission of his or her evidence on the issue of permanent total disability prior to the later of the following: Termination of active employment or the initial receipt of full old-age retirement benefits under the Social Security Act. Once the claimant has terminated active employment and has begun to receive full old-age social security retirement benefits, the claimant may not produce additional evidence of permanent total disability nor shall the claim be remanded for the production of the evidence.

(b) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, has the sole and exclusive jurisdiction to initially hear and decide any claim or request pertaining, in whole or in part, to §23-4-6(d) or (n) of this code. Any claim or request for permanent total disability benefits arising under said subdivisions shall first be presented as part of the initial claim filing or by way of an application for modification or adjustment pursuant to §23-4-16 of this code. The Board of Review may consider a claim only after the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, has entered an appropriate order.

WV Legislature

§23-4-25. Permanent total disability benefits; reduction of disability benefits for wages earned by claimant.

(a) After April 8, 1993, a reduction in the amount of benefits as specified in subsection (b) of this section shall be made whenever benefits are being paid for a permanent total disability award regardless of when the benefits were awarded. This section is not applicable to the receipt of medical benefits or the payment for medical benefits, the receipt of permanent partial disability benefits, the receipt of benefits by partially or wholly dependent persons, or to the receipt of benefits pursuant to the provisions of §23-4-10(e) of this code. Prior to the application of this section to any claimant, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall give the claimant notice of the effect of this section upon a claimant's award if and when the claimant later earns wages.

(b) Whenever applicable benefits are paid to a claimant with respect to the same time period in which the claimant has earned wages as a result of his or her employment, the following reduction in applicable benefits shall be made. The claimant's applicable monthly benefits and monthly net wages received from the current employment shall be added together. If the total exceeds by more than 120 percent of the amount of the claimant's monthly net wages earned during his or her last employment prior to the award of permanent total disability benefits, the excess shall be reduced by $1 for each $2 that the claimant's monthly benefits and monthly net wages exceed the 120 percent level: *Provided*, That in no event shall applicable benefits be reduced below the minimum weekly benefits as provided in §23-4-6(b) and (d) of this code.

WV Legislature