WEST VIRGINIA CODE CHAPTER 23

§23-1-1. Regulation of the workers' compensation system by the Insurance Commissioner; findings.

(a) As recognized by the Supreme Court of Appeals of West Virginia in Wampler Foods, Inc. v. Workers' Compensation Division, 216 W.Va. 129, 602 S.E.2d 805 (2004), and in recognition that a deficit of such critical proportions existed in the workers' compensation fund that it constituted an immediate and long term threat to the solvency of the fund, as well as a substantial deterrent to the economic development of this state, and further that lawmakers are uniquely charged with the responsibility for passing laws designed to cure such serious concerns and that substantial deference is accorded to legislative actions aimed at doing so, it was and remains the intent of the Legislature that the amendments to this chapter enacted in the year 2003 be applied from the date upon which the enactment was made effective by the Legislature.

(b) It is the further intent of the Legislature that this chapter be interpreted so as to assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter. It is the specific intent of the Legislature that workers' compensation cases shall be decided on their merits and that a rule of "liberal construction" based on any "remedial" basis of workers' compensation legislation shall not affect the weighing of evidence in resolving such cases. The workers' compensation system in this state is based on a mutual renunciation of common law rights and defenses by employers and employees alike. Employees' rights to sue for damages over and above medical and health care benefits and wage loss benefits are to a certain degree limited by the provisions of this chapter and employers' rights to raise common law defenses, such as lack of negligence, contributory negligence on the part of the employee, and others, are curtailed as well. Accordingly, the Legislature hereby declares that any remedial component of the workers' compensation laws is not to cause the workers' compensation laws to receive liberal construction that alters in any way the proper weighing of evidence as required by §23-4-1g of this code.

(c) It is the intent of the Legislature, expressed through its enactment of legislation, to transfer the regulation of the workers' compensation system to the Insurance Commissioner. By proclamation of the Governor, as authorized by §23-2C-1 *et seq*. of this code, the Workers' Compensation Commission was terminated on December 31, 2005. To further the transition from the state-operated workers' compensation system to a system of private insurance, the duties and responsibilities of the Workers' Compensation Commission and the board of managers, including, but not limited to, ratemaking and adjudication of claims now reside with the Insurance Commissioner.

§23-1-1a.

Repealed.

Acts, 2015 Reg. Sess., Ch. 53.

§23-1-1b. Powers and duties of Insurance Commissioner.

The Insurance Commissioner shall have the power and duty to:

(1) Establish operating guidelines and policies designed to ensure the effective regulation of the workers' compensation insurance market in West Virginia and effectuate the provisions of this chapter;

(2) Employ, direct, and supervise all employees required in the connection with the performance of the duties assigned to the Insurance Commissioner by this chapter;

(3) Reorganize the work of the Insurance Commissioner, its divisions, sections, and offices to the extent necessary to achieve the most efficient performance of its functions.

(4) Keep accurate and complete accounts and records necessary to the collection, administration, and distribution of the workers' compensation funds created in §23-2C-6 of this code;

(5) Invoke any legal or special remedy for the enforcement of orders or the provisions of this chapter;

(6) Ensure that all employees of the Insurance Commissioner follow the orders, operating guidelines, and policies of the agency as they relate to the agency's overall policymaking, management, and adjudicatory duties under this chapter;

(7) Delegate all powers and duties vested in the Insurance Commissioner to his or her appointees and employees: *Provided*, That the Insurance Commissioner is responsible for their acts;

(8)(A) Contract or employ counsel to perform all legal services for the Insurance Commissioner including, but not limited to, representing the Insurance Commissioner in any administrative proceeding and in any state or federal court. Additionally, the Insurance Commissioner may, but shall not be required to, call upon the Attorney General for legal assistance and representation as provided by law. The Attorney General shall not approve or exercise authority over in-house counsel or contract counsel hired pursuant to this section;

(B) In addition to the authority granted by this section to the Insurance Commissioner and notwithstanding any provision to the contrary elsewhere in this code, use any attorney regularly employed by the Insurance Commissioner or the Office of the Attorney General to represent the Insurance Commissioner in any matter arising from the performance of his or her duties or the execution of his or her powers under this chapter.

(9) Propose rules for approval by the Industrial Council created in §23-2C-5 of this code, under which agencies of this state shall revoke or refuse to grant, issue, or renew any contract, license, permit, certificate, or other authority to conduct a trade, profession, or business to or with any employing unit who is in default as set forth in §23-2C-19(d)(1) of

this code or listed in the Employer Violator System with the Insurance Commissioner. The term "agency" includes any unit of state government such as officers, agencies, divisions, departments, boards, commissions, authorities, or public corporations. An employing unit is not in default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with its obligations under the repayment agreements;

(A) The rules shall provide that, before granting, issuing, or renewing any contract, license, permit, certificate, or other authority to conduct a trade, profession, or business to or with any employing unit, the designated agencies shall review a list or lists provided by the Insurance Commissioner of employers that are in default. If the employing unit's name is not on the list, the agency, unless it has actual knowledge that the employing unit is in default, may grant, issue, or renew the contract, license, permit, certificate, or other authority to conduct a trade, profession, or business. The list may be provided to the agency in the form of a computerized database or databases that the agency can access. Any objections to the refusal to issue or renew shall be reviewed under the appropriate provisions of this chapter. The prohibition against granting, issuing, or renewing any contract, license, permit, certificate, or other authority under this subdivision shall remain in full force and effect as promulgated under §21A-2-6 of this code until the rules required by this subdivision are promulgated and in effect;

(B) The rules shall also provide a procedure allowing any agency or interested person, after being covered under the rules for at least one year, to petition the Insurance Commissioner to be exempt from the provisions of the rules;

(10) Deposit to the credit of the appropriate special revenue account or fund, notwithstanding any other provision of this code and to the extent allowed by federal law, all amounts of delinquent payments or overpayments, interest, and penalties thereon and attorneys' fees and costs collected under the provisions of this chapter. The amounts collected shall not be treated by the Auditor or Treasurer as part of the general revenue of the state;

(11) Regularly audit or examine and monitor programs established by self-insured employers or third-party administrators under this chapter to ensure compliance with the Insurance Commissioner's rules and the law;

(12) Oversee the Insurance Fraud Unit that has the responsibility and authority for investigating and controlling insurance fraud and workers' compensation fraud in the State of West Virginia as set forth in §33-41-1 *et seq*. of this code. The fraud unit shall be under the supervision of an inspector general, who shall be appointed by the Insurance Commissioner. Nothing in this section shall preclude private carriers from independently investigating and controlling abuse.

(A) The inspector general shall, with the consent and advice of the Insurance Commissioner, employ all personnel as necessary for the institution, development and finalization of procedures and investigations which serve to ensure that only necessary and proper

workers' compensation benefits and expenses are paid to or on behalf of injured employees. Qualification, compensation, and personnel practice relating to the employees of the fraud and abuse unit, including that of the position of inspector general, shall be governed by the provisions of the statutes and rules of the classified service pursuant to §29-6-1, *et seq*. of this code. The inspector general shall supervise all personnel;

(B) The fraud unit shall have the following powers and duties:

(i) The fraud unit will take action to identify and prevent and discourage any and all fraud and abuse;

(ii) The fraud unit, in cases of criminal fraud, has the authority to review and prosecute those cases for violations of §23-1-1 *et seq*., §33-1-1 *et seq*., §61-3-1 *et seq*., and §61-4-5 of this code, as well as any other criminal statutes that may be applicable. In addition, the fraud unit not only has the authority to prosecute and refer cases involving criminal fraud to appropriate state authorities for prosecution, but it also has the authority, and is encouraged, to cooperate with the appropriate federal authorities for review and possible prosecution, by either state or federal agencies, of cases involving criminal fraud concerning the Workers' Compensation System in West Virginia; and

(iii) The fraud unit is expressly authorized to initiate investigations and participate in the development of, and if necessary, the prosecution of any health care provider, including a provider of rehabilitation services and in-home caretaker, alleged to have violated the provisions of §23-4-3c of this code;

(C) Specific personnel, designated by the inspector general, shall be permitted to operate vehicles owned or leased for the state displaying Class A registration plates;

(D) Notwithstanding any provision of this code to the contrary, specific personnel designated by the inspector general may carry handguns in the course of their official duties after meeting specialized qualifications established by the Governor's Committee on Crime, Delinquency and Correction, which qualifications shall include the successful completion of handgun training provided to law-enforcement officers by the West Virginia State Police: *Provided*, That nothing in this subsection shall be construed to include the personnel so designated by the inspector general to carry handguns within the meaning of the term law-enforcement official as defined in §30-29-1 of this code;

(E) The fraud unit is not subject to any requirement of §6-9a-1 et seq. of this code and the investigations conducted by the fraud unit and the materials placed in the files of the unit as a result of any such investigation are exempt from public disclosure under the provisions of chapter 29B of this code;

(F) In the event that a final judicial decision adjudges that the statewide prosecutorial powers vested by this subdivision in the fraud unit may only be exercised by a public official other than an employee of the fraud unit, then to that extent the provisions of this

subdivision vesting statewide prosecutorial power shall thenceforth be of no force and effect, the remaining provisions of this subdivision shall continue in full force and effect, and prosecutions hereunder may only be exercised by the prosecuting attorneys of this state and their assistants or special assistant prosecuting attorneys appointed as provided by law;

(13) Enter into interagency agreements to assist in exchanging information and fulfilling the default provisions of this chapter;

(14) Establish an employer violator system to identify individuals and employers who are in default, as defined by §23-2C-19(d)(1) of this code. The employer violator system shall prohibit violators who own, control or have a 10 percent or more ownership interest, or other ownership interest as may be defined by the Insurance Commissioner, in any company from obtaining or maintaining any license, certificate or permit issued by the state until the violator has paid all moneys owed to the Insurance Commissioner or has entered into and remains in compliance with a repayment agreement;

(15) Perform all other functions necessary for the regulation of the workers' compensation insurance industry, including, but not limited to: ratemaking, self-insurance, office of judges, and board of review; and

(16) Perform all duties set forth in §23-2C-1 *et seq*. of this code.

§23-1-1c. Payment withholding; interception; penalty.

[Repealed.]

§23-1-1d. Rules of former division of workers' compensation.

[Repealed.]

§23-1-1e. Transfer of assets and contracts; ability to acquire, own, lease and otherwise manage property.

[Repealed.]

§23-1-1f. Authority of Insurance Commission to exempt employees from classified service; exemption from purchasing rules.

Notwithstanding any other provision of this code, the Insurance Commissioner may:

(1) Exempt no more than 20 positions of the offices of the Insurance Commissioner from the classified service of the state, the employees of which positions shall serve at the will and pleasure of the commissioner: *Provided*, That such exempt positions shall be in addition to those positions in classified-exempt service under the classification plan adopted by the Division of Personnel; and

(2) Expend such sums for professional services as he or she determines are necessary to perform duties under this chapter. The provisions of §5A-3-1 *et seq*. of this code relating to the Purchasing Division of the Department of Administration shall not apply to these contracts, and the Insurance Commissioner shall award the contract or contracts on a competitive basis.

§23-1-1g. Legislative intent to create a quasi-public entity.

[Repealed.]

§23-1-1h. Powers and duties of Office of Judges transferred to Board of Review; definition of certain terms effective July 1, 2022.

(a) Notwithstanding any other provision of this code, with regard to an objection, protest, or any other decision issued after June 30, 2022, all powers and duties of the Workers' Compensation Office of Judges, as provided in this chapter, shall be transferred to the Workers' Compensation Board of Review.

(b) Notwithstanding any other provision of this code, the West Virginia Intermediate Court of Appeals has exclusive appellate jurisdiction over the following matters:

(1) Decisions or orders issued by the Office of Judges after June 30, 2022, and prior to its termination; and

(2) Decisions of the Workers' Compensation Board of Review, issued after June 30, 2022, as provided in §23-5-8a and §51-11-1 *et seq*. of this code.

(c) Unless the context clearly indicates a different meaning, effective July 1, 2022, the following terms shall have the following meanings for the purposes of this chapter, except when used in §23-5-1 *et seq*. of this code:

(1) "Administrative law judge" means a member of the Workers' Compensation Board of Review, or a hearing examiner designated by the Board of Review as authorized in §23-5-1 *et seq*. of this code;

(2) "Office of judges" means the "Workers' Compensation Board of Review"; and

(3) "Workers' Compensation Board of Review" or "Board of Review" when used in reference to an appeal of a Board of Review decision, means the West Virginia Intermediate Court of Appeals, created by §51-11-1 *et seq*. of this code.

§23-1-2. Oversight of the workers' compensation commission.

[Repealed.]

§23-1-3. Payment of salaries and expenses generally; manner; limitation.

[Repealed.]

§23-1-4. Records; confidentiality; exceptions.

Except as expressly provided for in this subsection, information obtained regarding employers and claimants pursuant to this chapter for the purposes of its administration is not subject to the provisions of Chapter 29B of this code unless the provisions are hereafter specifically made applicable, in whole or in part. The information that is reasonably necessary may be released in formal orders or opinions of any tribunal or court which is presented with an issue arising under this chapter as well as in the presentations of the parties before the tribunal or court. Similarly, claimants or other interested parties to an issue arising under this chapter may, upon request, obtain information from the Insurance Commissioner's records to the extent necessary for the proper presentation or defense of a claim or other matter. Information may be released pursuant to the provisions of Chapter 29B of this code only if all identifying information has first been eliminated from the records. Nothing in this subsection shall prevent the release of information to another agency of the state or of the federal government for the legitimate purposes of those agencies: *Provided*, That the agency shall guarantee the confidentiality of the information provided to the fullest extent possible in keeping with its own statutory and regulatory mandates. Nothing in this section shall prevent the Insurance Commissioner from complying with any subpoena duces tecum: *Provided, however*, That the issuing tribunal or court shall take such actions as proper to maintain the confidentiality of the information.

The Insurance Commissioner may release, pursuant to a proper request under the provisions of Chapter 29B of this code, the following information:

(1) Whether or not a specific employer has obtained coverage under the provisions of this chapter;

(2) Whether or not a specific employer is in good standing or is delinquent or in default according to the Insurance Commissioner's records and the time periods thereof; and

(3) If a specific employer is delinquent or in default, what the payments due the Insurance Commissioner are and what the components of that payment are, including the time periods affected.

§23-1-4a. Bond for executive director and associate director.

[Repealed.]

§23-1-5. Office of Insurance Commissioner; hearings.

The Insurance Commissioner shall keep and maintain his or her office at the seat of government and shall provide a suitable room or rooms, necessary office furniture, supplies, books, periodicals, maps, and other equipment. After due notice, showing the time and place, the Insurance Commissioner may hold hearings anywhere within the state, or elsewhere by agreement of claimant and employer, with the approval of the Insurance Commissioner.

§23-1-6. Employment of associate director and other assistants; compensation and travel expenses.

[Repealed.]

§23-1-7. Associate director to act during executive director's absence or inability to act and in case of vacancy; bond of associate director.

[Repealed.]

§23-1-8. Authority of Insurance Commissioner and employees as to oaths and evidence.

The Insurance Commissioner and other employees appointed by the Insurance Commissioner may, for the purpose contemplated by this chapter, administer oaths, certify official acts, take depositions, issue subpoenas, and compel the attendance of witnesses and the production of pertinent books, accounts, papers, records, documents, and testimony.

§23-1-9. Compelling compliance with order or subpoena.

In case of failure or refusal of any person to comply with the order of the Insurance Commissioner, or subpoena issued by him or her, or duly appointed employee, or on the refusal of a witness to testify to any matter regarding which he or she may be lawfully interrogated, or refusal to permit an inspection as aforesaid, the circuit judge of the county in which the person resides, on application of the Insurance Commissioner or any duly appointed employee, shall compel obedience by attachment proceedings as for contempt, as in the case of disobedience of the requirements of a subpoena issued from the court on a refusal to testify in the court.

§23-1-10. Fee of officer serving subpoena; fees and mileage of witnesses.

Each officer who serves subpoenas on behalf of the Insurance Commissioner shall receive the same fee as a sheriff and each witness who appears in obedience to a subpoena before the Insurance Commissioner or duly appointed employee shall receive for his or her attendance the fees and mileage provided for witnesses in civil cases in the circuit court if the witness was subpoenaed without the request of either claimant or employer at the instance of the Insurance Commissioner or duly appointed employee. The witness fees and mileage of any witness subpoenaed by, or at the instance of, either claimant or employer shall be paid by the party who subpoenas the witness.

§23-1-11. Depositions; investigations.

(a) In an investigation into any matter arising under this chapter, the Insurance Commissioner may cause depositions of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in the circuit court, but the depositions shall be upon reasonable notice to claimant and employer or other affected persons or their respective attorneys.

(b) The Insurance Commissioner also has discretion to accept and consider depositions taken within or without the state by either the claimant or employer or other affected person, provided due and reasonable notice of the taking of the depositions was given to the other parties or their attorneys, if any: *Provided*, That the Insurance Commissioner, upon due notice to the parties, has authority to refuse or permit the taking of depositions or to reject the depositions after they are taken, if they were taken at a place or under circumstances which imposed an undue burden or hardship upon the other parties. The Insurance Commissioner's discretion to accept, refuse to approve or reject the depositions is binding in the absence of abuse of the discretion.

§23-1-12. Copies of proceedings as evidence.

A transcribed copy of the evidence and proceedings, or any specific part thereof, on any investigation or hearing, taken by a stenographer appointed by the Insurance Commissioner and certified and sworn to by the stenographer to be a true and correct transcript of the testimony in the investigation or hearing, or of a particular witness, or of a specific part thereof, or to be a correct transcript of the proceedings had on the investigation or hearing purporting to be taken and subscribed, may be received in evidence by the Insurance Commissioner with the same effect as if the stenographer were present and testified to the facts certified. A copy of the transcript shall be furnished on demand to any party upon payment of the fee prescribed in the rules and policies of the Insurance Commissioner. The fee shall not exceed that prescribed for transcripts in the circuit court.

§23-1-13. Rules of procedure and evidence; persons authorized to appear in proceedings; withholding of psychiatric and psychological reports and providing summaries thereof.

(a) The Insurance Commissioner shall adopt reasonable and proper rules of procedure, regulate and provide for the kind and character of notices, and the service of the notices, in cases of accident and injury to employees, the nature and extent of the proofs and evidence, the method of taking and furnishing of evidence to establish the rights to benefits or compensation from the fund hereinafter provided for, or directly from employers as hereinafter provided, as the case may require, and the method of making investigations, physical examinations and inspections and prescribe the time within which adjudications and awards shall be made.

(b) At hearings and other proceedings before the Insurance Commissioner or before the duly authorized representative of the Insurance Commissioner, an employer who is a natural person may appear, and a claimant may appear, only as follows:

(1) By an attorney duly licensed and admitted to the practice of law in this state;

(2) By a nonresident attorney duly licensed and admitted to practice before a court of record of general jurisdiction in another state or country or in the District of Columbia who has complied with the provisions of rule 8.0 - admission pro hac vice, West Virginia Supreme Court Rules for admission to the practice of law, as amended;

(3) By a representative from a labor organization who has been recognized by the Insurance Commissioner as being qualified to represent a claimant or who is an individual otherwise found to be qualified by the Insurance Commissioner to act as a representative. The representative shall participate in the presentation of facts, figures, and factual conclusions as distinguished from the presentation of legal conclusions in respect to the facts and figures; or

(4) Pro se.

(c) At hearings and other proceedings before the Insurance Commissioner or before the duly authorized representative of the Insurance Commissioner, an employer who is not a natural person may appear only as follows:

(1) By an attorney duly licensed and admitted to the practice of law in this state;

(2) By a nonresident attorney duly licensed and admitted to practice before a court of record of general jurisdiction in another state or country or in the District of Columbia who has complied with the provisions of rule 8.0 - admission pro hac vice, West Virginia Supreme Court Rules for admission to the practice of law, as amended;

(3) By a member of the board of directors of a corporation or by an officer of the corporation for purposes of representing the interest of the corporation in the presentation of facts,

figures, and factual conclusions as distinguished from the presentation of legal conclusions in respect to the facts and figures; or

(4) By a representative from an employer service company who has been recognized by the Insurance Commissioner as being qualified to represent an employer or who is an individual otherwise found to be qualified by the Insurance Commissioner to act as a representative. The representative shall participate in the presentation of facts, figures, and factual conclusions as distinguished from the presentation of legal conclusions in respect to the facts and figures.

(d) The Insurance Commissioner or his or her representative may require an individual appearing on behalf of a natural person or corporation to produce satisfactory evidence that he or she is properly qualified and authorized to appear pursuant to this section.

(e) The provisions of §23-1-13(b), (c), and (d) of this code shall not be construed as being applicable to proceedings before the office of judges or board of review pursuant to the provisions of §23-5-1 *et seq*. of this code.

(f) At the direction of a treating or evaluating psychiatrist or clinical doctoral-level psychologist, a psychiatric or psychological report concerning a claimant who is receiving treatment or is being evaluated for psychiatric or psychological problems may be withheld from the claimant. In that event, a summary of the report shall be compiled by the reporting psychiatrist or clinical doctoral-level psychologist. The summary shall be provided to the claimant upon his or her request. Any representative or attorney of the claimant must agree to provide the claimant with only the summary before the full report is provided to the representative or attorney for his or her use in preparing the claimant's case. The report shall only be withheld from the claimant in those instances where the treating or evaluating psychiatrist or clinical doctoral-level psychologist certifies that exposure to the contents of the full report is likely to cause serious harm to the claimant or is likely to cause the claimant to pose a serious threat of harm to a third party.

(g) In any matter arising under §23-1-1 *et seq.*, §23-2-1 *et seq.*, §23-2A-1 *et seq.*, §23-2C-1 *et seq.*, §23-4-1 *et seq.*, §23-4A-1, §23-4B-1 *et seq.*, and §23-5-1 *et seq*. of this code in which the Insurance Commissioner is required to give notice to a party, if a party is represented by an attorney or other representative, then notice to the attorney or other representative is sufficient notice to the party represented.

§23-1-14. Forms.

The Insurance Commissioner shall prepare and furnish free of cost forms (and provide in his or her rules for their distribution so that they may be readily available) of applications for benefits for compensation, notices to employers, proofs of injury or death, of medical attendance, of employment and wage earnings, and any other forms considered proper and advisable. It is the duty of employers to constantly keep on hand a sufficient supply of the forms.

§23-1-15. Procedure before Insurance Commissioner.

The Insurance Commissioner is not bound by the usual common-law or statutory rules of evidence, but shall adopt formal rules of practice and procedure as herein provided, and may make investigations in a manner that in his or her judgment is best calculated to ascertain the substantial rights of the parties and to carry out the provisions of this chapter.

§23-1-16.

Repealed.

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

§23-1-17. Annual report by the Insurance Commissioner and Occupational Pneumoconiosis Board.

[Repealed.]

§23-1-18. Insurance Commissioner employees not subject to subpoena for workers' compensation hearings.

No employee of the Insurance Commissioner shall be compelled to testify as to the basis, findings, or reasons for any decision or order rendered by the employee under this chapter in any hearing conducted pursuant to §23-5-1 *et seq*. of this code.

§23-1-19. Civil remedies.

(a) Any person, firm, corporation, or other entity which willfully, by means of false statement or representation, or by concealment of any material fact, or by other fraudulent scheme, device, or artifice on behalf of himself or herself, itself, or others, obtains or attempts to obtain benefits, payments, allowances, or reduced premium costs or other charges, including Workers' Compensation coverage, from the Insurance Commissioner, a private carrier, or self-insured employer, to which he, she, or it is not entitled, or in a greater amount than that to which he, she, or it is entitled, shall be liable to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, in an amount equal to three times the amount of such benefits, payments, or allowances to which he, she, or it is not entitled and shall be liable for the payment of reasonable attorney fees and all other fees and costs of litigation.

(b) No criminal action or indictment need be brought against any person, firm, corporation, or other entity as a condition for establishing civil liability hereunder.

(c) A civil action under this section may be prosecuted and maintained on behalf of the Insurance Commissioner, a private carrier, or self-insured employer by any attorney in contract with or employed by the Insurance Commissioner, a private carrier, or self-insured employer to provide such representation.

(d) Venue for a civil action under this section shall be either in the county in which the defendant resides or in Kanawha County as selected by the Insurance Commissioner. Venue for a civil action under this section for private carriers and self-insured employers shall be either in the county in which the defendant resides or the county in which the injured worker was employed, as selected by the private carrier or self-insured employer.

(e) The remedies and penalties provided in this section are in addition to those remedies and penalties provided elsewhere by law.

§23-1-20. Employment preference for employees in workers' compensation litigation unit.

[Repealed.]

§23-1-21. Authorization to require the electronic invoices and transfers.

(a) The Insurance Commissioner shall establish a program to require the acceptance of disbursements by electronic transfer from the funds created in §23-2C-1 *et seq*. of this code to employers, vendors, claimants, and all others lawfully entitled to receive such disbursements.

(b) The Insurance Commissioner may establish a program to require payments of deposits and other funds into the funds created in §23-2C-1 *et seq*. of this code by electronic transfer of funds.

(c) The Insurance Commissioner may establish a program whereby invoices and other charges against the funds created in §23-2C-1 *et seq*. of this code may be submitted to the Insurance Commissioner by electronic means.

(d) Any program authorized by this section must be implemented through a rule promulgated by the Workers' Compensation Industrial Council.

§23-2-1. Employers subject to chapter; elections not to provide certain coverages; notices; filing of business registration certificates.

(a) The State of West Virginia and all governmental agencies or departments created by it, including county boards of education, political subdivisions of the state, any volunteer fire department or company, and other emergency service organizations as defined by §15-5-1 *et seq*. of this code, and all persons, firms, associations, and corporations regularly employing another person or persons for the purpose of carrying on any form of industry, service, or business in this state, are employers within the meaning of this chapter and are subject to all requirements of this chapter and all rules prescribed by the Industrial Council pursuant to §23-2C-5 of this code.

(b) The following employers are not required to procure workers' compensation insurance, but may elect to do so:

(1) Employers of employees in domestic services;

(2) Employers of five or fewer full-time employees in agricultural service;

(3) Employers of employees while the employees are employed without the state except in cases of temporary employment without the state;

(4) Casual employers. An employer is a casual employer when the number of his or her employees does not exceed three and the period of employment is temporary, intermittent, and sporadic in nature and does not exceed 10 calendar days in any calendar quarter;

(5) Churches;

(6) Employers engaged in organized professional sports activities, including employers of trainers and jockeys engaged in thoroughbred horse racing;

(7) Any volunteer rescue squad or volunteer police auxiliary unit organized under the auspices of a county commission, municipality, or other government entity or political subdivision; volunteer organizations created or sponsored by government entities or political subdivisions; or area or regional emergency medical services boards of directors in furtherance of the purposes of the Emergency Medical Services Act of §16-4C-1 *et seq*. of this code: *Provided*, That if any of the employers described in this subdivision have paid employees, to the extent of those paid employees, the employer shall procure workers' compensation insurance based upon the gross wages of the paid employees, but with regard to the volunteers, the coverage remains optional;

(8) Taxicab drivers of taxicab companies operating under §24A-2-1 *et seq*. of this code, who provide taxicab service pursuant to a written or electronic agreement that identifies the taxicab driver as an independent contractor consistent with the West Virginia Employment Law Worker Classification Act as set forth in §21-5I-1 *et seq*. of this code: *Provided*, That any such taxicab driver identified as an independent contractor shall not be eligible for workers'

compensation benefits under this chapter as an employee of the taxicab company.

(9) Any employer whose employees are eligible to receive benefits under the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §901 *et seq*., but only for those employees eligible for those benefits.

(c) Notwithstanding any other provision of this chapter to the contrary, whenever there are churches in a circuit which employ one individual clergyman and the payments to the clergyman from the churches constitute his or her full salary, such circuit or group of churches may elect to be considered a single employer.

(d) The following employers may elect not to provide coverage to certain of their employees under the provisions of this chapter:

(1) Any political subdivision of the state including county commissions and municipalities, boards of education, or emergency services organizations organized under the auspices of a county commission may elect not to provide coverage to any elected official. The election not to provide coverage does not apply to individuals in appointed positions or to any other employees of the political subdivision;

(2) If an employer is a partnership, sole proprietorship, association, or corporation, the employer may elect not to include as an "employee" within this chapter any member of the partnership, the owner of the sole proprietorship, or any corporate officer or member of the board of directors of the association or corporation. The officers of a corporation or an association shall consist of a president, a vice president, a secretary, and a treasurer, each of whom is elected by the board of directors at the time and in the manner prescribed by the bylaws. Other officers and assistant officers that are considered necessary may be elected or appointed by the board of directors or chosen in any other manner prescribed by the bylaws and, if elected, appointed, or chosen, the employer may elect not to include the officer or assistant officer as an "employee" within the meaning of this chapter: *Provided*, That except for those persons who are members of the board of directors or who are the corporation's or association's president, vice president, secretary, and treasurer and who may be excluded by reason of their positions from workers' compensation benefits required by this chapter even though their duties, responsibilities, activities, or actions may have a dual capacity of work which is ordinarily performed by an officer and also of work which is ordinarily performed by a worker, an administrator, or an employee who is not an officer, no other officer or assistant officer who is elected or appointed shall be excluded by election from coverage or be denied benefits merely because he or she is an officer or assistant officer if, as a matter of fact:

(A) He or she is engaged in a dual capacity of having the duties and responsibilities for work ordinarily performed by an officer and also having duties and work ordinarily performed by a worker, administrator, or employee who is not an officer;

(B) He or she is engaged ordinarily in performing the duties of a worker, an administrator,

or an employee who is not an officer and receives pay for performing the duties in the capacity of an employee; or

(C) He or she is engaged in an employment palpably separate and distinct from his or her official duties as an officer of the association or corporation;

(3) If an employer is a limited liability company, the employer may elect not to include as an "employee" within this chapter a total of no more than four persons, each of whom are acting in the capacity of manager, officer, or member of the company.

(e) "Regularly employing" or "regular employment" means employment by an employer which is not a casual employer under this section.

§23-2-1a. Employees subject to chapter.

(a) Employees subject to this chapter are all persons in the service of employers, except those classified as an independent contractor pursuant to §21-5I-4 of this code, and employed by them for the purpose of carrying on the industry, business, service, or work in which they are engaged, including, but not limited to:

(1) Persons regularly employed in the state whose duties necessitate employment of a temporary or transitory nature by the same employer without the state;

(2) Every person in the service of the state or of any political subdivision or agency thereof, under any contract of hire, express or implied, and every appointed official or officer thereof while performing his or her official duties;

(3) Checkweighmen employed according to law;

(4) All members of rescue teams assisting in mine accidents with the consent of the owner who, in such case, shall be deemed the employer, or at the direction of the director of the department of mines;

(5) All forest firefighters who, under the supervision of the Director of the Division of Natural Resources or his or her designated representative, assist in the prevention, confinement, and suppression of any forest fire; and

(6) Students while participating in a work-based learning experience with an employer approved as a part of the curriculum by the county board. The county board shall be the employer of record of students while participating in unpaid work-based experiences off school premises with employers other than the county board. Students in unpaid work-based learning experiences shall be considered to be paid the amount of wages so as to provide the minimum workers' compensation weekly benefits required by §23-4-6 of this code.

(b) The right to receive compensation under this chapter shall not be affected by the fact that a minor is employed or is permitted to be employed in violation of the laws of this state relating to the employment of minors, or that he or she obtained his or her employment by misrepresenting his or her age.

§23-2-1b. Special provisions as to premiums.

[Repealed.]

§23-2-1c. Extraterritorial coverage; approval and change of agreements.

(a) Whenever there is a possibility of conflict with respect to the application of workers' compensation laws because the contract of employment is entered into and all or some portion of the work is performed or is to be performed in a state or states other than this state, the employer and the employee may agree to be bound by the laws of this state or by the laws of any other state in which all or some portion of the work of the employee is to be performed: *Provided*, That nothing in this section shall be construed as to require an agreement in those instances where §23-2-1(b)(3) or §23-2-1a(a)(1) of this code are applicable. If the parties agree to be bound by the laws of this state, an employee injured within the terms and provisions of this chapter is entitled to benefits under this chapter regardless of the situs of the injury or exposure to occupational pneumoconiosis or other occupational disease, and the rights of the employee and his or her dependents under the laws of this state shall be the exclusive remedy against the employer on account of injury, disease, or death in the course of and as a result of the employment.

(b) If the parties agree to be bound by the laws of another state and the employer has complied with the laws of that state, the rights of the employee and his or her dependents under the laws of that state shall be the exclusive remedy against the employer on account of injury, disease, or death in the course of and as a result of the employment without regard to the situs of the injury or exposure to occupational pneumoconiosis or other occupational disease.

(c) If the employee is a resident of a state other than this state and is subject to the terms and provisions of the workers' compensation law or similar laws of a state other than this state, the employee and his or her dependents are not entitled to the benefits payable under this chapter on account of injury, disease, or death in the course of and as a result of employment temporarily within this state, and the rights of the employee and his or her dependents under the laws of the other state shall be the exclusive remedy against the employer on account of any injury, disease or death.

(d) If any employee or his or her dependents are awarded workers' compensation benefits or recover damages from the employer under the laws of another state for an injury received in the course of and resulting from the employment, the amount awarded or recovered, whether paid or to be paid in future installments, shall be credited against the amount of any benefits payable under this chapter for the same injury.

§23-2-1d. Prime contractors and subcontractors liability.

(a) The Legislature finds that every prime contractor should be responsible to ensure that any subcontractor with which it directly contracts is either self-insured or maintains workers' compensation coverage throughout the periods during which the services of a subcontractor are used and, further, if the subcontractor is neither self-insured nor covered, then the prime contractor rather than the Uninsured Employer Fund should be responsible for the payment of statutory benefits. It is also the intent of the Legislature that this section not be used as the basis for expanding the liability of a prime contractor beyond the limited purpose of providing coverage in the limited circumstances and in the manner expressly addressed by this section: *Provided*, That receipt by the prime contractor of a certificate of coverage from a subcontractor shall be deemed to relieve the prime contractor of responsibility regarding the subcontractor's workers' compensation coverage.

(b) If an employee of a subcontractor suffers an injury or disease and, on the date of injury or last exposure, his or her employer did not have workers' compensation coverage or was not an approved self-insured employer, and the prime contractor did not obtain certification of coverage from the subcontractor, then that employee may file a claim against the prime contractor for which the subcontractor performed services on the date of injury or last exposure, and such claim shall be administered in the same manner as claims filed by injured employees of the prime contractor: *Provided*, That a subcontractor that subcontracts with another subcontractor shall, with respect to such subcontract, be the prime contractor for the purposes of this section: *Provided, however*, That the provisions of this subsection do not relieve a subcontractor from any requirements of this chapter, including the duty to maintain coverage on its employees. The subcontractor shall provide proof of continuing coverage to the prime contractor by providing a certificate showing current as well as renewal or replacement coverage during the term of the contract between the prime contractor and the subcontractor. The subcontractor shall provide notice to the prime contractor within two business days of cancellation of expiration of coverage.

(c) Notwithstanding that an injured employee of a subcontractor is eligible for workers' compensation benefits pursuant to this section from the prime contractor's carrier or the self-insured prime contractor, whichever is applicable, a subcontractor who has failed to maintain workers' compensation coverage on its employees:

(1) May not claim the exemption from liability provided by §23-2-6 and §23-2-6a of this code;

(2) May be held liable to an injured employee pursuant to the provisions of §23-2-8 of this code; and

(3) Is the designated employer for the purposes of any "deliberate intention" action brought by the injured worker pursuant to the provisions of §23-4-2 of this code.

(d) If a claim of an injured employee of a subcontractor is accepted or conditionally accepted into the Uninsured Employer Fund, both the prime contractor and subcontractor are jointly

and severally liable for any payments made by the fund, and the Insurance Commissioner may seek recovery of the payments, plus administrative costs and attorneys' fees, from the prime contractor, the subcontractor, or both: *Provided*, That a prime contractor who is held liable pursuant to this subsection for the payment of benefits to an injured employee of a subcontractor may recover the amount of such payments from the subcontractor, plus reasonable attorneys' fee and costs: Provided, however, That if a prime contractor has performed due diligence in all matters requiring the verification of a subcontractor's maintenance of workers' compensation insurance coverage, then the prime contractor is not liable for any claim made hereunder against the subcontractor.

§23-2-2. Insurance Commissioner to be furnished information by employers, State Tax Commissioner, and WorkForce West Virginia; secrecy of information; examination of employers, etc.; violation a misdemeanor.

(a) Every employer shall furnish the Insurance Commissioner, upon request, all information required by him or her to carry out the purposes of this chapter. Every employer shall have a continuous and ongoing duty to maintain current information about its activities, risks, and rates regarding workers' compensation coverage. The Insurance Commissioner may examine under oath any employer or officer, agent, or employee of any employer.

(b) Notwithstanding the provisions of any other statute to the contrary, specifically, but not exclusively, §11-10-5, §11-10-5b, and §21A-10-11 of this code, the Insurance Commissioner may receive the following information:

(1) Upon written request to the State Tax Commissioner: The names, addresses, places of business, and other identifying information of all businesses receiving a business franchise registration certificate and the dates thereof; and the names and social security numbers or other tax identification numbers of the businesses and of the businesses' workers and employees, if otherwise collected, and the quarterly or other applicable reporting period and annual gross wages or other compensation paid to the workers and employees of businesses reported pursuant to the requirement of withholding of tax on income.

(2) Upon written application to WorkForce West Virginia: In addition to the information that may be released to the Insurance Commissioner for the purposes of this chapter under the provisions of Chapter 21A of this code, the names, addresses, and other identifying information of all employing units filing reports and information pursuant to §21A-10-11 of this code as well as information contained in those reports regarding the number and names, addresses, and social security numbers of employees employed and the gross quarterly or other applicable reporting period wages paid by each employing unit to each identified employee.

(c) All information acquired by the Insurance Commissioner pursuant to §23-2-2(b) of this code shall be used only for the performance of the functions necessary for the regulation of the workers' compensation insurance industry and other duties as set forth in this chapter.

(d) Reasonable costs of compilation and production of any information made available pursuant to §23-2-2(b) of this code shall be charged to the Insurance Commissioner.

(e) Information acquired by the Insurance Commissioner pursuant to §23-2-2(b) of this code is not subject to disclosure under the provisions of Chapter 29B of this code.

§23-2-3. Report forms and other forms for use of employers.

The Insurance Commissioner shall prepare and furnish report forms for the use of employers subject to this chapter. Every employer receiving from the Insurance Commissioner any form or forms with direction for completion and returning to the Insurance Commissioner shall return the form, within the period fixed by the Insurance Commissioner, completed as to answer fully and correctly all pertinent questions in the form, and if unable to do so, shall give good and sufficient reasons for the failure.

§23-2-4. Classification of industries; rate of premiums; authority to adopt various systems; accounts.

[Repealed.]

§23-2-5. Notice to employees.

Upon discovery that an employer is not maintaining West Virginia workers' compensation insurance, the Insurance Commissioner shall issue a written notice to the employees of that employer. Notice to employees provided in this section shall be given by posting written notice that the employer is defaulted under the compensation law of West Virginia and that the defaulted employer is liable to its employees for injury or death, both in Workers' Compensation benefits and in damages at common law or by statute. The notice shall be in the form prescribed by the Insurance Commissioner and shall be posted in a conspicuous place at the chief works of the employer, as it appears in records of the Insurance Commissioner. If the chief works of the employer cannot be found or identified, the notices shall be posted at the front door of the courthouse of the county in which the chief works are located, according to the Insurance Commissioner's records. Any person who shall, prior to the reinstatement of the employer, as provided in this section, or prior to sixty days after the posting of the notice, whichever shall first occur, remove, deface, or render illegible the notice, shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined $1,000. The notice shall state this provision upon its face. The Insurance Commissioner may require any sheriff, deputy sheriff, constable, or other official of the State of West Virginia, authorized to serve civil process, to post the notice and to make return thereof of the fact of the posting to the Insurance Commissioner. Any failure of the officer to post any notice within 10 days after he or she has received the notice from the Insurance Commissioner, without just cause or excuse, constitutes a willful failure or refusal to perform a duty required of him or her by law within the meaning of §61-5-28 of this code. Any person actually injured by reason of the failure has an action against the official, and upon any official bond he or she may have given, for the damages as the person may actually have incurred, but not to exceed, in the case of any surety upon the bond, the amount of the penalty of the bond. Any official posting the notice as required in this section is entitled to the same fee as is now or may hereafter be provided for the service of process in suits instituted in courts of record in the State of West Virginia. The fee shall be paid by the Insurance Commissioner out of any funds at his or her disposal.

§23-2-5a. Collection of premiums from defaulting employers; interest and penalties; civil remedies; creation and enforcement of lien against employer and purchaser; duty of Secretary of State to register liens; distraint powers; insolvency proceedings; Secretary of State to withhold certificates of dissolution; injunctive relief; bond; attorney fees and costs.

(a) The Insurance Commissioner in the name of the state may commence a civil action against an employer who, after due notice, defaults in any payment required by this chapter. If judgment is against the employer, the employer shall pay the costs of the action. A civil action under this section shall be given preference on the calendar of the court over all other civil actions. Upon prevailing in a civil action, the Insurance Commissioner is entitled to recover its attorneys' fees and costs of action from the employer.

(b) In addition to the provisions of §23-2-5a(a) of this code, any payment, interest and penalty due and unpaid under this chapter is a personal obligation of the employer immediately due and owing to the Insurance Commissioner and shall, in addition, be a lien enforceable against all the property of the employer: *Provided*, That the lien shall not be enforceable as against a purchaser (including a lien creditor) of real estate or personal property for a valuable consideration without notice, unless docketed as provided in §38-10C-1 of this code: *Provided, however*, That the lien may be enforced as other judgment liens are enforced through the provisions of said chapter and the same is considered deemed by the circuit court to be a judgment lien for this purpose.

(c) In addition to all other civil remedies prescribed, the Insurance Commissioner may in the name of the state, after giving appropriate notice as required by due process, distrain upon any personal property, including intangible property, of any employer delinquent for any payment, interest, and penalty thereon. If the Insurance Commissioner has good reason to believe that the property or a substantial portion of the property is about to be removed from the county in which it is situated, upon giving appropriate notice, either before or after the seizure, as is proper in the circumstances, the Insurance Commissioner may likewise distrain in the name of the state before the delinquency occurs. For that purpose, the Insurance Commissioner may require the services of a sheriff of any county in the state in levying the distress in the county in which the sheriff is an officer and in which the personal property is situated. A sheriff collecting any payment, interest, and penalty thereon is entitled to the compensation as provided by law for his or her services in the levy and enforcement of executions. Upon prevailing in any distraint action, the Insurance Commissioner is entitled to recover its attorneys' fees and costs of action from the employer.

(d) In case a business subject to the payments, interest, and penalties thereon imposed under this chapter is operated in connection with a receivership or insolvency proceeding in any state court in this state, the court under whose direction the business is operated shall, by the entry of a proper order or decree in the cause, make provisions, so far as the assets in administration will permit, for the regular payment of the payments, interest, and penalties as they become due.

(e) The Secretary of State of this state shall withhold the issuance of any certificate of dissolution or withdrawal in the case of any corporation organized under the laws of this state or organized under the laws of any other state and admitted to do business in this state, until notified by the Insurance Commissioner that all payments, interest, and penalties thereon against the corporation which is an employer under this chapter have been paid or that provision satisfactory to the Insurance Commissioner has been made for payment.

(f) In any case when an employer is in default to the Old Fund or has a liability to the Uninsured Employer Fund or is in default on a policy or otherwise fails to maintain mandatory workers' compensation coverage, the Insurance Commissioner may bring action in the circuit court of Kanawha County to enjoin the employer from continuing to operate the employer's business as provided for in §33-2-22 of this code: *Provided*, That the Insurance Commissioner may, in his or her sole discretion and as an alternative to this action, require the delinquent employer to file a bond in the form prescribed by the Insurance Commissioner with satisfactory surety in an amount not less than 150 percent of the total payments, interest, and penalties due.

§23-2-5b.

Repealed.

Acts, 2003 2nd Ex. Sess., Ch. 27.

§23-2-5c. Statute of limitations; effective date for new payments; previous payments due not affected.

[Repealed.]

§23-2-5d. Uncollectible receivables; write-offs.

[Repealed.]

§23-2-6. Exemption of contributing employers from liability.

Any employer subject to this chapter who procures and continuously maintains workers' compensation insurance as required by this chapter or who elects to make direct payments of compensation as provided in this section is not liable to respond in damages at common law or by statute for the injury or death of any employee, however occurring, after so subscribing or electing, and during any period in which the employer is not in default and has complied fully with all other provisions of this chapter. Continuation in the service of the employer shall be considered a waiver by the employee and by the parents of any minor employee of the right of action as aforesaid, which the employee or his or her parents would otherwise have: *Provided*, That in case of employers not required by this chapter to procure and maintain workers' compensation insurance, the injured employee has remained in the employer's service with notice that his or her employer has elected to procure and maintain workers' compensation insurance, or has elected to make direct payments as aforesaid.

§23-2-6a. Exemption from liability of officers, managers, agents, representatives or employees of contributing employers.

The immunity from liability set out in the preceding section shall extend to every officer, manager, agent, representative or employee of such employer when he is acting in furtherance of the employer's business and does not inflict an injury with deliberate intention.

§23-2-7. Benefits of chapter may not be waived by contract or regulation.

No employer or employee shall exempt himself or herself from the burden or waive the benefits of this chapter by any contract, agreement, rule, or regulation, and any such contract, agreement, rule, or regulation shall be pro tanto void.

§23-2-8. Liability of employer for failing to procure or maintain workers' compensation insurance; certain common-law defenses prohibited; exceptions.

All employers who fail to procure and continuously maintain workers' compensation insurance as required by this chapter or who fail to obtain permission to self-insure their workers' compensation risk as permitted by §23-2-9 of this code shall be liable to their employees (within the meaning of this article) for all damages suffered by reason of personal injuries sustained in the course of employment caused by the wrongful act, neglect, or default of the employer or any of the employer's officers, agents, or employees while acting within the scope of their employment and in the course of their employment and also to the personal representatives of such employees where death results from such personal injuries, and in any action by any such employee or personal representative thereof, such defendant shall not avail himself or herself of the following common-law defenses: The defense of the fellow-servant rule; the defense of the assumption of risk; or the defense of contributory negligence; and further shall not avail himself or herself of any defense that the negligence in question was that of someone whose duties are prescribed by statute: *Provided*, That such provision depriving a defendant employer of certain common-law defenses under the circumstances therein set forth shall not apply to an action brought against a county court, Board of Education, municipality, or other political subdivision of the state, or against any employer not required to cover his or her employees under the provisions of this chapter.

§23-2-9. Election of employer or employers' group to be self-insured and to provide own system of compensation; exceptions; self administration; rules; penalties; regulation of self-insurers.

(a) Notwithstanding any provisions of this chapter to the contrary, the following types of employers or employers' groups may apply for permission to self-insure their workers' compensation risk.

(1) The types of employers are:

(A) Any employer who is of sufficient capability and financial responsibility to ensure the payment to injured employees and the dependents of fatally injured employees of benefits provided in this chapter at least equal in value to the compensation provided for in this chapter;

(B) Any employer or group of employers as provided in §23-2-9(a)(1)(A) of this code of such capability and financial responsibility that maintains its own benefit fund or system of compensation to which its employees are not required or permitted to contribute and whose benefits are at least equal in value to those provided in this chapter; or

(C) Any employer who is signatory to a collective bargaining agreement that allows for participation in a group workers' compensation insurance program may join with any other employer or employers that are signatory to a collective bargaining agreement or agreements that allow for participation in a group workers' compensation program and jointly apply to the Insurance Commissioner to collectively self-insure their obligations under this chapter. The employers must collectively meet the conditions set forth in §23-2-9(a)(1)(A) and (B) of this code. There shall be joint and several liability for all employers who choose to jointly self-insure under the provisions of this article.

(2) In order to be approved for self-insurance status, the employer shall:

(A) Submit all information requested by the Insurance Commissioner;

(B) Provide security or bond, in an amount and form determined by the Insurance Commissioner, which shall balance the employer's financial condition based upon an analysis of its audited financial statements and the full accrued value of current liability for future claim payments based upon generally accepted actuarial and accounting principles of the employer's existing and expected liability;

(C) Meet the financial responsibility requirements set forth in rules promulgated by the industrial council;

(D) Obtain and maintain a policy of excess insurance if required to do so by the Insurance Commissioner; and

(E) Have an effective health and safety program at its workplaces.

(3) Upon a finding that the employer has met all of the requirements of this section and any rules promulgated thereunder, the employer may be permitted self-insurance status. An annual review of each self-insurer's continuing ability to meet its obligations and the requirements of this section shall be made by the Insurance Commissioner. At the time of such review, the Insurance Commissioner may require that the self-insured employer post a bond or security or obtain and maintain an excess insurance policy. This review shall also include a recalculation of the amount of any security, bond, or policy of excess insurance previously required to be posted or obtained under any provision of this chapter or any rules promulgated thereunder. Failure to provide the required amount or form of security or bond or to obtain or maintain the required excess insurance policy may cause the employer's self-insurance status to be terminated by the Insurance Commissioner.

(4) Whenever a self-insured employer furnishes security or bond, including replacement and amended bonds and other securities, as surety to ensure the employer's or guarantor's payment of all obligations under this chapter for which the security or bond was furnished, the security or bond shall be in the most current form or forms approved and authorized by the Insurance Commissioner for use by the employer or its guarantors, surety companies, banks, financial institutions, or others in its behalf for that purpose.

(b)(1) Notwithstanding any provision in this chapter to the contrary, self-insured employers shall, effective July 1, 2004, administer their own claims. The Insurance Commissioner shall, pursuant to rules promulgated by the industrial council, regulate the administration of claims by employers granted permission to self-insure their obligations under this chapter. A self-insured employer shall comply with rules promulgated by the industrial council governing the self-administration of its claims.

(2) An employer or employers' group that self-insures its risk and self-administers its claims shall exercise all authority and responsibility granted to the Insurance Commissioner or private carriers in this chapter and provide notices of action taken to effect the purposes of this chapter to provide benefits to persons who have suffered injuries or diseases covered by this chapter. An employer or employers' group granted permission to self-insure and self-administer its obligations under this chapter shall at all times be bound and shall comply fully with all of the provisions of this chapter. Furthermore, all of the provisions contained in §23-4-1 *et seq*. of this code pertaining to disability and death benefits are binding on and shall be strictly adhered to by the self-insured employer in its administration of claims presented by employees of the self-insured employer. Violations of the provisions of this chapter and such rules relating to this chapter as may be approved by the industrial council may constitute sufficient grounds for the termination of the authority for any employer to self-insure its obligations under this chapter.

(c) Each self-insured employer shall, on or before the last day of the first month of each quarter or other assigned reporting period, file with the Insurance Commissioner a certified statement of the total gross wages and earnings of all of the employer's employees subject to this chapter for the preceding quarter or other assigned reporting period.

(d)(1) If a self-insured employer defaults in the payment of any portion of surcharges or assessments required under this chapter or rules promulgated thereunder, or in any payment required to be made as benefits provided by this chapter to the employer's injured employees or dependents of fatally injured employees, the Insurance Commissioner shall, in an appropriate case, determine the full accrued value based upon generally accepted actuarial and accounting principles of the employer's liability, including the costs of all awarded claims and of all incurred but not reported claims. The amount determined may, in an appropriate case, be assessed against the employer. The Insurance Commissioner may demand and collect the present value of the defaulted liability. Interest shall accrue upon the demanded amount as provided in §23-2-13 of this code until the liability is fully paid. Payment of all amounts then due to the Insurance Commissioner and to the employer's employees is a sufficient basis for reinstating the employer to good standing with the Insurance Commissioner and removing the employer from default status.

(2) The assessments and surcharges required to be paid by self-insured employers pursuant to the provisions of this chapter and the rules promulgated thereunder are special revenue taxes under and according to the provisions of state workers' compensation law and are considered to be tax claims, as priority claims or administrative expense claims according to those provisions under the law provided in the United States bankruptcy code, Title 11 of the United States Code. In addition, as the same was previously intended by the prior provisions of this section, this amendment and reenactment is for the purpose of clarification of the taxing authority of the Insurance Commissioner.

(e) Any self-insured employer which has had a period of inactivity due to the nonemployment of employees which results in its reporting of no wages on reports to the Insurance Commissioner for a period of four or more consecutive quarters may have its status inactivated and shall apply for reactivation to status as a self-insured employer prior to its reemployment of employees. Despite the inactivation, the self-insured employer shall continue to make payments on all awards for which it is responsible. Upon application for reactivation of its status as an operating self-insured employer, the employer shall document that it meets the eligibility requirements needed to maintain self-insured employer status under this section and any rules adopted to implement it. If the employer is unable to requalify and obtain approval for reactivation, the employer shall, effective with the date of employment of any employee, purchase workers' compensation insurance as provided in §23-2C-1 *et seq*. of this code, but shall continue to be a self-insurer as to the prior period of active status and to furnish security or bond and meet its prior self-insurance obligations.

(f) Self-insured employers may withdraw from self-insured status and purchase workers' compensation insurance as provided in §23-2C-1 *et seq*. of this code, but said self-insured employers shall remain liable for their self-insured employer claims liabilities for each claim with a date of injury or last exposure prior to the effective date of insurance coverage.

(g) Any employer subject to this chapter, who elects to carry the employer's own risk by being a self-insured employer and who has complied with the requirements of this section and of any applicable rules, shall not be liable to respond in damages at common law or by

statute for the injury or death of any employee, however occurring, after the election's approval and during the period that the employer is allowed to carry the employer's own risk.

(h) An employer may not hire any person or group to self-administer claims under this chapter as a third-party administrator unless the person or group has been determined to be qualified to be a third-party administrator by the Insurance Commissioner pursuant to rules adopted by the industrial council. Any person or group whose status as a third-party administrator has been revoked, suspended, or terminated by the Insurance Commissioner shall immediately cease administration of claims and shall not administer claims unless subsequently authorized by the Insurance Commissioner.

§23-2-9a. Sanctions for default by self-insured employers; rulemaking authority.

Whenever the authority of an employer to self-insure its obligations under this chapter is terminated and such employer is thereafter in default in the payment of any portion of surcharges or assessments required under this chapter or by rules promulgated thereunder, or in any payment required to be made as benefits provided by this chapter to the employer's injured employees or dependents of fatally injured employees, such employer shall be ineligible for government contracts to the same extent as an employer in "employer default," as provided for in section ten-a, article three, chapter five-a of this code, and shall also be subject to the license and permit revocation and termination sanctions to the same extent as employers in "employer default" pursuant to the provisions of subdivision (1), subsection (e), section nineteen, article two-c of this chapter. The Insurance Commissioner shall propose rules, as provided in section five, article two-c of this chapter, establishing administrative penalties for nonpayment of obligations under this chapter.

§23-2-10. Application of chapter to interstate commerce.

(a) In case any employer within the meaning of this chapter is also engaged in interstate or foreign commerce, and for whom a rule of liability or method of compensation has been established by the Congress of the United States, this chapter applies to him or her only to the extent that his or her mutual connection with work in this state is clearly separable and distinguishable from his or her interstate work, and to the extent that the work in this state is clearly separable and distinguishable from his or her interstate work, the employer is subject to the terms and provisions of this chapter in like manner as all other employers under this chapter. Payments of premiums shall be on the basis of the payroll of those employees who perform work in this state only.

(b) Unless and until the Congress of the United States has by appropriate legislation established a rule of liability or method of compensation governing employers and employees engaged in commerce within the purview of the commerce clause of the United States Constitution (article I, section 8), section one of this article applies without regard to the interstate or intrastate character or nature of the work or business engaged in.

§23-2-11. Partial invalidity of chapter.

If any provision of this chapter or the application of such provision to any circumstance is held to be unconstitutional or otherwise invalid, the remainder of this chapter or the application of the provisions to other circumstances shall not be affected thereby. The Legislature hereby declares that it would have passed the remainder of this chapter if it had known that such provision, or its application to any circumstances, would be declared unconstitutional or otherwise invalid.

§23-2-12. Effect of repeal or invalidity of chapter on action for damages.

If the provisions of this chapter relating to compensation for injuries to, or death of, workers are repealed or adjudged invalid or unconstitutional, the period intervening between the occurrence of any injury or death and the repeal, or the final adjudication of invalidity or unconstitutionality, shall not be computed as a part of the time limited by law for the commencement of any action relating to the injuries or death, but the amount of any compensation which may have been paid on account of injury or death shall be deducted from any judgment for damages recovered on account of the injury or death.

§23-2-13. Interest.

The interest due on payments pursuant to §23-2-9(d)(1) and §23-2C-8(d)(1) of this code shall be the prime rate plus four percent rounded to the nearest whole percent. The prime rate shall be the rate published in the Wall Street Journal on the last business day of the prior fiscal year reflecting the base rate on corporate loans posted by at least 75 percent of the nation's 30 largest banks: *Provided*, That in no event shall the rate of interest charged to a political subdivision of the state or a volunteer fire department exceed 10 percent per annum.

§23-2-14. Sale or transfer of business; attachment of lien for premium, etc.; payments due; criminal penalties for failure to pay; creation and avoidance or elimination of lien; enforcement of lien; successor liability.

[Repealed.]

§23-2-15. Liabilities of successor employer; waiver of payment by commission; assignment of predecessor employer's premium rate to successor.

[Repealed.]

§23-2-16. Acceptance or assignment of premium rate.

[Repealed.]

§23-2-17. Employer right to hearing; content of petition; appeal.

Notwithstanding any provision in this chapter to the contrary and notwithstanding any provision in §29A-5-5 of this code to the contrary, in any situation where an employer objects to a decision or action of the Insurance Commissioner, the employer is entitled to file a written demand for hearing upon the decision or action in accordance with §33-2-13 of this code. The written demand must be filed within 30 days of the employer's receipt of notice of the disputed Insurance Commissioner's decision or action or, in the absence of such receipt, within 60 days of the date of the decision, the time limitations being hereby declared to be a condition of the right to litigate the decision or action and therefore jurisdictional.

The employer's written demand shall clearly identify the decision or action disputed and the bases upon which the employer disputes the decision or action. Upon receipt of a written demand, the Insurance Commissioner shall schedule a hearing which shall be conducted in accordance with the provisions of §29A-5-1 *et seq*. and §33-2-13 of this code. An appeal from a final decision of the Insurance Commissioner shall be taken in accord with the provisions of §33-2-13 of this code.

§23-2-18.

Repealed.

Acts, 1995 Reg. Sess., Ch. 253.

§23-2A-1. Subrogation; limitations.

(a) Where a compensable injury or death is caused, in whole or in part, by the act or omission of a third party, the injured worker or, if he or she is deceased or physically or mentally incompetent, his or her dependents or personal representative are entitled to compensation under the provisions of this chapter, and shall not by having received compensation be precluded from making claim against the third party.

(b) Notwithstanding the provisions of §23-2A-1(a) of this code, if an injured worker, his or her dependents, or his or her personal representative makes a claim against the third party and recovers any sum for the claim:

(1) With respect to any claim arising from a right of action that arose or accrued, in whole or in part, on or after January 1, 2006, the private carrier or self-insured employer, whichever is applicable, shall be allowed statutory subrogation with regard to indemnity and medical benefits paid as of the date of the recovery.

(2) With respect to any claim arising from a right of action that arose or accrued, in whole or in part, prior to January 1, 2006, the Insurance Commissioner shall be allowed statutory subrogation with regard to only medical payments paid as of the date of the recovery: *Provided*, That with respect to any recovery arising out of a cause of action that arose or accrued prior to July 1, 2003, any money received by the Insurance Commissioner or self-insured employer as subrogation to medical benefits expended on behalf of the injured or deceased worker shall not exceed 50 percent of the amount received from the third party as a result of the claim made by the injured worker, his or her dependents or personal representative, after payment of attorneys' fee and costs, if such exist.

(3) Notwithstanding the provisions of §23-2A-1(b)(1) and (2) of this code, the Insurance Commissioner, acting as administrator of the Uninsured Employer Fund, shall be allowed statutory subrogation with regard to indemnity and medical benefits paid and to be paid from such fund regardless of the date on which the cause of action arose.

(c) For claims that arose or accrued, in whole or in part, prior to the effective date of the reenactment of this section in 2009, and all claims thereafter, the party entitled to subrogation shall permit the deduction from the amount received reasonable attorneys' fees and reasonable costs and may negotiate the amount to accept as subrogation.

(d) In the event that an injured worker, his or her dependents or personal representative makes a claim against a third party, there shall be, and there is hereby created, a statutory subrogation lien upon the moneys received which shall exist in favor of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable.

(e) It is the duty of the injured worker, his or her dependents, his or her personal representative, or his or her attorney to give reasonable notice to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, after a

claim is filed against the third party and prior to the disbursement of any third-party recovery. The statutory subrogation described in this section does not apply to uninsured and underinsured motorist coverage or any other insurance coverage purchased by the injured worker or on behalf of the injured worker. If the injured worker obtains a recovery from a third party and the injured worker, personal representative, or the injured worker's attorney fails to protect the statutory right of subrogation created herein, the injured worker, personal representative, and the injured worker's attorney shall lose the right to retain attorney fees and costs out of the subrogation amount. In addition, such failure creates a cause of action for the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, against the injured worker, personal representative, and the injured worker's attorney for the amount of the full subrogation amount and the reasonable fees and costs associated with any such cause of action.

§23-2A-2.

Repealed.

Acts, 1995 Reg. Sess., Ch. 253.

§23-2B-1. Occupational safety and health activities; voluntary compliance; consultative services.

[Repealed].

§23-2B-2. Mandatory programs; safety committees; requirements; rules; exceptions.

[Repealed].

§23-2B-3. Premium rate credits; qualified loss management program; loss management firms; penalties; rules.

[Repealed].

§23-2C-1. Findings and purpose.

(a) The Legislature finds that:

(1) There is a long-term actuarial funding crisis in the state-run monopolistic workers' compensation system;

(2) Similar short-term and long-term crises have been ongoing during the past two decades;

(3) During the current crisis, employers in West Virginia find it increasingly difficult to afford the rates charged by the Workers' Compensation Commission for workers' compensation coverage and that paying said rates adversely impacts employers' ability to compete in a global economic environment;

(4) The cost of obtaining workers' compensation coverage from the state system may result in many employers leaving the state;

(5) Employers' access to competitive workers' compensation rates and the resulting economic development benefit is of utmost importance to the citizens of West Virginia;

(6) A mechanism is needed to provide an enduring solution to this recurring workers' compensation crisis;

(7) An employers' mutual insurance company or a similar entity has proven to be a successful mechanism in other states for helping employers secure insurance and for stabilizing the insurance market;

(8) There is a substantial public interest in creating a method to provide a stable workers' compensation insurance market in this state;

(9) The state-run workers' compensation program is a substantial actual and potential liability to the state;

(10) There is substantial public benefit in transferring certain actual and potential future liability of the state to the private sector and creating a stable self-sufficient entity which will be a potential source of workers' compensation coverage for employers in this state;

(11) A stable, financially viable insurer in the private sector will aid in providing a continuing source of insurance funds to compensate injured workers; and

(12) Because the public will greatly benefit from the formation of an employers' mutual insurance company, state efforts to encourage and support the formation of such an entity, including providing funding for the entity's initial capital, is in the clear public interest.

(b) The purpose of this article is to create a mechanism for the formation of an employers' mutual insurance company that will provide:

(1) A means for employers to obtain workers' compensation insurance that is reasonably available and affordable; and

(2) Compensation to employees of mutual policyholders who suffer work place injuries as defined in this chapter.

(c) The employers' mutual insurance company contemplated and created as the successor to the former Workers' Compensation Commission in this article began operation on January 1, 2006. The state opened to a private, competitive market for workers' compensation insurance on July 1, 2008. This section remains in this code for historical purposes.

§23-2C-2. Definitions.

(a) “Insurance Commissioner” means the Insurance Commissioner of West Virginia as provided in §33-2-1 of this code.

(b) “Policy default” means a policyholder that has failed to comply with the terms of its workers’ compensation insurance policy and is consequently without workers’ compensation insurance coverage.

(c) “Workers’ compensation insurance” means insurance which provides all compensation and benefits required by this chapter.

(d) “Insurer” includes:

(1) A self-insured employer; and

(2) A private carrier.

(e) “Industrial Council” means the advisory group established in §23-2C-5 of this code.

(f) “Old Fund” means a fund held by the State Treasurer’s office consisting of those funds transferred to it from the defunct Workers’ Compensation Fund or other sources and those funds due and owing the defunct Workers’ Compensation Fund as of June 30, 2005, that are thereafter collected. The Old Fund and assets in the fund remain property of the state after the transition to a private market.

(g) “Old Fund liabilities” mean all claims payment obligations (indemnity and medical expenses), related liabilities and appropriate administrative expenses necessary for the administration of all claims, actual and incurred but not reported, for any claim with a date of injury or last exposure on or before June 30, 2005: *Provided*, That Old Fund liabilities include all claims payments for any claim, regardless of date of injury or last exposure, through December 31, 2005: *Provided, however*, That Old Fund liabilities include all claims with dates of injuries or last exposure prior to July 1, 2004, for bankrupt self-insured employers that had defaulted on their claims obligations which were recognized by the former Workers’ Compensation Commission in its actuarially determined liability number as of June 30, 2005.

(h) “Private carrier” means any insurer or the legal representative of an insurer authorized by the Insurance Commissioner to provide workers’ compensation insurance pursuant to this chapter. The term does not include a self-insured employer or private employers.

(i) “Uninsured Employer Fund” means a fund held by the State Treasurer’s office consisting of those funds transferred to it from the defunct Workers’ Compensation Fund and any other source. Disbursements from the Uninsured Employer Fund shall be upon requisitions signed by the Insurance Commissioner, and as otherwise set forth in an exempt legislative rule promulgated by the Industrial Council.

(j) “Self-Insured Employer Guaranty Risk Pool” is a fund held by the State Treasurer’s office consisting of those funds transferred to it from the guaranty pool created pursuant to 85 CSR 19 (2007) and any future funds collected through continued administration of that exempt legislative rule as administered by the Insurance Commissioner. Disbursements shall be made from the Self-Insured Employer Guaranty Risk Pool upon requisitions signed by the Insurance Commissioner. The obligations of the fund are as provided in 85 CSR 19 (2007).

(k) “Self-Insured Employer Security Risk Pool” is a fund held by the State Treasurer consisting of those funds paid into it through the Insurance Commissioner’s administration of 85 CSR 19 (2007). Disbursement from the fund shall be made from the Self-Insured Employer Security Risk Pool upon requisitions signed by the Insurance Commissioner. The obligations of the fund are as provided in 85 CSR 19: *Provided*, That the liabilities are limited to those self-insured employers who default on their claims obligations after the termination of the former Workers’ Compensation Commission.

(l) “Voluntary market” means the workers’ compensation insurance market in which insurers voluntarily offer coverage to applicants who meet the insurers’ underwriting standards or guidelines.

§23-2C-3. Private carriers not subject to certain premium taxes, surcharges, and credits; regulatory surcharge imposed on private carriers and self-insured employers.

Private carriers including the company, are not subject to payment of insurance premium taxes, surcharges, and credits contained in §33-3-1 et seq. of this code on premiums received for workers' compensation insurance coverage under this chapter. In lieu thereof, the workers' compensation insurance market is subject to the following:

(1)(A) With respect to fiscal years beginning on and after July 1, 2008, each private carrier shall collect a surcharge in the amount of five and five-tenths percent of the premium collected plus the total of all premium discounts based on deductible provisions that were applied: *Provided*, That prior to June 30, 2013, and every five years thereafter, the Insurance Commissioner shall review the percentage surcharge and determine a new percentage as he or she deems necessary; and

(B) The amounts required to be collected under §23-2C-3(a)(1)(A) of this code shall be remitted to the Insurance Commissioner on or before the twenty-fifth day of the month succeeding the end of the quarter in which they are collected, except for the fourth quarter for which the surcharge shall be remitted on or before March 1 of the succeeding year.

(2) Each fiscal year, the Insurance Commissioner shall calculate a percentage surcharge to be remitted on a quarterly basis by self-insured employers and said percentage shall be calculated by dividing the previous year's self-insured payroll in the state into the portion of the Insurance Commissioner's budget amount attributable to regulation of the self-insured employer market. This resulting percentage shall be applied to each self-insured employer's payroll and the resulting amount shall be remitted as a regulatory surcharge by each self-insured employer. The Industrial Council may promulgate a rule for implementation of this section. All private carriers and self-insured employers shall furnish the Insurance Commissioner with all required information and cooperate in all respects necessary for the Insurance Commissioner to perform the duties set forth in this section and in other provisions of this chapter and Chapter 33 of this code. The surcharge shall be calculated so as to only defray the costs associated with the administration of this chapter and the funds raised shall not be used for any other purpose.

§23-2C-3a. Employers' mutual insurance company - additional provisions enacted in November 2005.

[Repealed.]

§23-2C-4. Governance and organization.

[Repealed.]

§23-2C-5. Creation of the industrial council; duties.

(a) There is hereby created within the Office of the Insurance Commissioner an industrial council.

(b) On or before July 1, 2005, the Governor, with the advice and consent of the Senate, shall appoint five voting members to the industrial council who meet the requirements and qualifications prescribed in this subsection. Two members of the West Virginia Senate and two members of the West Virginia House of Delegates shall serve as advisory nonvoting members of the board. The Governor shall appoint the legislative members to the board. No more than three of the legislative members may be of the same political party. The Insurance Commissioner shall serve as an advisory nonvoting member of the board.

(1) (A) Five members shall be appointed by the Governor with the advice and consent of the Senate for terms that begin upon appointment after the effective date of this legislation and expire as follows:

(i) One member shall be appointed for a term ending June 30, 2007;

(ii) Two members shall be appointed for a term ending June 30, 2008; and

(iii) Two members shall be appointed for a term ending June 30, 2009.

(B) Except for appointments to fill vacancies, each subsequent appointment shall be for a term ending June 30 of the fourth year following the year the preceding term expired. In the event a vacancy occurs, it shall be filled by appointment for the unexpired term. A member whose term has expired shall continue in office until a successor has been duly appointed and qualified. No member of the council may be removed from office by the Governor except for official misconduct, incompetency, neglect of duty, or gross immorality.

(C) No appointed member may be a candidate for or hold elected office. Members may be reappointed for no more than two full terms.

(2) Each of the appointed voting members of the council shall be appointed based upon his or her demonstrated knowledge and experience to effectively accomplish the purposes of this chapter. They shall meet the minimum qualifications as follows:

(A) Each shall hold a baccalaureate degree from an accredited college or university: *Provided*, That no more than one of the appointed voting members may serve without a baccalaureate degree from an accredited college or university if the member has a minimum of 15 years' experience in his or her field of expertise as required in this subdivision;

(B) Each shall have a minimum of 10 years' experience in his or her field of expertise. The Governor shall consider the following guidelines when determining whether potential candidates meet the qualifications of this subsection: Expertise in insurance claims management; expertise in insurance underwriting; expertise in the financial management of

pensions or insurance plans; expertise as a trustee of pension or trust funds of more than 200 beneficiaries or $300 million; expertise in workers' compensation management; expertise in loss prevention and rehabilitation; expertise in occupational medicine demonstrated by licensure as a medical doctor in West Virginia and experience, board certification, or university affiliation; or expertise in similar areas of endeavor;

(C) At least one shall be a certified public accountant with financial management or pension or insurance audit expertise; at least one shall be an attorney with financial management experience; one shall be an academician holding an advanced degree from an accredited college or university in business, finance, insurance, or economics; and one shall represent organized labor;

(D) The council shall appoint one member to serve as chairperson. The chairperson shall serve for a one-year term and may serve more than one consecutive term. The council shall hold meetings at the request of the chairperson or at the request of at least three of the members of the council, but no less frequently than once every three months. The chairperson shall determine the date and time of each meeting. Three members of the council constitute a quorum for the conduct of the business of the council. No vacancy in the membership of the council shall impair the right of a quorum to exercise all the rights and perform all the duties of the council. No action shall be taken by the council except upon the affirmative vote of three members of the council.

(3)(A) Each voting appointed member of the council shall receive compensation of not more than $350 per day for each day during which he or she is required to and does attend a meeting of the board.

(B) Each voting appointed member of the council is entitled to be reimbursed for actual and necessary expenses incurred for each day or portion thereof engaged in the discharge of official duties in a manner consistent with guidelines of the Travel Management Office of the Department of Administration.

(C) Each member of the council shall be provided appropriate liability insurance, including, but not limited to, errors and omissions coverage, without additional premium, by the state Board of Risk and Insurance Management established pursuant to §29-12-1 *et seq*. of this code.

(c) The industrial council shall:

(1) In consultation with the Insurance Commissioner, establish operating guidelines and policies designed to ensure the effective administration of the workers' compensation insurance market in West Virginia.

(2) Review and approve, reject or modify rules that are proposed by the Insurance Commissioner for operation and regulation of the workers' compensation insurance market before the rules are filed with the Secretary of State. The rules adopted by the industrial

council are not subject to §29A-3-9 through §29A-3-16 of this code. The industrial council shall follow the remaining provisions of said chapter for giving notice to the public of its actions and for holding hearings and receiving public comments on the rules.

(3) In accordance with the laws and rules of West Virginia, establish and monitor performance standards and measurements to ensure the timeliness and accuracy of activities performed under chapter 23 of this code and applicable rules.

(4) Submit for approval by the Legislature, as an isolated and clearly discernable component of the Insurance Commissioner's budget, a budget for the sufficient administrative resources and funding requirements necessary for their duties under this article.

(5) Perform all record and information gathering functions necessary to carry out its duties under this code.

(6) Perform all other duties as specifically provided in this chapter for the industrial council and those duties incidental thereto.

(7) Establish a method of indexing claims of injured workers that will make information concerning the injured workers of one insurer available to other insurers.

(A) Every insurer shall provide information, as required by the industrial council, for establishing and maintaining the claims index.

(B) If an employee files a claim with an insurer, the insurer is entitled to receive from the administrator a list of the prior claims of the employee. If the insurer desires to inspect the files related to the prior claims, he or she must obtain the written consent of the employee or the Insurance Commissioner or his or her designee. The use of the information contained in the files is limited to the administration of the claim.

§23-2C-6. Continuation of old fund, uninsured employer fund, self-insured employer guaranty risk pool, and self-insured employer security risk pool.

There is hereby continued in the State Treasury a “Workers’ Compensation Old Fund”, “Workers’ Compensation Uninsured Employers’ Fund”, “Self-insured Employer Guaranty Risk Pool”, and “Self-insured Employer Security Risk Pool”. The Insurance Commissioner shall have full authority to administer the Old Fund, the Uninsured Employers’ Fund, the Self-Insured Employer Guaranty Risk Pool, and the Self-Insured Employer Security Risk Pool.

§23-2C-7. Custody, investment and disbursement of funds.

The State Treasurer shall be the custodian of the Old Fund, the Uninsured Employer Fund, the Self-Insured Employer Guaranty Risk Pool, and the Self-Insured Employer Security Risk Pool, and moneys payable to each of these funds shall be deposited in the State Treasury to the credit of the funds. Each fund shall be a separate and distinct fund upon the books and records of the Auditor and Treasurer. Disbursements from these funds shall be made upon requisitions signed by the Insurance Commissioner. The Old Fund, the Uninsured Employer Fund, the Self-Insured Employer Guaranty Risk Pool, and the Self-Insured Employer Security Risk Pool are participant plans as defined in §12-6-2 of this code and are subject to the provisions of §12-6-9a of this code. The funds may be invested by the Investment Management Board in accordance with §12-6-1 *et seq*. of this code.

§23-2C-8. Workers' Compensation Uninsured Employer Fund.

(a) The Workers' Compensation Uninsured Employer Fund shall be governed by the following:

(1) All money and securities in the fund must be held by the State Treasurer as custodian thereof to be used solely as provided in this article.

(2) The State Treasurer may disburse money from the fund only upon written requisition of the Insurance Commissioner.

(3) *Assessments*. — The Insurance Commissioner shall assess each private carrier and may assess self-insured employers an amount to be deposited in the fund. The assessment may be collected by each private carrier from its policyholders in the form of a policy surcharge. To establish the amount of the assessment, the Insurance Commissioner shall determine the amount of money necessary to maintain an appropriate balance in the fund for each fiscal year and shall allocate a portion of that amount to be payable by each of the groups subject to the assessment. After allocating the amounts payable by each group, the Insurance Commissioner shall apply an assessment rate to:

(A) Private carriers that reflects the relative hazard of the employments covered by the private carriers, results in an equitable distribution of costs among the private carriers and is based upon expected annual premiums to be received;

(B) Self-insured employers, if assessed, that results in an equitable distribution of costs among the self-insured employers and is based upon expected annual expenditures for claims; and

(C) Any other groups assessed that results in an equitable distribution of costs among them and is based upon expected annual expenditures for claims or premium to be received.

(4) The Industrial Council may adopt rules for the establishment and administration of the assessment methodologies, rates, payments, and any penalties that it determines are necessary to carry out the provisions of this section.

(b) *Payments from the fund*. —

(1) Except as otherwise provided in this subsection, an injured employee of any employer required to be covered under this chapter who has failed to obtain coverage may receive compensation from the Uninsured Employer Fund if such employee meets all jurisdictional and entitlement provisions of this chapter, files a claim with the Insurance Commissioner and makes an irrevocable assignment to the Insurance Commissioner of a right to be subrogated to the rights of the injured employee.

(2) Employees who are injured while employed by a self-insured employer are ineligible for benefits from the Workers' Compensation Uninsured Employer Fund.

(c) *Initial determination upon receipt of a claim. —*

If a claim is filed against the Uninsured Employer Fund, the Insurance Commissioner or his or her third-party administrator shall: (1) Accept the claim into the fund if it is determined that the employer was required to maintain workers' compensation coverage with respect to the injured worker but failed to do so; (2) reject the claim if it is determined that the employer maintained such coverage or was not required to do so; or (3) in a claim involving the availability of benefits pursuant to §23-2-1d of this code, either reject or conditionally accept the claim. An aggrieved party may file a protest with the Office of Judges, or Board of Review upon the termination of the Office of Judges, to any decision by the Insurance Commissioner or the third-party administrator to accept or reject a claim into the fund, as well as to any claims decisions made with respect to any claim accepted into the fund and such protests shall be determined in the same manner as disputed claims are determined pursuant to the provisions of §23-5-1 et seq. of this code: *Provided*, That in any proceeding involving the decision to accept or refuse to accept a claim into the fund, the employer has the burden of proving that it either provided mandatory workers' compensation insurance coverage or that it was not required to do so.

(d) *Employer liability. —*

(1) Any employer who has failed to provide mandatory coverage required by the provisions of this chapter is liable for all payments made and to be made on its behalf, including any benefits, administrative costs and attorney's fees paid from the fund or incurred by the Insurance Commissioner, plus interest calculated in accordance with the provisions of §23-2-13 of this code.

(2) The Insurance Commissioner:

(A) May bring a civil action in a court of competent jurisdiction to recover from the employer the amounts set forth in §23-2C-8(d)(1) of this code. In any such action, the Insurance Commissioner may also recover the present value of the estimated future payments to be made on the employer's behalf and administrative costs and attorney's fees attributable to such claim: *Provided*, That the failure of the Insurance Commissioner to include a claim for future payments shall not preclude one or more subsequent actions for such amounts;

(B) May enter into a contract with any person, including the third-party administrator of the Uninsured Employer Fund, to assist in the collection of any liability of an uninsured employer; and

(C) In lieu of a civil action, may enter into an agreement or settlement regarding the collection of any liability of an uninsured employer.

(3) In addition to any other liabilities provided in this section, the Insurance Commissioner may impose an administrative penalty of not more than $10,000 against an employer if the employer fails to provide mandatory coverage required by this chapter. All penalties and

other moneys collected pursuant to this section shall be deposited into the Uninsured Employer Fund.

§23-2C-9.

Repealed.

Acts, 2008 Reg. Sess., Ch. 120.

§23-2C-10. West Virginia adverse risk assignment.

(a) The Insurance Commissioner shall provide for the development and administration of an assigned risk plan to provide workers' compensation insurance coverage to employers who are unable to procure coverage in the voluntary market.

(b) To qualify for coverage under the plan, an employer must have been categorically declined coverage by at least two insurers that are not affiliated with each other. The employer has the burden of establishing that at least two unaffiliated insurers are unwilling to provide coverage at any premium level that is reasonably related to the risk presented by the employer. The assigned risk plan may also provide for other reasonable qualifications and for the termination of coverage under the plan for specified reasons.

(c) Any employer that satisfies the requirements of subsection (b) of this section and other qualifications established in the plan shall be provided coverage at a premium level to be determined or approved by the Insurance Commissioner, which premiums shall be actuarially sound, consistent with classification and rate-making methodologies found in the insurance industry, and calculated to enable the plan to be self-sustaining and, to the greatest extent possible, able to operate without subsidies from employers and insurers in the voluntary market. Rates may not be excessive, inadequate or unfairly discriminatory.

(d) The Insurance Commissioner may designate any third party, including any private carrier or rating organization with substantial experience in developing and administering similar programs in other states, to develop and administer the assigned risk plan for a period of three years, and thereafter, shall contract with any qualified party, including the then current administrator, to continue the administration of the assigned risk plan: Provided, That the Insurance Commissioner must approve the plan prior to the plan becoming operative. The plan established pursuant to this section shall require that all private carriers participate as a condition of their authority to transact business in this state.

(e) In the event the plan incurs a deficit in one or more policy years, the Insurance Commissioner may assess all private carriers providing workers' compensation insurance in voluntary market funds as are necessary to cover the deficits. The assessments shall result in an equitable distribution of costs among private carriers based upon premiums received by the private carriers in the private market. Assessments made upon the policies of each private carrier pursuant to this section may be collected by each carrier in the form of a surcharge.

§23-2C-11. Transfer of assets from new fund to the mutual insurance company established as a successor to the commission; transfer of commission employees.

[Repealed.]

§23-2C-12. Certain personnel provisions governing Workers' Compensation Commission employees and employees laid off by the employers' mutual insurance company during its initial year of operation.

A person who was employed by the former Workers' Compensation Commission upon its termination or was laid off by the employers' mutual insurance company created in this article on or before June 30, 2008, is entitled to be placed on an appropriate reemployment list maintained by the Department of Personnel and to be allowed a preference on that list. The Department of Personnel shall maintain such an employee on the reemployment list indefinitely, or until the employee has declined three offers of employment at a paygrade substantially similar to that of his or her position upon termination of the former Workers' Compensation Commission, or until he or she is reemployed by the executive branch of state government, whichever occurs earlier.

§23-2C-13. Certain retraining benefits to those employees laid-off by the mutual during its first year of operation.

[Repealed.]

§23-2C-14. Certain benefits provided to commission employees.

[Repealed.]

§23-2C-15. Mandatory coverage; changing of coverage.

(a) An employer may elect to purchase workers' compensation insurance from another a private carrier licensed and otherwise authorized to transact workers' compensation insurance in this state or (3) self-insure its obligations if it satisfies all requirements of this code to so self-insure and is permitted to do so. Private carriers are permitted to sell workers' compensation insurance through licensed agents in the state. To the extent that a private carrier markets workers' compensation insurance through a licensed agent, it is subject to all applicable provisions of Chapter 33 of this code.

(b) Every employer shall continuously post a notice upon its premises in a conspicuous place identifying its workers' compensation insurer. The notice must include the name, business address, and telephone number of the insurer and of the person to contact with questions about a claim.

(c) Any rule promulgated by the Industrial Council empowering agencies of this state to revoke or refuse to grant, issue, or renew any contract, license, permit, certificate, or other authority to conduct a trade, profession, or business to or with any employer whose account is in default with regard to any liability under this chapter shall be fully enforceable by the Insurance Commissioner against the employer.

(d) Private carriers may cancel a policy upon the issuance of 30 days' written advance notice to the policyholder and may refuse to renew a policy upon the issuance of 60 days' written advance notice to the policyholder: *Provided*, That cancellation of the policy by the carrier for failure of consideration to be paid by the policyholder or for refusal to comply with a premium audit is effective after 10 days' advance written notice of cancellation to the policyholder.

(e) Every private carrier shall notify the Insurance Commissioner as follows: (1) Of the issuance or renewal of insurance coverage, within 30 days of: (A) The effective date of coverage; or (B) the private carrier's receipt of notice of the employer's operations in this state, whichever is later; (2) of a termination of coverage by the private carrier due to refusal to renew or cancellation, at least 10 days prior to the effective date of the termination; and (3) of a termination of coverage by an employer, within 10 days of the private carrier's receipt of the employer's request for such termination; the notifications shall be on forms developed or in a manner prescribed by the Insurance Commissioner.

(f) For the purposes of §23-2C-15(d) and (e) of this code, the transfer of a policyholder between insurance companies within the same group is not considered a cancellation or refusal to renew a workers' compensation insurance policy.

§23-2C-16. Administration of Old Fund, Uninsured Employer Fund, Self-Insured Employer Guaranty Risk Pool, Self-Insured Employer Security Risk Pool, and Private Carrier Guaranty Fund.

(a) The Insurance Commissioner shall review claims determined to be payable from the Old Fund, Uninsured Employer Fund, Self-Insured Employer Guaranty Risk Pool, Self-Insured Employer Security Risk Pool, and Private Carrier Guaranty Fund and may contest the determination pursuant to the provisions of §23-5-1 *et seq*. of this code. The Insurance Commissioner may retain a third-party administrator for said funds. The administrative duties may include, receipt of all claims, processing said claims, providing for the payment of said claims through the State Treasurer's office or other applicable state agency, and ensuring, through the selection and assignment of counsel, that claims decisions are properly defended.

(b) The Insurance Commissioner may conduct or cause to be conducted an annual audit to be performed on said funds.

(c) The Insurance Commissioner may contract or employ counsel to perform legal services related solely to the collection of moneys due the Old Fund, including the collection of moneys due the Old Fund and enforcement of repayment agreements entered into for the collection of moneys due on or before June 30, 2005, in any administrative proceeding and in any state or federal court.

(d) During the fiscal years beginning July 1, 2019, July 1, 2020, July 1, 2021, July 1, 2022, and July 1, 2023, the Insurance Commissioner may, in his or her discretion, transfer special revenue moneys contained in the Insurance Commission Fund to the Old Fund in any fiscal year in which the Insurance Commissioner has determined, and an independent Auditor has attested thereto, that a deficit balance existed in the Old Fund for the prior fiscal year.

§23-2C-17. Administration of a competitive system.

(a) Every policy of insurance issued by a private carrier:

(1) Shall be in writing;

(2) Shall contain the insuring agreements and exclusions; and

(3) If it contains a provision inconsistent with this chapter, it shall be deemed to be reformed to conform with this chapter.

(b) The Industrial Council shall promulgate a rule which prescribes the requirements of a basic policy to be used by private carriers.

(c) A private carrier or self-insured employer may enter into a contract to have its plan of insurance administered by a third-party administrator if the administrator is licensed with the Insurance Commissioner in accordance with article forty-six, chapter thirty-three of this code. Notwithstanding any other provision of this code to the contrary, any third-party administrator who, directly or indirectly, underwrites or collects charges or premiums from, or adjusts or settles claims on residents of this state, in connection with workers' compensation coverage offered or provided by a private carrier or self-insured employer, is subject to the provisions of article forty-six, chapter thirty-three of this code to the same extent as those persons included in the definition set forth in subsection (a), section two of said article. The Insurance Commissioner shall propose rules, as provided in section five, article two-c of this chapter, to regulate the use of third-party administrators by private carriers and self-insured employers, including rules setting forth mandatory provisions for agreements between third-party administrators and self-insured employers or private carriers.

(d) A self-insured employer or a private carrier may:

(1) Enter into a contract or contracts with one or more organizations for managed care to provide comprehensive medical and health care services to employees for injuries and diseases that are compensable pursuant to this chapter. The managed care plan must be approved pursuant to the provisions of section three, article four of this chapter.

(2) Require employees to obtain medical and health care services for their industrial injuries from those organizations and persons with whom the self-insured employer or private carrier has contracted or as the self-insured employer or private carrier otherwise prescribes.

(3) Except for emergency care, require employees to obtain the approval of the self-insured employer or private carrier before obtaining medical and health care services for their industrial injuries from a provider of health care who has not been previously approved by the self-insured employer or private carrier.

(e) A private carrier or self-insured employer may inquire about and request medical records

of an injured employee that concern a preexisting medical condition that is reasonably related to the industrial injury of that injured employee.

(f) An injured employee must sign all medical releases necessary for his or her self-insured employer or his or her employer's private carrier to obtain information and records about a preexisting medical condition that is reasonably related to the industrial injury of the employee and that will assist the insurer to determine the nature and amount of workers' compensation to which the employee is entitled.

§23-2C-18. Ratemaking; Insurance Commissioner.

(a)(1) Rates for workers' compensation insurance are subject to the provisions of this section, §23-2C-18a of this code, and §33-20-1 *et seq*. of this code.

(2) In the event of any conflict, the provisions of this article shall have paramount effect, but the provisions in this chapter and Chapter 33 of this code shall be construed as complementary and harmonious unless so clearly in conflict that they cannot reasonably be reconciled.

(b) An insurer shall file its rates by filing a multiplier or multipliers to be applied to prospective loss costs that have been filed by the designated advisory organization on behalf of the insurer in accordance with §23-2C-18a of this code and may also file carrier specific rating plans.

(c) Rates must not be excessive, inadequate, or unfairly discriminatory, nor may an insurer charge any rate which if continued will have or tend to have the effect of destroying competition or creating a monopoly.

(d) The Insurance Commissioner may disapprove rates if there is not a reasonable degree of price competition at the consumer level with respect to the class of business to which they apply. In determining whether a reasonable degree of price competition exists, the Insurance Commissioner shall consider all relevant tests, including:

(1) The number of insurers actively engaged in the class of business and their shares of the market;

(2) The existence of differentials in rates in that class of business;

(3) Whether long-run profitability for private carriers generally of the class of business is unreasonably high in relation to its risk;

(4) Consumers' knowledge in regard to the market in question; and

(5) Whether price competition is a result of the market or is artificial. If competition does not exist, rates are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to the risk of the class of business, or if expenses are unreasonably high in relation to the services rendered.

(e) Rates are inadequate if they are clearly insufficient, together with the income from investments attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

(f) One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with similar exposure to

loss but different expense factors, or similar expense factors but different exposure to loss, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise, or blanket policy.

§23-2C-18a. Designation of rating organization.

(a) For the purposes of this section:

(1) "Classification system" or "classification" means the plan, system or arrangement for grouping risks with similar characteristics or a specified class of risk by recognizing differences in exposure to hazards.

(2) "Experience rating" means a statistical procedure utilizing past risk experience to produce a prospective premium credit, debit or unity modification.

(3) "Prospective loss costs" means historical aggregate losses and loss adjustment expenses projected through development to their ultimate value and through trending to a future point in time. Prospective loss costs do not include provisions for profit or expenses other than loss adjustment expenses.

(4) "Statistical plan" means the plan, system or arrangement used in collecting data for ratemaking or other purposes.

(b) The Insurance Commissioner shall designate one rating organization to:

(1) Assist the commissioner in gathering, compiling and reporting relevant statistical information on an aggregate basis;

(2) Develop and administer, subject to approval by the commissioner, the uniform statistical plan, uniform classification plan and uniform experience rating plan;

(3) Develop and file manual rules, subject to the approval of the commissioner, that are reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan and the uniform classification plan; and

(4) File with the commissioner for approval all prospective loss costs, provisions for special assessments, all supplementary rating information and any changes, amendments or modification of the forgoing proposed in this state.

(c) Each workers' compensation insurer shall:

(1) Record and report its workers' compensation experience to the designated rating organization as set forth in the uniform statistical plan approved by the commissioner; and

(2) Adhere to the uniform classification plan and uniform experience rating plan developed by the designated rating organization and approved by the commissioner.

(d) The commissioner may promulgate exempt legislative rules to implement the provisions of this section, including a rule providing for the equitable sharing and recovery of the expense of the designated rating organization in performing the functions set forth in

subsection (b) of this section.

§23-2C-19. Premium payment; employer default; special provisions as to employer default collection.

(a) Each employer who is required to purchase and maintain workers' compensation insurance or who elects to purchase workers' compensation insurance shall pay a premium to a private carrier. Each carrier shall notify its policyholders of the mandated premium payment methodology and under what circumstances a policyholder will be found to be in policy default.

(b) An employer who is required to purchase and maintain workers' compensation insurance but fails to do so or otherwise enters policy default shall be deprived of the benefits and protection afforded by this chapter, including §23-2-6 of this code, and the employer is liable as provided in §23-2-8 of this code: The policy defaulted employer's liability under these sections is retroactive to the day the policy default occurs: The private carrier shall notify the policy defaulted employer of the method by which the employer may be reinstated with the private carrier.

(c) In addition to any other liabilities provided in this section, the Insurance Commissioner may impose an administrative fine of not more than $10,000 against an employer if the employer fails to provide mandatory coverage required by this chapter.

(d) Every agency shall, upon notification of employer default by the Insurance Commissioner, immediately begin the process to revoke or terminate any contract, license, permit, certificate, or other authority to conduct a trade, profession, or business in this state and shall refuse to issue, grant, or renew any such contract, license, permit, certificate, or authority.

(1) The term "employer default" means having an outstanding balance or liability to the Old Fund or to the Uninsured Employers' Fund or being in policy default, as defined in §23-2C-2 of this code, or failure to maintain mandatory workers' compensation coverage. An employer is not in default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

(2) The term "agency" includes any unit of state government such as officers, agencies, divisions, departments, boards, commissions, authorities, or public corporations.

(e) Any amounts owed by an employer to the state as a result of an employer default is a personal liability of the employer, its officers, owners, partners, and directors and is immediately due and owing and shall, in addition, be a lien enforceable against all the property of the employer, its officers, owners, partners, and directors: *Provided*, That the lien shall not be enforceable as against a purchaser, including a lien creditor, of real estate or personal property for a valuable consideration without notice, unless docketed as provided in §38-10C-1 of this code: *Provided, however*, That the lien may be enforced as other judgment liens are enforced through the provisions of chapter 38 of this code and the

same is considered by the circuit court to be a judgment lien for this purpose.

(f) The Insurance Commissioner shall propose rules for adoption by the industrial council to effectuate the purposes of this section including the conditions under which agencies shall comply with the provisions of §23-2C-19(d) of this code and specifying how notice of default shall be given by the Insurance Commissioner.

§23-2C-20. Claims administration issues.

(a) Private carriers and self-insured employers shall at all times be bound and shall comply fully with all of the provisions of this chapter. Furthermore, all of the provisions contained in §23-4-1 *et seq*. of this code pertaining to disability and death benefits are binding on and shall be strictly adhered to by the successor to the commission, private carriers, and the self-insured employer in their administration of claims presented by employees of the self-insured employer private carriers and self-insured employers.

(b) The Occupational Pneumoconiosis Board shall be administered by the Insurance Commissioner. Private carriers and self-insured employers shall have all authority and responsibility in the administration and processing of occupational pneumoconiosis claims.

(c) Upon termination of the former Workers' Compensation Commission, claims allocation responsibilities transferred to the Insurance Commissioner.

(d) The Insurance Commissioner's third-party administrator for the Old Fund has administrative and adjudicatory authority in administering old law liability and deciding old law claims.

§23-2C-21. Limitation of liability of insurer or third-party administrator; administrative fines are exclusive remedies.

(a) No civil action may be brought or maintained by an employee against a private carrier or a third-party administrator, or any employee or agent of a private carrier or third-party administrator, who violates any provision of this chapter or Chapter 33 of this code.

(b) Any administrative fines or remedies provided in this chapter or Chapter 33 of this code or rules promulgated by the Insurance Commissioner are the exclusive civil remedies for any violation of this chapter committed by a private carrier or a third-party administrator or any agent or employee of a private carrier or a third-party administrator.

(c) Upon a determination by the Office of Judges, or by the Board of Review upon the termination of the Offices Judges, that a denial of compensability, a denial of an award of temporary total disability, or a denial of an authorization for medical benefits was unreasonable, reasonable attorney's fees and the costs actually incurred in the process of obtaining a reversal of the denial shall be awarded to the claimant and paid by the private carrier or self-insured employer which issued the unreasonable denial. A denial is unreasonable if, after submission by or on behalf of the claimant, of evidence of the compensability of the claim, the entitlement to temporary total disability benefits or medical benefits, the private carrier or self-insured employer is unable to demonstrate that it had evidence or a legal basis supported by legal authority at the time of the denial which is relevant and probative and supports the denial of the award or authorization. Payment of attorney's fees and costs awarded under this subsection will be made to the claimant at the conclusion of litigation, including all appeals, of the claimant's protest of the denial.

§23-2C-22. Rules.

Except as otherwise provided in this chapter, all rules applicable to the former Workers' Compensation Commission are hereby adopted and made effective as to the operation of the Workers' Compensation insurance market to the extent that they are not in conflict with the current law. Authority to enforce the existing rules and the regulatory functions of the commission as set forth in chapter twenty-three of the code shall transfer from the commission to the Insurance Commissioner effective upon termination of the commission.

§23-2C-23. Transfer of assets and contracts.

[Repealed.]

§23-2C-24. Surplus note or other loan arrangement for new fund.

[Repealed.]

§23-2D-1. Short title.

[Repealed.]

§23-2D-2. Legislative findings; legislative intent.

[Repealed.]

§23-2D-3. Definitions.

[Repealed.]

§23-2D-4. Workers' Compensation debt reduction revenue bonds; amount; when may issue.

[Repealed.]

§23-2D-5. Special account created; use of moneys in the Fund.

[Repealed.]

§23-2D-5a. Excess regular coal severance taxes.

[Repealed.]

§23-2D-6. Creation of Debt Service Fund; disbursements to pay debt service on Workers' Compensation debt reduction revenue bonds.

[Repealed.]

§23-2D-7. Covenants of state.

[Repealed.]

§23-2D-8. Workers' compensation debt reduction revenue bonds lawful investments.

[Repealed.]

§23-2D-9. Refunding bonds.

[Repealed.]

§23-2D-10. Approval and payment of all necessary expenses.

[Repealed.]

§23-3-1. Compensation Fund; catastrophe and catastrophe payment defined; compensation by employers.

[Repealed.]

§23-3-1a. Transfer of silicosis fund to workers' compensation fund; claims under former article six.

[Repealed.]

§23-3-2. Custody, investment and disbursement of funds.

[Repealed.]

§23-3-3. Investment of surplus funds required.

[Repealed.]

§23-3-4. Deposits and disbursements considered abandoned property; disposition of property.

[Repealed.]

§23-3-5. Authorization to require the electronic invoices and transfers.

[Repealed.]

§23-3-6. Emergency fiscal measures.

[Repealed.]

§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.

(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,

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

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.

§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, with like notice or a copy of the notice to the workers' compensation commission 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. The notice may be given to the workers' compensation commission by mail.

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

It is the duty of every employer to report to the commission, the successor to the commission or another private carrier, whichever is applicable, every injury sustained by any person in his or her employ. The report shall be on forms prescribed by the commission or the Insurance Commissioner, whichever is applicable, and shall be made within five days of the employer's receipt of the employee's notice of injury, required by section one-a of this article, or within five days after the employer has been notified by the commission or the Insurance Commissioner, whichever is applicable, that a claim for benefits has been filed on account of such injury, whichever is sooner, and, notwithstanding any other provision of this chapter to the contrary, the five-day period may not be extended by the commission the successor to the commission, or another private carrier, whichever is 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 or not, 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 article five of this chapter; 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 paid by the commission, the successor to the commission, or another private carrier 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.

§23-4-1c.§23-4-1c. Payment of temporary total disability benefits directly to claimant; payment of medical benefits; payments of benefits during protest; right of commission, successor to the commission, 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 section one of this article 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, whichever is applicable, 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 section sixteen of this article 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 sixty days of the filing that his or her employment position was to be eliminated, including, but not limited to, 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 sixty 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.

(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

section one, article five of this chapter: Provided, That if the successor to the commissioner, other private carrier or self-insured, whichever is applicable, 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 self-insured employer, private carrier or other issuing entity, denying the compensability of the claim, denying temporary total disability benefits or denying medical authorization, the Office of Judges shall provide a hearing on the protest on an expedited basis as determined by rule of the Office of Judges.

(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 section five of this article, 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 sections six and fourteen of this article, and the payment of the expenses provided for in subsection (a), section three of this article, relating to the injury, without waiting for the expiration of the thirty-day period during which objections may be filed to the findings as provided in section one, article five of this chapter. 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 fifteen 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 r information necessary for a determination. The Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, shall give to 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 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 ninety days: Provided, That when the Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, 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 ninety 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 employee is entitled. If an employer does not furnish this information within fifteen 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 commission obtains from reports made pursuant to subsection (b), section two, article two of this chapter. 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, whichever is applicable, 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 section sixteen of this article, 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 sections six and fourteen of this article shall immediately commence, and the expenses provided for in subsection (a), section three of this article, relating to the disability, without waiting for the expiration of the thirty-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 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 section nine, article two of this chapter, 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, 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 subsection (a), section three of this article, the division shall continue to pay to the claimant such benefits and expenses during the period of such disability. Where it is subsequently found by the Insurance Commissioner, private carrier or self-insured, whichever is applicable, that the claimant was not entitled to receive such temporary total disability benefits or expenses, or any part thereof, so paid, the Insurance Commissioner, private carrier or self-insured, whichever is applicable, shall credit said employer's account with the amount of the overpayment. 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 amount of benefits or expenses is considered overpaid. For all awards made or nonawarded

partial benefits paid the Insurance Commissioner, private carriers or self-insured employer may 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.

(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, whichever is applicable, 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 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.

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

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

(b) When the commission, successor to the commission, other private carrier, self-insured employer, the office of judges 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 by the employer, the commission the successor to the commission or other private carrier, 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 twelve 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 commission, successor to the commission, other 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. Any interest payable shall be charged to the account of the employer or shall be paid by the employer if it has elected to carry its own risk.

(d) If a timely protest to the award is filed, as provided in section one or nine, article five of this chapter, benefits shall continue to be paid to the claimant benefits 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, in which event the commission shall, where the employer is a subscriber to the fund, credit the employer's account with the amount of the overpayment. 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 benefit paid shall be considered overpaid. For all awards made or nonawarded partial benefits paid the commission, successor to the commission, other private carrier or self-insured employer,

whichever is applicable, may only recover that amount by withholding, in whole or in part, as determined by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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.

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

(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 commission, successor to the commission, other 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 commission, successor to the commission, other 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.

§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 commission, successor to the commission, other 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 sections fourteen or sixteen of article seven, chapter twenty-five 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 subsection (5), subsection (a) of sections fourteen and sixteen of article seven, chapter twenty-five of this code.

§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.

(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.

§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.

§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

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

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:

(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:

(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

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.

§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.

§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 Workers' Compensation Commission, and effective upon termination of the commission, the Insurance Commissioner, shall establish and alter from time to time, as it 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 and 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 commission and effective upon termination of the commission, the Insurance Commissioner, also, on the first day of each regular session and also from time to time, as it may consider appropriate, shall submit the schedule, with any changes thereto, to the Legislature.

The commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, 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 commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, shall determine that which is reasonably required within the meaning of this section in accordance with the guidelines developed by the health care advisory panel pursuant to section three-b of this article: Provided, That nothing in this section shall prevent the implementation of guidelines applicable to a particular type of treatment or service or to a particular type of injury before guidelines have been developed for other types of treatment or services or injuries: Provided, however, That any guidelines for utilization review which are developed in addition to the guidelines provided for in section three-b of this article may be used by the commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, until superseded by guidelines developed by the health care advisory panel pursuant to said section. Each health care provider who seeks to provide services or treatment which are not within any guideline shall submit to the commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, specific justification for the need for the additional services in the particular case and the commission shall have the justification reviewed by a health care professional before authorizing the additional services. The commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, 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 commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, considers proper, but no payments or disbursements shall be made or awarded by the commission unless duly verified statements on forms prescribed by the commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, have been filed within six months after the rendering of the treatment or the delivery of such goods, supplies or items or within ninety days of a subsequent compensability ruling if a claim is initially rejected: Provided, That no payment under this section shall be made unless a verified statement shows no charge for or with respect to the treatment or for 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 set forth therefor in the commission 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) In the event that a claimant elects to receive health care services from a health care provider from outside of the State of West Virginia and if that health care provider refuses to abide by and accept as full payment the reimbursement made by the Workers' Compensation Commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, pursuant to the schedule of maximum reasonable amounts of fees authorized by this subsection, with the exceptions noted below, the claimant is personally liable for the difference between the scheduled fee and the amount demanded by the out-of-state health care provider.

(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 commission, upon application by the claimant, may authorize the claimant to 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 section eight, article two of this chapter, 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, the successor to the commission, other 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, successor to the commission, other private carrier or self-insured employer that provides a managed health care plan approved by the commission or, upon termination of the commission, 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 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, except as provided under subdivision (3) of this subsection. 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 commission to do so and the approval is given pursuant to criteria established by rule of the commission.

(3) If the commission enters into an agreement which has been approved by the board of managers with a managed health care plan, including, but not limited to, a preferred provider organization or program, a health maintenance organization or managed care organization or other health care delivery organization or organizations or other medical cost containment relationship with the providers of medical, hospital or other health care, then:

(A) If an injured employee's employer does not provide a managed health care plan approved by the commission for its employees as described in subdivision (2) of this subsection, the commission may require the employee to use health care providers authorized by the commission's managed health care plan for care and treatment of his or her compensable injuries; and

(B) If a claimant seeks to change his or her initial choice of health care provider where neither the employer nor the commission had an approved health care management plan at the time the initial choice was made, and if the claimant's employer does not provide access to such a plan as part of the employer's general health insurance benefit, then the claimant shall be provided with a new health care provider from the commission's managed health care plan available to him or her.

(c) When an injury has been reported to the commission by the employer without protest, the commission or self-insured employer may pay, within the maximum amount provided by schedule established under this section, bills for health care services without requiring the injured employee to file an application for benefits.

(d) The commission, successor to the commission, other 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 commission, successor to the commission, other private carrier or self-insured employer shall pay for these devices, when needed, notwithstanding any time limits provided by law.

(e) No payment shall be made to a health care provider who is suspended or terminated under the terms of section three-c of this article except as provided in subsection (c) of said section. (f) The commission, successor to the commission, other private carrier or self-

insured employer, whichever is applicable, may engage in and contract for medical cost containment programs, pharmacy benefits management programs, medical case management programs and utilization review programs. Payments for these programs shall be made from the Workers' Compensation Fund or the funds of the successor to the commission, other private carrier, or self-insured employer. 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable.

(g) Notwithstanding the provisions of this section, the commission, successor to the commission, other private carrier or self-insured employer may establish fee schedules, make payments and take other actions required or allowed pursuant to article twenty-nine-d, chapter sixteen of this code.

§23-4-3a.

Repealed.

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

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

(a) The commission shall establish a health care advisory panel consisting of representatives of the various branches and specialties among health care providers in this state which shall be in existence until termination of the commission. There shall be a minimum of five members of the health care advisory panel who shall receive reasonable compensation for their services and reimbursement for reasonable actual expenses. Each member of this panel shall be provided appropriate professional or other liability insurance, without additional premium, by the state Board of Risk and Insurance Management created pursuant to article twelve, chapter twenty-nine of this code. The panel shall:

(1) Establish guidelines for the health care which is reasonably required for the treatment of the various types of injuries and occupational diseases within the meaning of section three of this article;

(2) Establish protocols and procedures for the performance of examinations or evaluations performed by physicians or medical examiners pursuant to sections seven-a and eight of this article;

(3) Assist the commission in establishing guidelines for the evaluation of the care provided by health care providers to injured employees for purposes of section three-c of this article;

(4) Assist the commission in establishing guidelines regarding the anticipated period of disability for the various types of injuries pursuant to subsection (b), section seven-a of this article; and

(5) Assist the commission in establishing appropriate professional review of requests by health care providers to exceed the guidelines for treatment of injuries and occupational diseases established pursuant to subdivision (1) of this section.

(b) In addition to the requirements of subsection (a) of this section, on or before December 31, 2003, the board of managers shall promulgate a rule establishing the process for the medical management of claims and awards of disability which includes, but is not limited to, reasonable and standardized guidelines and parameters for appropriate treatment, expected period of time to reach maximum medical improvement and range of permanent partial disability awards for common injuries and diseases or, in the alternative, which incorporates by reference the medical and disability management guidelines, plan or program being utilized by the commission for the medical and disability management of claims, with the requirements, standards, parameters and limitations of such guidelines, plan or program having the same force and effect as the rule promulgated in compliance herewith.

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

(a) The commission may suspend for up to three years or permanently terminate the right of any health care provider, including a provider of rehabilitation services within the meaning of section nine of this article, to obtain payment for services rendered to injured employees:

(1) If the commission finds that the health care provider is regularly providing to injured employees health care that is excessive, medically unreasonable or unethical, which shall include abusing the workers' compensation system in the treatment provided to injured employees or in its billing practices;

(2) If the commission finds that a health care provider is attempting to make any charge or charges against the injured employee or any other person, firm or corporation which would result in a total charge for any treatment rendered in excess of the maximum amount set by the commission, in violation of section three of this article;

(3) If the commission determines that the health care provider has had his or her license to practice suspended or terminated by the appropriate authority in this state or in another state;

(4) If the commission determines that the health care provider has been convicted of any crime in relation to his or her practice, or any felony; or

(5) If the commission determines that the health care provider has made medically unsupported recommendations regarding a percentage of disability or has prescribed medically unsupported treatment including medication. The rules promulgated under this section shall establish criteria for determining whether recommendations or treatment are medically unsupported.

The executive director shall consult with medical experts, including the health care advisory panel established pursuant to section three-b of this article, for purposes of determining whether a health care provider should be suspended or terminated pursuant to this section.

(b) Upon the determination by the executive director that there is probable cause to believe that a health care provider should be suspended or terminated pursuant to this section, the executive director shall provide the health care provider with written notice stating the nature of the charges against the health care provider and the time and place of a hearing. Upon issuance of the notice and due consideration of the executive director's fiduciary duties, the executive director may immediately suspend payment to the health care provider pending the final order of suspension or termination. The health care provider shall appear to show cause why the health care provider's right to receive payment under this chapter should not be suspended or terminated. At the hearing the health care provider shall be afforded an opportunity to review the evidence, to cross-examine the witnesses, and present testimony and enter evidence in support of its position. The hearing shall be conducted in accordance with the provisions of article five, chapter twenty-nine-a of this code. The

hearing may be conducted by the executive director or a hearing officer appointed by the executive director. The executive director or hearing officer has the power to subpoena witnesses, papers, records, documents and other data and things in connection with the proceeding under this subsection and to administer oaths or affirmations in the hearing. If, after reviewing the record of the hearing, the executive director determines that the right of the health care provider to obtain payment under this article should be suspended for a specified period of time or should be permanently terminated, the executive director shall issue a final order suspending or terminating the right of the health care provider to obtain payment for services under this article. The order shall set forth findings of fact and conclusions of law in support of the decision. The order shall be mailed to the health care provider by certified mail, return receipt requested. Any appeal by the health care provider shall be brought in the circuit court of Kanawha County or in the county in which the provider's principal place of business is located. The scope of the court's review of the final order shall be as provided in section four, article five, chapter twenty-nine-a of this code. The provider may be suspended or terminated, based upon the final order of the executive director or hearing officer, pending final disposition of any appeal. The final order may be stayed by the circuit court after hearing, but shall not be stayed in or as a result of any ex parte proceeding. If the health care provider does not appeal the final order within thirty days, it is final.

(c) No payment shall be made to a health care provider or to an injured employee for services provided by a health care provider after the effective date of a final order terminating or suspending the health care provider: Provided, That nothing in this subsection shall prohibit payment by the executive director or self-insured employer to a suspended or terminated health care provider for medical services rendered where the medical services were rendered to an injured employee in an emergency situation. The suspended or terminated provider may not make any charge or charges for any services provided against the injured employee unless the injured employee, before any services are rendered, is given notice by the provider in writing that the provider does not participate in the workers' compensation program and that the injured employee will be solely responsible for all payments to the provider and unless the injured employee also signs a written consent, before any services are rendered, to make payment directly and to waive any right to reimbursement from the executive director or the self-insured employer. The written consent and waiver signed by the injured employee shall be filed by the provider with the executive director and shall be made a part of the claim file.

(d) The executive director shall notify each claimant, whose duly authorized treating physician or other health care provider has been suspended or terminated pursuant to this section, of the suspension or termination of the provider's rights to obtain payment under this chapter and shall assist the claimant in arranging for transfer of his or her care to another physician or provider.

(e) Each suspended or terminated provider shall post in the provider's public waiting area or areas a written notice, in the form required by the executive director, of the suspension or termination of the provider's rights to obtain payment under this chapter.

(f) A suspended provider may apply for reinstatement at the end of the term of suspension.

(g) The board of managers shall promulgate rules for the purpose of implementing this section.

§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 commission, and upon its termination, the Insurance Commissioner, shall be paid from the fund, or the private carrier, payment to be made to the persons who have furnished the services and supplies, or to the persons who have advanced payment for the services and supplies, as the commission may determine proper, in addition to any award made to the employee's dependents.

(b) A funeral director or cemeterian, 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 commission, and upon its termination, 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 commission or 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 commission or 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 commission or 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 twelve months, or both.

§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 provided for in the two next preceding sections, 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.

§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 section fourteen of this article except for the purpose of computing temporary total disability benefits for part-time employees pursuant to the provisions of section six-d of this article.

(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 sixty-six and two-thirds percent of the average weekly wage earnings, wherever earned, of the injured employee, at the date of injury, not to exceed one hundred 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, 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 thirty-three and one-third percent of the average weekly wage in West Virginia, except as provided in sections six-d and nine of this article. 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 two hundred eight 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 one hundred four 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 one hundred four 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 division 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 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 sixty-six 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 one hundred 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: Provided, That the provisions of sections one through eight, inclusive, article four-a of this chapter shall be applied thereafter to all prior awards that were previously subject to its provisions. A single or aggregate permanent disability of eighty-five 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, however, That the claimant must also be at least fifty percent medically impaired upon a whole body basis or has sustained a thirty-five 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 commission, successor to the commission, other 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 further, 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: Sixty-six and two-thirds percent of the average weekly wage earnings, wherever earned, of the injured employee at the date of injury, not to exceed seventy 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.

(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 ten 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 twenty-five percent disability.

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

The loss of a foot shall be considered a thirty-five percent disability.

The loss of a leg shall be considered a forty-five percent disability.

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

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

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

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

The loss of thumb and index fingers shall be considered a thirty-two percent disability.

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

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

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

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

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

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

The loss of four fingers shall be considered a thirty-two percent disability.

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

The loss of forearm shall be considered a fifty-five percent disability.

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

The total and irrecoverable loss of the sight of one eye shall be considered a thirty-three percent disability. For the partial loss of vision in one or both eyes, the percentages of disability shall be determined by the commission, 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 twenty-two and one-half percent disability. The total and irrecoverable loss of hearing of both ears shall be considered a fifty-five percent disability.

For the partial loss of hearing in one or both ears, the percentage of disability shall be determined by the commission, successor to the commission, other 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 commission makes the proper award for the injury, the commission 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 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 in section six-b of this article, 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 section six-b of this article, the degree of disability shall be determined exclusively by the provisions of said subdivision and said section. The occupational pneumoconiosis board created pursuant to section eight-a of this article shall premise its decisions on the degree of pulmonary function impairment that claimants suffer solely upon whole body medical impairment. The Workers' Compensation Commission 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 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) From a list of names of seven persons submitted to the executive director by the health care advisory panel, the executive director shall appoint an interdisciplinary examining board consisting of five members to evaluate claimants, including by examination if the board elects. The interdisciplinary examining board shall terminate upon termination of the commission and all administrative and adjudicatory functions performed by the interdisciplinary examining board shall be performed by the following reviewing bodies for those claims over which they have administrative jurisdiction: (1) The Insurance Commissioner or his or her designated administrator of each of the funds set forth in this chapter; (2) private carriers; or (3) self-insured employers. The reviewing bodies shall employ or otherwise engage adequate resources, including medical professionals, to perform the functions of the interdisciplinary examining board. The board shall be composed of three qualified physicians with specialties and expertise qualifying them to evaluate medical impairment and two vocational rehabilitation specialists who are qualified to evaluate the ability of a claimant to perform gainful employment with or without retraining. One member of the board shall be designated annually as chairperson by the executive director. The term

of office of each member of the board shall be six years and until his or her successor has been appointed and has qualified. Any member of the board may be appointed to any number of terms. Any two physician members and one vocational rehabilitation specialist member shall constitute a quorum for the transaction of business. The executive director, from time to time, shall fix the compensation to be paid to each member of the board, and the members are also entitled to reasonable and necessary traveling and other expenses incurred while actually engaged in the performance of their duties. The board shall perform the duties and responsibilities assigned by the provisions of this chapter, consistent with the administrative policies developed by the executive director with the approval of the board of managers.

(1) The executive director shall establish requirements for the proper completion and support for an application for permanent total disability benefits within an existing or a new rule no later than January 1, 2004. Upon adoption of the rule by the board of managers, no issue of permanent total disability may be referred to the interdisciplinary examining board, or, any other reviewing body, unless a properly completed and supported application for permanent total disability benefits has been first filed. Prior to the referral of any issue to the interdisciplinary examining board, or, upon its termination, prior to a reviewing body's adjudication of a permanent total disability application, the commission, or 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 and forward them to the board at the time of the referral. The commission or reviewing body shall provide adequate notice to the employer of the filing of the request for a permanent total disability award and the employer shall be granted an appropriate period in which to respond to the request. The claimant and the employer may furnish all pertinent information to the board or other reviewing body and shall furnish to the board or other reviewing body any information requested. The claimant and the employer may each submit no more than one report and opinion regarding each issue present in a given claim. The employer may have the claimant examined by medical specialists and vocational rehabilitation specialists: Provided, That the employer is entitled to only one examination on each issue present in a given claim. Any additional examinations must be approved by the commission or other reviewing body and shall be granted only upon a showing of good cause. The reports from all employer-conducted examinations must be filed with the board or other reviewing body and served upon the claimant. The board or other reviewing body may request that those persons who have furnished reports and opinions regarding a claimant provide it with additional information considered necessary. Both the claimant and the employer, as well as the commission, or other reviewing body may submit or obtain 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) If the board or a quorum of the board elects to examine a claimant, the individual members shall conduct any examinations that are pertinent to each of their specialties. If a claim presents an issue beyond the expertise of the board, the board may obtain advice or evaluations by other specialists. In addition, if the board of managers determines that the

number of applications pending before the interdisciplinary examining board has exceeded the level at which the board can review and make recommendations within a reasonable time, the board of managers may authorize the executive director to appoint any additional members to the board that are necessary to reduce the backlog of applications. The additional members shall be recommended by the health care advisory panel. The executive director may make any appointments he or she chooses from the recommendations. The additional board members shall not serve a set term but shall serve until the board of managers determines that the number of pending applications has been reduced to an acceptable level.

(3) Referrals to the board shall be limited to matters related to the determination of permanent total disability under the provisions of subdivision (n) of this section and to questions related to medical cost containment, utilization review decisions and managed care decisions arising under section three of this article.

(4) In the event the board members or other reviewing body elects to examine a claimant, the board or other 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 board or other reviewing body and the reasons for the findings. Copies of the reports of all examinations made by the board or other reviewing body shall be served upon the parties and the commission until its termination. Each shall be given an opportunity to respond in writing to the findings and conclusions stated in the reports.

(5) The board or other reviewing body shall state its initial recommendations to the commission in writing with an explanation for each recommendation setting forth the reasons for each. The recommendations shall be served upon the parties and the commission and each shall be afforded a thirty-day opportunity to respond in writing to the board or other reviewing body regarding its recommendations. The board or other 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 commission, or, upon its termination, the private carrier or self-insured employer. 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 commission or other 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 with the commission or other reviewing body: Provided, That upon notification of the commission or other reviewing body by a claimant or his or her representative that the claimant seeks to be evaluated for permanent total disability, the commission or other reviewing body shall send the claimant or his or her representative the proper application form. The commission or other reviewing body shall set time limits for the return of the application. A properly completed and supported application returned within the time limits set by the commission or other reviewing body shall be treated as if received on the date the commission or other reviewing body 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.

(6) Except as noted below, objections pursuant to section one, article five of this chapter to any order shall be limited in scope to matters within the record developed before the Workers' Compensation Commission and the board or other reviewing body and shall further be limited to the issue of whether the board or other reviewing body properly applied the standards for determining medical impairment, if applicable, and the issue of whether the board's findings are clearly wrong in view of the reliable, probative and substantial evidence on the whole record. The preponderance of the evidence set forth in article one of this chapter shall apply to decisions made by reviewing bodies other than the commission instead of the clearly wrong standard. If either party contends that the claimant's condition has changed significantly since the review conducted by the board or other reviewing body, the party may file a motion with the administrative law judge, together with a report supporting that assertion. Upon the filing of the motion, the administrative law judge shall cause a copy of the report to be sent to the examining board or other reviewing body asking the board to review the report and provide comments if the board chooses within sixty days of the board's receipt of the report. The board or other reviewing body may either supply comments or, at the board's or other reviewing body's discretion, request that the claim be remanded to the board for further review. If remanded, the claimant is not required to submit to further examination by the employer's medical specialists or vocational rehabilitation specialists. Following the remand, the board or other reviewing body shall file its recommendations with the administrative law judge for his or her review. If the board or other reviewing body elects to respond with comments, the comments shall be filed with the administrative law judge for his or her review. Following the receipt of either the board's or other reviewing body's recommendations or comments, the administrative law judge shall issue a written decision ruling upon the asserted change in the claimant's condition. No additional evidence may be introduced during the review of the objection before the office of judges or elsewhere on appeal: Provided, That each party and the commission may submit one written opinion on each issue pertinent to a given claim based upon a review of the evidence of record either challenging or defending the board's or other reviewing body's findings and conclusions. Thereafter, based upon the evidence of record, the administrative law judge shall issue a written decision containing his or her findings of fact and conclusions of law regarding each issue involved in the objection. The limitation of the scope of review otherwise provided in this subsection is not applicable upon termination of the commission and any objections shall be subject to article five of this chapter in its entirety.

(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 fifty percent in prior permanent partial disability awards; (B) must have suffered a single occupational injury or disease which results in a finding by the commission that the claimant has suffered a medical impairment of fifty percent; or (C) has sustained a thirty-five percent statutory disability pursuant to the provisions of subdivision (f) of this section. Upon filing an application, the claim will be reevaluated by the examining board or other reviewing body pursuant to subdivision (i) of this section to determine if the claimant has suffered a whole body medical impairment of fifty 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 thirty-five percent statutory disability pursuant to the provisions of subdivision (f) of this section. A claimant whose prior permanent partial disability awards total eighty-five percent or more shall also be examined by the board or other reviewing body and must be found to have suffered a whole body medical impairment of fifty percent in order for his or her request to be eligible for further review. The examining board or other 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 fifty percent or has sustained a thirty-five 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 fifty percent whole body medical impairment or has sustained a thirty-five 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 eighty-five percent or more and who have been found to have a whole body medical impairment of at least fifty percent

or have sustained a thirty-five 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 seventy-five 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 age seventy years. In addition, the vocational standards adopted pursuant to subsection (m), section seven, article three of this chapter shall be considered once they are effective.

(3) In the event that a claimant, who has been found to have at least a fifty percent whole body medical impairment or has sustained a thirty-five 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 section nine of this article, 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 sections six-d and fourteen of this article:

(A) Eighty percent for the first year;

(B) Seventy percent for the second year;

(C) Sixty percent for the third year; and

(D) Fifty percent for the fourth year: Provided, That in no event shall the benefits exceed one hundred 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, may elect to have any recipient of a permanent total disability award undergo one independent medical examination during each of the first five years that the permanent total disability award is paid and one independent medical examination during each three-year period thereafter until the claimant reaches the age of seventy years: Provided, That the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, may elect to have any recipient of a permanent total disability award under the age of fifty years undergo one independent medical examination during each year that the permanent total disability award is paid until the recipient reaches the age of fifty years, and thereafter one independent medical examination during each three-year period thereafter until the claimant reaches the age of seventy years.

§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 section one of this article, the percentage of permanent disability is determined by the degree of medical impairment that is found by the occupational pneumoconiosis board. The commission, successor to the commission, other 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 commission for purposes of section one, article five of this chapter. If a decision is objected to, the office of judges 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 subdivisions (d), (e), (g), (h), (i), (j), (k), (m) and (n), section six of this article: 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 two thousand three, 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 section ten of this article; as to the benefits, sections eleven to fourteen, inclusive, of this article apply.

In cases of permanent disability or death due to occupational pneumoconiosis, as defined in section one of this article, accompanied by active tuberculosis of the lungs, compensation shall be payable as for disability or death due to occupational pneumoconiosis alone.

The provisions of section sixteen of this article and sections two, three, four and five, article five of this chapter 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.

§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.

(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.

§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.

§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 twenty-five 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 twenty-five 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 twenty-five 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 twenty-five hours per week.

(b) For purposes of establishing temporary total disability weekly benefits pursuant to subdivision (b), section six of this article 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 commission pursuant to subsection (b), section two, article two of this chapter: 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 commission, 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.

§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; that the prompt dissemination of medical information to the commission and employer as to diagnosis, treatment and recovery is essential if these two objectives are to be achieved; that claimants are increasingly burdened with the task of contacting their treating physicians to request the furnishing of detailed medical information to the commission and their employers; that the commission is increasingly burdened with the administrative responsibility of providing copies of medical reports to the employer involved, whereas in other states the employer can obtain the necessary medical information direct from the treating physician; that much litigation is occasioned in this state because of a lack of medical information having been received by the employer as to the continuing disability of a claimant; and that detailed narrative reports from the treating physician are often necessary in order for the commission, the claimant's representatives and the employer to evaluate a claim and determine whether additional or different treatment is indicated.

(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 commission, successor to the commission, other 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 providing this medical information to the commission, the employer or to the employer's representative. 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, the employer shall forward a copy of the medical report to the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, within ten days from the date the employer received the medical report from the physician.

§23-4-7a. Monitoring of injury claims; legislative findings; review of medical evidence; recommendation of authorized treating physician; independent 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 commission 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 commission, in consultation with the health care advisory panel, 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 by the commission. If satisfied, after reviewing the medical evidence, that the claimant would not benefit by an independent medical evaluation, the commission shall mark the claim file accordingly and shall diary the claim file as to the next date for required review which shall not exceed sixty days. If the commission concludes that the claimant might benefit by an independent medical evaluation, the commission 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 fifteen percent or less, the commission 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 fifteen percent, or recommends a permanent total disability award, the claimant's entitlement to temporary total disability benefits ceases upon the receipt by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, of the medical report. The commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall refer the claimant to a physician or physicians of its selection for independent evaluation prior to the entry of a permanent disability award: Provided, That 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 subdivision (e), section six of this article 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 independent 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 commission, successor to the commission, other 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, concludes that an independent medical evaluation is indicated, or that a claimant may be ready for disability evaluation in accordance with other provisions of this chapter, the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable.

(e) Notwithstanding any provision in subsection (c) of this section, the commission, successor to the commission, other 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 when:

(1) The physician or physicians selected by the commission conclude that the claimant has reached his or her maximum degree of improvement;

(2) When the authorized treating physician advises the commission, successor to the commission, other 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 commission, successor to the commission, other 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 inconsistent with his or her compensable workers' compensation injury.

In all cases, a finding by the commission, successor to the commission, other 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 subdivision (e), section six of this article until entry of a permanent disability award, pursuant to an evaluation by a physician or physicians selected by the commission, successor to the commission, other 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 one hundred twenty 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 commission under other provisions of this chapter), the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall refer the claimant to a physician or physicians of the commission's selection for examination and evaluation in accordance with the provisions of subsection (d) of this section 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 commission, successor to the commission, other 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 the health care advisory panel pursuant to section three-b of this article: Provided, That the physician may exceed these protocols when additional evaluation is medically necessary.

(i) The commission, successor to the commission, other 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. The executive director shall propose rules for approval by the commission to implement the provisions of this subsection.

§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.

§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.

§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 executive director. Effective upon termination of the commission, the physicians shall be appointed by the Insurance Commissioner: Provided, That those physicians serving as of the termination of the commission shall continue to serve until replaced. 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 executive director. The term of office of each member of the board shall be six years. The five members of the existing board in office on the effective date of this section shall continue to serve until their terms expire and until their successors have been appointed and have qualified. 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 executive director and, effective upon termination of the commission, 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 executive director and, effective upon termination of the commission, 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 executive director or 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 board of managers and Governor as to reasonable reimbursement per unit of time expended based on comparative data for physicians within the state in the same medical specialties.

§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, successor to the commission, other 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 accurately and scientifically to 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.

§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 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 ten years during the fifteen 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 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 board, the party shall file with the Office of Judges, within sixty days from receipt of the copy to that party, unless for good cause shown the chief administrative law judge extends the time, the party's objections to the findings and conclusions of the board in writing, specifying the particular statements of the 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 therefore jurisdictional. After the time has expired for the filing of

objections to the findings and conclusions of the board, the commission or administrative law judge 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 board no objections have been filed, the report of a majority of the 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 board, notice of the objection shall be given to the board and the members of the board joining in the findings and conclusions shall appear at the time fixed by the Office of Judges 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 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 ninety days. Any previously filed, but unruled upon, claim shall be consolidated with the claim in which the 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 section fifteen of this article.

(f) Effective upon termination of the commission, the Insurance Commissioner shall assume all administrative powers and responsibilities necessary to administer sections eight-a, eight-b and eight-c of this article.

§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.

§23-4-8e.

Repealed.

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

§23-4-8f.

Repealed.

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

§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 commission, successor to the commission, other 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 commission 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, in its sole discretion determines will directly assist the employee's return to employment, the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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 section three of this article and are subject to the provisions of sections three, three-b and three-c of this article. 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable. Notwithstanding any other provision of this section to the contrary, the commission may determine under rules promulgated by the board of managers that a rehabilitation plan or any component thereof is not appropriate for an injured employee.

(c) In every case in which the commission, successor to the commission, other 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 seventy 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 sections six, six-d and fourteen of this article 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 subdivision (b), section six of this article, nor may the benefits exceed the temporary total disability benefits to which the injured employee would be entitled pursuant to sections six, six-d and fourteen of this article 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 two thousand three shall be for a period not exceeding fifty-two 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 one hundred four weeks. The amount of temporary partial rehabilitation benefits payable under this subsection shall be reviewed

every ninety 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 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 executive director, in consultation with the board of managers, 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 section three of this article authorizing employers to participate in a managed health care plan, including a managed health care plan that provides physical and vocational rehabilitation services, an employer 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.

§23-4-9a

Repealed

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

§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.

§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

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.

§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 commission, successor to the commission, other 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 commission considers proper and it operates to discharge all other claims for the benefits.

§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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable.

§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.

§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 commission, and, effective January 1, 2006, 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 commission, successor to the commission, other 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 twelve 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 section six-d of this article.

(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 commission pursuant to subsection (b), section two, article two of this chapter, 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 section six-d of this article.

(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 sections ten and eleven, article six, chapter twenty-one-a 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 wage in West Virginia.

§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 with the commission 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 sixty 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.

§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 commission, successor to the commission, other 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.

§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 sixty 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 sixty 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 ten 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 ten years during the fifteen 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 ten 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 ten years during the fifteen 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 sixty days while in the employ of the employer within ten 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 ten 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 ten years during the fifteen 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, whichever is applicable, 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 ninety days following receipt by the Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, 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 sixty days after receipt of the notice, objects to the findings and, unless an objection is filed within the sixty-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 chief administrative law judge shall set a hearing as provided in section nine, article five of this chapter. 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 administrative law judge concludes after the protest 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 sections ten and twelve, article five of this chapter. If the administrative law judge concludes after the protest 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.

§23-4-15c.

Repealed.

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

§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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, over each case is continuing and the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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. Upon and after February 2, 1995, the period in which a claimant may request a modification, change or reopening of a prior award that was entered either prior to or after that date 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 section twenty-two of this article, 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, a new five-year period begins upon the date of the subsequent award. With the advice of the health care advisory panel, the executive director and the board of managers shall by rule designate those progressive diseases which are customarily the subject of claims.

(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 subsection (d), section three of this article, 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 commission, successor to the commission, other 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall pass upon the request within thirty 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 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 commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, shall pass upon the request within thirty days of its receipt and, if the commission determines that the claimant may be entitled to an award, the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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 commission, successor to the commission, other 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 commission, successor to the commission, other 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 commission, successor to the commission, other 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 commission, successor to the commission, other 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 commission may determine, the commission may require the claimant to provide documents and other information to the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, 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 before the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, or its duly authorized representative and answer questions; and suspend or terminate any benefits of a claimant who willfully fails to provide the information or appear as required: Provided, That the commission shall develop, implement and complete a program as soon as reasonably possible that requires each person receiving permanent total disability benefits on the effective date of the amendment and reenactment of this section in the year 2003,

and each person who is awarded those benefits thereafter, to submit the tax returns and the affidavit described herein at least once: Provided, however, That this requirement does not restrict the commission's authority to require the information that may be required herein at such other times as the commission may determine. The commission, successor to the commission, other 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 subdivision (n), section six of this article. 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 commission, successor to the commission, other 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 affirm the original permanent total disability award as the record requires. The claimant's former employer shall not be a party to the reevaluation, but shall be notified of the reevaluation and may submit any information as the employer may elect. 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 Workers' Compensation Commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable. In addition, the Workers' Compensation Commission, successor to the commission, other 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 with the reimbursement being made from the fund. The board of managers shall adopt criteria for the determination of reasonable attorneys' fees.

(3) This subsection shall not be applied to awards made under the provisions of subdivision (m), section six of this article. The claimant may seek review of the final order as otherwise provided in article five of this chapter for review of orders granting or denying permanent disability awards.

(4) The commission shall establish by rule criteria for review, reopening and reevaluating a claim under this subsection. The commission shall at least quarterly provide a report of the exercise of its authority to continuously monitor permanent total disability awards under this section to the Joint Committee on Government and Finance and the Joint Commission on Economic Development.

(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.

§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 commission, successor to the commission, other 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. Any interest payable shall be charged to the account of the protesting or appealing employer to the extent that the benefits upon which such interest is computed are charged to the account of the employer.

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

The commission, successor to the commission, other 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 commission, successor to the commission, other 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.

§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 section sixteen, article five of this chapter, and other than for the enforcement of orders for child or spousal support entered pursuant to the provisions of chapter forty-eight of this code. Payments may be made in the periodic installments determined by the commission 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.

§23-4-19.

Repealed.

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

§23-4-20. Postmortem examinations.

The commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, may, after due notice to the employer and 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 commission a written report of his or her findings. The claimant and the employer, respectively, have the right to select a physician of his her or its own choosing and, at his or her or its own expense, to participate in the postmortem examination. The respective physicians selected by the claimant and the employer have the right to concur in any report made by the physician selected by the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, or each may file with the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, a separate report. In any case, including silicosis cases, in which either the employer or a claimant requests that an autopsy be performed, the autopsy shall be directed as provided in this section. In the event that a claimant for compensation for the death refuses to consent and permit the autopsy to be made all rights to compensation shall be forfeited.

§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.

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

Notwithstanding any provision in this chapter to the contrary, any claim which was closed for the receipt of temporary total disability benefits or which was closed on a no-lost-time basis and which was more than five years prior to the effective date of this section shall not be considered to still be open or the subject for an evaluation of the claimant for permanent disability merely because an evaluation has not previously been conducted and a decision on permanent disability has not been made: Provided, That if a request for an evaluation was made in a claim prior to the March 29, 1993, the commission shall have the evaluation performed. In every instance, a claim shall be a case in which no award has been made for the purposes of section sixteen of this article. In every claim closed after the effective date of this section, the commission shall give notice to the parties of the claimant's right to a permanent disability evaluation.

§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 subdivision (d), (m) or (n), section six of this article or under section eight-c of this article. 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 subsection (e), section ten of this article. 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 subdivisions (b) and (d), section six of this article.

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

(d) The board of managers 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.

§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 subdivision (d) or (n), section six of this article or section eight-c of this article who terminates active employment and is receiving full old-age retirement benefits under the Social Security Act, 42 U.S.C. §401 and 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 Workers' Compensation Commission, successor to the commission, other 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 subdivision (d) or (n), section six of this article. Any claim or request for permanent total disability benefits arising under said subdivisions shall first be presented to the commission as part of the initial claim filing or by way of an application for modification or adjustment pursuant to section sixteen of this article. The office of judges may consider a claim only after the commission, successor to the commission, other private carrier or self-insured employer, whichever is applicable, has entered an appropriate order.

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

(a) After April 8, one thousand nine hundred ninety-three, 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 subsection (e), section ten of this article. Prior to the application of this section to any claimant, the commission, successor to the commission, other 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 one hundred twenty 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 one hundred twenty percent level: Provided, That in no event shall applicable benefits be reduced below the minimum weekly benefits as provided in subdivisions (b) and (d), section six of this article.

§23-4A-1. Disabled Workers' Relief Fund.

Persons who are receiving benefits from the Disabled Workers' Relief Fund at the time the amendments made to this article by the Legislature during the 2022 regular session become effective shall continue to receive said benefits as awarded.

§23-4A-2. To whom benefits paid.

[Repealed.]

§23-4A-3. Computation of benefits.

[Repealed.]

§23-4A-4. Mode of payment.

[Repealed.]

§23-4A-5. Employers providing own system of compensation.

[Repealed.]

§23-4A-6. Powers of commission over disabled workers' relief fund.

[Repealed.]

§23-4A-7.

Repealed.

Acts, 2003 2nd Ex. Sess., Ch. 27.

§23-4A-8. Disabled workers' relief fund; how funded.

[Repealed.]

§23-4A-9. Transfer of authority to the Insurance Commissioner.

[Repealed.]

§23-4B-1. Purpose.

The purpose of this article is to establish a fund to provide benefits to coal miners who are totally disabled by pneumoconiosis and to eligible dependents of coal miners whose deaths were due to pneumoconiosis or who were totally disabled from pneumoconiosis at time of their deaths. The further purpose of this article is to provide a readily available insurer of liability created by Title IV of the federal Coal Mine Health and Safety Act of 1969, as amended, for claims incurred under said Act, including all claims where the date of last exposure is on or before December 31, 2005, without regard to the date the claim is filed.

§23-4B-2. Coal-Workers' Pneumoconiosis Fund established.

For the relief of persons who are entitled to receive benefits by virtue of Title IV of the federal Coal Mine Health and Safety Act of 1969, as amended, for claims incurred under said Act, including all claims where the date of last exposure is on or before December 31, 2005, without regard to the date the claim is filed, there is continued a fund to be known as the Coal-Workers' Pneumoconiosis Fund. The Coal-Workers' Pneumoconiosis Fund shall consist of premiums and other funds paid to the fund by employers, subject to the provisions of Title IV of the federal Coal Mine Health and Safety Act of 1969, as amended, who shall elect to subscribe to the fund to ensure the payment of benefits required by the Act for claims incurred under said Act, including all claims where the date of last exposure is on or before December 31, 2005, without regard to the date the claim is filed.

The State Treasurer shall be the custodian of the Coal-Workers' Pneumoconiosis Fund and all premiums, deposits, or other moneys paid to the fund shall be deposited in the State Treasury to the credit of the Coal-Workers' Pneumoconiosis Fund. Disbursements from the fund shall be made upon requisition signed by the Insurance Commissioner. The West Virginia Investment Management Board may invest any surplus, reserve, or other moneys belonging to the Coal-Workers' Pneumoconiosis Fund in accordance with §12-6-1 *et seq*. of this code.

§23-4B-3. To whom benefits paid.

Only those classes of persons who are entitled to benefits under Title IV of the federal Coal Mine Health and Safety Act of 1969, as amended, for claims incurred under said Act, including all claims where the date of last exposure is on or before December 31, 2005, without regard to the date the claim is filed, are eligible to participate in the Coal-Workers' Pneumoconiosis Fund.

§23-4B-4. Who may subscribe.

Only those employers who are subject to the provisions of Title IV of the federal Coal Mine Health and Safety Act of 1969, as amended, may elect to subscribe to the Coal-Workers' Pneumoconiosis Fund to insure the liability imposed upon such employers under the provisions of Title IV of the Act. Coverage by the Coal-Workers' Pneumoconiosis Fund will be provided only for claims incurred under the Act, including all claims where the date of last exposure is on or before December 31, 2005, without regard to the date the claim is filed. Pursuant to §23-4B-9 of this code, the Coal-Workers' Pneumoconiosis Fund was closed to new subscribers after December 31, 2005, upon the termination of the former Workers' Compensation Commission. Only those persons entitled to benefits under §23-4B-3 of this code and who were employed by employers who elected to subscribe to the Coal-Workers' Pneumoconiosis Fund prior to its closure may apply for benefits.

§23-4B-5. Payment of benefits.

Upon receipt of an order of compensation issued pursuant to a claim for benefits filed under the provisions of Title IV of the federal Coal Mine Health and Safety Act of 1969, as amended, for claims incurred under said Act, including all claims where the date of last exposure is on or before December 31, 2005, without regard to the date the claim is filed, the Insurance Commissioner shall disburse the Coal-Workers' Pneumoconiosis Fund in the amounts and to the persons as directed by the order.

§23-4B-6. Coal-workers' pneumoconiosis fund; how funded.

[Repealed.]

§23-4B-7. Administration.

The Coal-Workers' Pneumoconiosis Fund shall be administered by the Insurance Commissioner, who shall employ any employees and contract with any parties necessary to discharge his or her duties and responsibilities under this article. All payments of salaries and expenses of the employees and all expenses peculiar to the administration of this article shall be made by the State Treasurer from the Coal-Workers' Pneumoconiosis Fund upon requisitions signed by the Insurance Commissioner. *Provided*, That the employers' mutual insurance company established pursuant to §23-2C-1 *et seq*. of this code shall be the administrator of the Coal-Workers' Pneumoconiosis Fund for a term not to exceed three years following the termination of the Workers' Compensation Commission pursuant to an agreement to be entered into between the Insurance Commissioner and the Company prior to the termination of the Workers' Compensation Commission. The Company's administrative duties may include, but not be limited to, receipt of all claims, processing said claims, providing for the payment of said claims through the State Treasurer's office and ensuring, through the selection and assignment of counsel, that claims decisions are properly defended. Any contract entered into by the Insurance Commissioner for the administration of the Coal-Workers' Pneumoconiosis Fund thereafter shall be subject to the procedures set forth in §5A-3-1 *et seq*. of this code.

§23-4B-8. Separable from workers' compensation fund.

[Repealed.]

§23-4B-8a. Legislative findings; transfers to the state; maximum transfer authorization; purpose for which moneys transferred may be disbursed and expended; maximum amount of transfer authorization; terms and conditions for repayment; premiums to be set without regard to transfers; creation of special account in State Treasury.

[Repealed.]

§23-4B-8b. Transfer of funds to workers' compensation fund.

[Repealed.]

§23-4B-9. Closure of Coal-Workers' Pneumoconiosis Fund.

Upon the termination of the former Workers' Compensation Commission, the Coal-Workers' Pneumoconiosis Fund shall close to new subscribers. All claims payment obligations, including indemnity benefits, medical benefits, administrative, and all other expenses necessary for the administration and defense of claims, where the date of last exposure is on or before December 31, 2005, without regard to the date the claim is filed, shall be an obligation of the Coal-Workers' Pneumonoconiosis Fund.

§23-4C-1. Purpose.

[Repealed.]

§23-4C-2. Employers' excess liability fund established.

[Repealed.]

§23-4C-3. Payment of excess damages from fund.

[Repealed.]

§23-4C-4. Employers' excess liability fund; how funded.

[Repealed.]

§23-4C-5. Administration.

[Repealed.]

§23-4C-6. Novation to the successor of the commission.

[Repealed.]

§23-5-1. Notice by commission or self-insured employer of decision; procedures on claims; objections and hearing; effective until June 30, 2022.

(a) The Insurance Commissioner, private carriers, and self-insured employers may determine all questions within their jurisdiction. In matters arising under §23-2C-8(c) of this code, and under §23-3-1 *et seq*. and §23-4-1 *et seq*. of this code, the Insurance Commissioner, private carriers, and self-insured employers shall promptly review and investigate all claims. The parties to a claim are the claimant and, if applicable, the claimant's dependents, and the employer, and with respect to claims involving funds created in §23-2C-1 *et seq*. of this code for which he or she has been designated the administrator, the Insurance Commissioner. In claims in which the employer had coverage on the date of the injury or last exposure, the employer's carrier has sole authority to act on the employer's behalf in all aspects related to litigation of the claim. With regard to any issue which is ready for a decision, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall promptly send the decision to all parties, including the basis of its decision. As soon as practicable after receipt of any occupational pneumoconiosis or occupational disease claim, or any injury claim in which temporary total benefits are being claimed, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall send the claimant a brochure approved by the Insurance Commissioner setting forth the claims process.

(b) (1) Except with regard to interlocutory matters, upon making any decision, upon making or refusing to make any award, or upon making any modification or change with respect to former findings or orders, as provided by §23-4-16 of this code, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall give notice, in writing, to the parties to the claim of its action. The notice shall state the time allowed for filing a protest to the finding. The action of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, is final unless the decision is protested within 60 days after the receipt of such decision unless a protest is filed within the 60-day period, the finding or action is final. This time limitation is a condition of the right to litigate the finding or action and hence jurisdictional. Any protest shall be filed with the Office of Judges with a copy served upon the parties to the claim, and other parties in accordance with the procedures set forth in §23-8-1 *et seq*. and §23-9-1 *et seq*. of this code. An employer may protest decisions incorporating findings made by the Occupational Pneumoconiosis Board, decisions made by the Insurance Commissioner acting as administrator of claims involving funds created in §23-2C-1 *et seq*. of this code or decisions entered pursuant to §23-4-7A(c)(1) of this code.

(2) (A) With respect to every application for benefits filed on or after July 1, 2008, in which a decision to deny benefits is protested and the matter involves an issue as to whether the application was properly filed as a new claim or a reopening of a previous claim, the party that denied the application shall begin to make conditional payment of benefits and must promptly give notice to the Office of Judges that another identifiable person may be liable. The Office of Judges shall promptly order the appropriate persons be joined as parties to the

proceeding: *Provided*, That at any time during a proceeding in which conditional payments are being made in accordance with the provisions of this subsection, the Office of Judges may, pending final determination of the person properly liable for payment of the claim, order that such conditional payments of benefits be paid by another party.

(B) Any conditional payment made pursuant to paragraph (A) of this subdivision shall not be deemed an admission or conclusive finding of liability of the person making such payments. When the administrative law judge has made a determination as to the party properly liable for payment of the claim, he or she shall direct any monetary adjustment or reimbursement between or among the Insurance Commissioner, private carriers, and self-insured employers as is necessary.

(c) The Office of Judges may direct that:

(1) An application for benefits be designated as a petition to reopen, effective as of the original date of filing;

(2) A petition to reopen be designated as an application for benefits, effective as of the original date of filing; or

(3) An application for benefits or petition to reopen filed with the Insurance Commissioner, private carrier, or self-insured employer be designated as an application or petition to reopen filed with another private carrier, self-insured employer, or Insurance Commissioner, effective as of the original date of filing.

(d) Where an employer protests a written decision entered pursuant to a finding of the Occupational Pneumoconiosis Board, a decision on a claim made by the Insurance Commissioner acting as the administrator of a fund created in §23-2C-1 *et seq*. of this code, or decisions entered pursuant to §23-4-7A(c)(1) of this code, and the employer does not prevail in its protest, and in the event the claimant is required to attend a hearing by subpoena or agreement of counsel, or at the express direction of the Office of Judges, then the claimant, in addition to reasonable traveling and other expenses, shall be reimbursed for loss of wages incurred by the claimant in attending the hearing.

(e) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may amend, correct, or set aside any order or decision on any issue entered by it, which, at the time of issuance or any time after that, is discovered to be defective or clearly erroneous or the result of mistake, clerical error, or fraud, or with respect to any order or decision denying benefits, otherwise not supported by the evidence, but any protest filed prior to entry of the amended decision is a protest from the amended decision unless and until the administrative law judge before whom the matter is pending enters an order dismissing the protest as moot in light of the amendment. Jurisdiction to issue an amended decision pursuant to this subsection continues until the expiration of two years from the date of a decision to which the amendment is made unless the decision is sooner affected by an action of an administrative law judge or other judicial officer or body: *Provided*, That

corrective actions in the case of fraud may be taken at any time.

(f) This section is of no force and effect after June 30, 2022.

§23-5-1a. Notice by commission or self-insured employer of decision; procedures on claims; objections and hearing; effective July 1, 2022.

(a) The Insurance Commissioner, private carriers, and self-insured employers may determine all questions within their jurisdiction. In matters arising under §23-2C-8(c), and under §23-3-1 *et seq*. and §23-4-1 *et seq*. of this code, the Insurance Commissioner, private carriers, and self-insured employers, whichever is applicable, shall promptly review and investigate all claims. The parties to a claim are the claimant and, if applicable, the claimant's dependents, the employer, and, with respect to claims involving funds created in §23-2C-1 *et seq*. of this code for which he or she has been designated the administrator, the Insurance Commissioner. In claims in which the employer had coverage on the date of the injury or last exposure, the employer's carrier has sole authority to act on the employer's behalf in all aspects related to litigation of the claim. With regard to any issue which is ready for a decision, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall promptly send the decision to all parties, including the basis of its decision. As soon as practicable after receipt of any occupational pneumoconiosis or occupational disease claim or any injury claim in which temporary total benefits are being claimed, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall send the claimant a brochure approved by the Insurance Commissioner setting forth the claims process.

(b) (1) Except with regard to interlocutory matters, upon making any decision, upon making or refusing to make any award, or upon making any modification or change with respect to former findings or orders, as provided by §23-4-16 of this code, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall give notice, in writing, to the parties to the claim of its action. The notice shall state the time allowed for filing an objection to the finding. The action of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, is final unless an objection to the decision is properly filed within 60 days after the receipt of such decision. This time limitation is a condition of the right to litigate the finding or action and hence jurisdictional. Any objection shall be filed with the Workers' Compensation Board of Review, as provided in §23-5-8a and §23-5-8b of this code, with a copy served upon the parties to the claim, and other parties in accordance with the procedures set forth in §23-5-8a and §23-5-9a of this code. An employer may file an objection to a decision incorporating findings made by the Occupational Pneumoconiosis Board, decisions made by the Insurance Commissioner acting as administrator of claims involving funds created in §23-2C-1 *et seq*. of this code, or decisions entered pursuant to §23-4-7a(c)(1) of this code.

(2) (A) With respect to every application for benefits in which an objection to a decision to deny benefits is filed and the matter involves an issue as to whether the application was properly filed as a new claim or a reopening of a previous claim, the party that denied the application shall begin to make conditional payment of benefits and must promptly give notice to the Workers' Compensation Board of Review that another identifiable person may be liable. The Workers' Compensation Board of Review shall promptly order the appropriate

persons be joined as parties to the proceeding: *Provided*, That at any time during a proceeding in which conditional payments are being made in accordance with the provisions of this subsection, the Workers' Compensation Board of Review may, pending final determination of the person properly liable for payment of the claim, order that such conditional payments of benefits be paid by another party.

(B) Any conditional payment made pursuant to paragraph (A) of this subdivision shall not be deemed an admission or conclusive finding of liability of the person making such payments. When the Workers' Compensation Board of Review has made a determination as to the party properly liable for payment of the claim, the Board of Review shall direct any monetary adjustment or reimbursement between or among the Insurance Commissioner, private carriers, and self-insured employers as is necessary.

(c) The member of the Workers' Compensation Board of Review assigned to an objection, as provided in §23-5-9a(b) of this code, may direct that:

(1) An application for benefits be designated as a petition to reopen, effective as of the original date of filing;

(2) A petition to reopen be designated as an application for benefits, effective as of the original date of filing; or

(3) An application for benefits or petition to reopen filed with the Insurance Commissioner, private carrier, or self-insured employer be designated as an application or petition to reopen filed with another private carrier, self-insured employer, or Insurance Commissioner, effective as of the original date of filing.

(d) Where an employer files an objection to a written decision entered pursuant to a finding of the Occupational Pneumoconiosis Board, a decision on a claim made by the Insurance Commissioner acting as the administrator of a fund created in §23-2C-1 *et seq*. of this code, or decisions entered pursuant to §23-4-7a(c)(1) of this code, and the employer does not prevail in its objection, and in the event the claimant is required to attend a hearing by subpoena, or agreement of counsel, or at the express direction of Workers' Compensation Board of Review, then the claimant, in addition to reasonable traveling and other expenses, shall be reimbursed for loss of wages incurred by the claimant in attending the hearing.

(e) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may amend, correct, or set aside any order or decision on any issue entered by it which, at the time of issuance or any time after that, is discovered to be defective, or clearly erroneous, or the result of mistake, clerical error, or fraud, or with respect to any order or decision denying benefits, otherwise not supported by the evidence: *Provided*, That any objection filed prior to entry of the amended decision is an objection to the amended decision unless and until the Workers' Compensation Board of Review enters an order dismissing the objection as moot in light of the amendment. Jurisdiction to issue an amended decision pursuant to this subsection continues until the expiration of two years from the date

of a decision to which the amendment is made unless the decision is sooner affected by an action of the Workers' Compensation Board of Review or a judicial officer or body: *Provided, however*, That corrective actions in the case of fraud may be taken at any time.

(f) This section becomes effective on July 1, 2022.

§23-5-2. Application by employee for further adjustment of claim; objection to modification; hearing.

In any case where an injured employee makes application in writing for a further adjustment of his or her claim under the provisions of section sixteen, article four of this chapter and the application discloses cause for a further adjustment, the commission shall, after due notice to the employer, make the modifications, or changes with respect to former findings or orders in the claim that are justified. Any party dissatisfied with any modification or change made by the commission, the successor to the commission, other private insurance carriers and self-insured employers, whichever is applicable, is, upon proper and timely objection, entitled to a hearing, as provided in section nine of this article.

§23-5-3. Refusal to reopen claim; notice; objection; effective until June 30, 2022.

(a) If it appears to the Insurance Commissioner, private insurance carriers, and self-insured employers, whichever is applicable, that an application filed under §23-2-1 *et seq*. of this code fails to disclose a progression or aggravation in the claimant's condition, or some other fact or facts which were not previously considered in its former findings and which would entitle the claimant to greater benefits than the claimant has already received, the Insurance Commissioner, private insurance carriers, and self-insured employers, whichever is applicable, shall, within a reasonable time, notify the claimant and the employer that the application fails to establish a prima facie cause for reopening the claim. The notice shall be in writing stating the reasons for denial and the time allowed for objection to the decision of the commission. The claimant may, within 60 days after receipt of the notice, object in writing to the finding. Unless the objection is filed within the 60-day period, no objection shall be allowed. This time limitation is a condition of the right to objection and hence jurisdictional. Upon receipt of an objection, the Office of Judges shall afford the claimant an evidentiary hearing as provided in §23-9-1 *et seq*. of this code.

(b) This section is of no force and effect after June 30, 2022.

§23-5-3a. Refusal to reopen claim; notice; objection; effective July 1, 2022.

(a) If it appears to the Insurance Commissioner, private insurance carriers, and self-insured employers, whichever is applicable, that an application filed under §23-5-2a of this code fails to disclose a progression or aggravation in the claimant's condition, or some other fact or facts which were not previously considered in its former findings, and which would entitle the claimant to greater benefits than the claimant has already received, the Insurance Commissioner, private insurance carriers, and self-insured employers, whichever is applicable, shall, within a reasonable time, notify the claimant and the employer that the application fails to establish a prima facie cause for reopening the claim. The notice shall be in writing stating the reasons for denial and the time allowed for objection to the decision of the commission. The claimant may, within 60 days after receipt of the notice, object in writing to the finding. Unless the objection is filed within the 60-day period, no objection shall be allowed. This time limitation is a condition of the right to objection and hence jurisdictional. Upon receipt of an objection, the Workers' Compensation Board of Review shall afford the claimant an evidentiary hearing as provided in §23-5-9a of this code.

(b) This section becomes effective on July 1, 2022.

§23-5-4. Application by employer for modification of award; objection to modification; hearing.

In any case in which an employer makes application in writing for a modification of any award previously made to an employee of the employer, the commission, the successor to the commission, other private insurance carriers and self-insured employers, whichever is applicable, shall make a decision upon the application. If the application discloses cause for a further adjustment, the commission, the successor to the commission, other private insurance carriers and self-insured employers, whichever is applicable, shall, after due notice to the employee, make the modifications or changes with respect to former findings or orders that are justified. Any party dissatisfied with any modification or change made or by the denial of an application for modification is, upon proper and timely objection, entitled to a hearing as provided in either §23-5-9 or §23-5-9a of this code.

§23-5-5. Refusal of modification; notice; objection; effective until June 30, 2022.

(a) If in any case it appears to the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, that the application filed pursuant to §23-4-1 *et seq*. of this code fails to disclose some fact or facts which were not previously considered by the commission in its former findings, and which would entitle the employer to any modification of the previous award, the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, shall, within 60 days from the receipt of the application, notify the claimant and employer that the application fails to establish a just cause for modification of the award. The notice shall be in writing stating the reasons for denial and the time allowed for objection to the decision of the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable. The employer may, within 30 days after receipt of the notice, object in writing to the decision. Unless the objection is filed within the 30-day period, no objection shall be allowed. This time limitation is a condition of the right to objection and hence jurisdictional. Upon receipt of the objection, the Office of Judges shall afford the employer an evidentiary hearing as provided in §23-9-1 *et seq*. of this code.

(b) This section is of no force and effect after June 30, 2022.

§23-5-5a. Refusal of modification; notice; objection; effective July 1, 2022.

(a) If in any case it appears to the Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, that the application filed pursuant to §23-5-4 of this code fails to disclose some fact or facts which were not previously considered in former findings, and which would entitle the employer to any modification of the previous award, the Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, shall, within 60 days from the receipt of the application, notify the claimant and employer that the application fails to establish a just cause for modification of the award. The notice shall be in writing stating the reasons for denial and the time allowed for objection to the decision of the Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable. The employer may, within 30 days after receipt of the notice, object in writing to the decision. Unless the objection is filed within the 30-day period, no objection shall be allowed. This time limitation is a condition of the right to objection and hence jurisdictional. Upon receipt of the objection, the Workers' Compensation Board of Review shall afford the employer an evidentiary hearing as provided in §23-5-9 of this code.

(b) This section becomes effective on July 1, 2022.

§23-5-6. Time periods for objections and appeals; extensions; effective until June 30, 2022.

(a) Notwithstanding the fact that the time periods set forth for objections, protests and appeals to or from the workers' compensation Office of Judges are jurisdictional, the periods may be extended or excused upon application of either party within a period of time equal to the applicable period by requesting an extension of the time period showing good cause or excusable neglect, accompanied by the objection or appeal petition. In exercising discretion, the administrative law judge, appeal board, or court, as the case may be, shall consider whether the applicant was represented by counsel and whether timely and proper notice was actually received by the applicant or the applicant's representative.

(b) This section is of no force and effect after June 30, 2022.

§23-5-6a. Time periods for objections and appeals; extensions; effective July 1, 2022.

(a) Notwithstanding the fact that the time periods set forth for objections, protests, and appeals to or from the Workers' Compensation Board of Review are jurisdictional, the periods may be extended or excused upon application of either party within a period of time equal to the applicable period by requesting an extension of the time period showing good cause or excusable neglect, accompanied by the objection or appeal petition. In exercising discretion, the Workers' Compensation Board of Review or court, as the case may be, shall consider whether the applicant was represented by counsel and whether timely and proper notice was actually received by the applicant or the applicant's representative.

(b) This section becomes effective on July 1, 2022.

§23-5-7. Compromise and settlement.

(a) The claimant, the employer, and the Workers" Compensation Commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, may negotiate a final settlement of any and all issues in a claim wherever the claim is in the administrative or appellate processes: Provided, That in the settlement of medical benefits for nonorthopedic occupational disease claims, the claimant shall be represented by legal counsel: Provided, however, That for the purposes of this section, the term "nonorthopedic occupational disease claim" does not include an occupational hearing loss or hearing impairment claim. If the employer is not active in the claim, the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, may negotiate a final settlement with the claimant and the settlement shall be made a part of the claim record. Except in cases of fraud, no issue that is the subject of an approved settlement agreement may be reopened by any party, including the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable. Any settlement agreement may provide for a lump-sum payment or a structured payment plan, or any combination thereof, or any other basis as the parties may agree. If a self-insured employer later fails to make the agreed-upon payment, the commission shall assume the obligation to make the payments and shall recover the amounts paid or to be paid from the self-insured employer and its sureties or guarantors, or both, as provided in §23-2-5 or §23-2-5a of this code.

(b) Each settlement agreement shall provide the toll-free number of the West Virginia State Bar Association and shall provide the injured worker with five business days to revoke the executed agreement. The Insurance Commissioner may void settlement agreements entered into by an unrepresented injured worker which are determined to be unconscionable pursuant to criteria established by rule of the commissioner.

(c) The amendments to this section enacted during the regular session of the Legislature, 2015, apply to all settlement agreements executed after the effective date.

§23-5-8. Designation of Office of Administrative Law Judges; powers of chief administrative law judge; effective until June 30, 2022.

(a) The Workers' Compensation Office of Administrative Law Judges previously created pursuant to Chapter 12, Acts of the Legislature, second extraordinary session, 1990, is hereby continued and designated to be an integral part of the workers' compensation system of this state. The Office of Judges shall be under the supervision of a chief administrative law judge who shall be appointed by the Governor with the advice and consent of the Senate.

(b) The chief administrative law judge shall be a person who has been admitted to the practice of law in this state and shall also have had at least four years of experience as an attorney. The chief administrative law judge's salary shall be set by the workers' compensation board of managers. The salary shall be within the salary range for comparable chief administrative law judges as determined by the state Personnel Board created by §29-6-6 of this code. The chief administrative law judge may only be removed by a vote of two-thirds of the members of the Workers' Compensation Board of managers. Upon transfer of the Office of Judges to the Insurance Commissioner, the chief administrative law judge shall continue to serve as chief administrative law judge until December 31, 2007. Thereafter, appointments of the chief administrative law judge shall be for terms of four years beginning January 1, 2008, and the chief administrative law judge may be removed only for cause by the vote of four members of the Industrial Council. No other provision of this code purporting to limit the term of office of any appointed official or employee or affecting the removal of any appointed official or employee is applicable to the chief administrative law judge.

(c) The chief administrative law judge shall employ administrative law judges and other personnel that are necessary for the proper conduct of a system of administrative review of orders issued by the Workers' Compensation Commission which orders have been objected to by a party. The employees shall be in the classified service of the state. Qualifications, compensation, and personnel practice relating to the employees of the office of judges, other than the chief administrative law judge, shall be governed by the provisions of this code and rules of the classified service pursuant to §29-6-1 of this code. All additional administrative law judges shall be persons who have been admitted to the practice of law in this state and shall also have had at least two years of experience as an attorney. The chief administrative law judge shall supervise the other administrative law judges and other personnel which collectively shall be referred to in this chapter as the Office of Judges.

(d) The administrative expense of the Office of Judges shall be included within the annual budget of the Workers' Compensation Commission and, upon termination of the commission, the Insurance Commissioner.

(e) The Office of Judges shall, from time to time, promulgate rules of practice and procedure for the hearing and determination of all objections to findings or orders of the Workers' Compensation Commission. The Office of Judges shall not have the power to initiate or to promulgate legislative rules as that phrase is defined in §29A-3-1 *et seq*. of this code. Any

rules adopted pursuant to this section which are applicable to the provisions of this article are not subject to §29A-3-9 through §29A-3-16 of this code. The Office of Judges shall follow the remaining provisions of said chapter for giving notice to the public of its actions and the holding of hearings or receiving of comments on the rules.

(f) The chief administrative law judge has the power to hear and determine all disputed claims in accordance with the provisions of this article, establish a procedure for the hearing of disputed claims, take oaths, examine witnesses, issue subpoenas, establish the amount of witness fees, keep records, and make reports that are necessary for disputed claims and exercise any additional powers, including the delegation of powers to administrative law judges or hearing examiners that are necessary for the proper conduct of a system of administrative review of disputed claims. The chief administrative law judge shall make reports that are requested of him or her by the workers' compensation board of managers.

(g) Effective upon termination of the commission, the Office of Judges and the Board of Review shall be transferred to the Insurance Commissioner, which shall have the oversight and administrative authority heretofore provided to the executive director and the board of managers.

(h) This section is of no force and effect after June 30, 2022.

§23-5-8a. Transfer of powers and duties of the Office of Administrative Law Judges to the Workers' Compensation Board of Review; powers of the Workers' Compensation Board of Review in relation to review of objections; effective July 1, 2022.

(a) The Workers' Compensation Office of Administrative Law Judges, referred to as the Office of Judges, shall terminate on or before October 1, 2022, as provided in §23-5-8b of this code. All powers and duties of the Office of Judges to review objections, protests, or any other matter authorized by this chapter, shall be transferred to the Workers' Compensation Board of Review on July 1, 2022: *Provided*, That any objection or other matter filed pursuant to this chapter and pending before the Office of Judges upon its termination, in which a final decision has not been issued, shall also be transferred to the Workers' Compensation Board of Review as provided in §23-5-8b of this code.

(b) Pursuant to §23-5-11a(n) of this code, the Workers' Compensation Board of Review shall employ hearing examiners and other personnel that are necessary for the proper conduct of a system of administrative review of objections to decisions of the Insurance Commissioner, private carriers, and self-insured employers, whichever is applicable, made pursuant to the provisions of §23-5-1a of this code and issued after June 30, 2022. All hearing examiners hired by the Workers' Compensation Board of Review shall be persons who have been admitted to the practice of law in this state and shall also have had at least four years of experience as an attorney. The chair of the Workers' Compensation Board of Review shall supervise hearing examiners and other personnel of the board, which collectively shall be referred to in this chapter as the Workers' Compensation Board of Review.

(c) The Workers' Compensation Board of Review has the power to hear and determine all objections in accordance with the provisions of this article, establish a procedure for the hearing of objections, take oaths, examine witnesses, issue subpoenas, establish the amount of witness fees, keep records, and make reports that are necessary for reviewing objections, and exercise any additional powers, including the delegation of powers to hearing examiners that are necessary for the proper conduct of a system of administrative review of objections. The chair of the Workers' Compensation Board of Review shall make reports that are requested of him or her by the Insurance Commissioner.

(d) Effective upon termination of the Office of Judges, the Insurance Commissioner shall have oversight and administrative authority over the Workers' Compensation Board of Review as heretofore provided to the Insurance Commissioner over the Office of Judges.

(e) This section becomes effective on July 1, 2022.

§23-5-8b. Transfer of jurisdiction to review objections to Workers' Compensation Board of Review; termination of Office of Judges; appeals of board decisions to Intermediate Court of Appeals; effective July 1, 2022.

(a) The Office of Judges has no jurisdiction to review objections to a decision of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, made pursuant to the provisions of this chapter and issued after June 30, 2022. The Workers' Compensation Board of Review has exclusive jurisdiction to review objections to a decision of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, made pursuant to the provisions of this chapter and issued after June 30, 2022.

(b) On or before September 30, 2022, the Office of Judges shall issue a final decision in, or otherwise dispose of, each and every objection or other matter pending before the Office of Judges. If the Office of Judges does not issue a final decision or otherwise dispose of any objection or other matter pending before the Office of Judges on or before September 30, 2022, the objection or other matter shall be transferred to the Workers' Compensation Board of Review. For any objections transferred from the Office of Judges to the Workers' Compensation Board of Review, the Board of Review shall adopt any existing records of proceedings in the Office of Judges, conduct further proceedings, and collect evidence as it determines to be necessary, and issue a final decision or otherwise dispose of the case according to the procedural rules promulgated pursuant to §23-5-11a(m) of this code.

(c) Upon the Office of Judges' disposition of every matter pending before the office, or on October 1, 2022, whichever occurs earlier, the Office of Judges is terminated.

(d) The West Virginia Intermediate Court of Appeals, created in §51-11-1 *et seq*. of this code, has exclusive appellate jurisdiction over the following:

(1) Decisions or orders issued by the Office of Judges after June 30, 2022, and prior to its termination; and

(2) All final orders or decisions issued by the Workers' Compensation Board of Review after June 30, 2022.

(e) Notwithstanding the requirements of this section, the Workers' Compensation Board of Review shall review and decide all remaining appeals filed with the Board of Review, of Office of Judges' decisions issued prior to June 30, 2022, according to the procedure and requirements for such appeals heretofore provided in this article.

(f) This section becomes effective on July 1, 2022.

§23-5-9. Hearings on objections to Insurance Commissioner; private carrier or self-insured employer decisions; mediation; remand; effective until June 30, 2022.

(a) Objections to a decision of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, made pursuant to the provisions of §23-5-1 *et seq*. of this code shall be filed with the Office of Judges. Upon receipt of an objection, the Office of Judges shall notify the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, and all other parties of the filing of the objection. The Office of Judges shall establish by rule promulgated in accordance with the provisions of §23-5-8(e) of this code an adjudicatory process that enables parties to present evidence in support of their positions and provides an expeditious resolution of the objection. The employer, the claimant, the Insurance Commissioner, private carrier, or self-insured employer, whichever are applicable, shall be notified of any hearing at least 10 days in advance. The Office of Judges shall review and amend, or modify, as necessary, its procedural rules by July 1, 2007.

(b) The Office of Judges shall establish a program for mediation to be conducted in accordance with the requirements of Rule 25 of the West Virginia Trial Court Rules. The parties may agree that the result of the mediation is binding. A case may be referred to mediation by the administrative law judge on his or her own motion, on motion of a party or by agreement of the parties. Upon issuance of an order for mediation, the Office of Judges shall assign a mediator from a list of qualified mediators maintained by the West Virginia State Bar.

(c) The Office of Judges shall keep full and complete records of all proceedings concerning a disputed claim. Subject to the rules of practice and procedure promulgated pursuant to §23-5-8 of this code, the record upon which the matter shall be decided shall include any evidence submitted by a party to the Office of Judges and evidence taken at hearings conducted by the Office of Judges. The record may include evidence or documents submitted in electronic form or other appropriate medium in accordance with the rules of practice and procedure. The Office of Judges is not bound by the usual common law or statutory rules of evidence.

(d) All hearings shall be conducted as determined by the chief administrative law judge pursuant to the rules of practice and procedure promulgated pursuant to §23-5-8 of this code. Upon consideration of the designated record, the chief administrative law judge or other authorized adjudicator within the Office of Judges shall, based on the determination of the facts of the case and applicable law, render a decision affirming, reversing, or modifying the action protested. The decision shall contain findings of fact and conclusions of law and shall be mailed to all parties.

(e) The Office of Judges may remand a claim to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, for further development of the facts or administrative matters as, in the opinion of the administrative law judge, may be necessary for a full and complete disposition of the case. The administrative law judge shall establish a time within which the Insurance Commissioner, private carrier, or self-insured employer,

whichever is applicable, must report back to the administrative law judge.

(f) The decision of the Office of Judges regarding any objections to a decision of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, is final and benefits shall be paid or denied in accordance with the decision, unless an order staying the payment of benefits is specifically entered by the Workers' Compensation Board of Review created in §23-5-11 of this code or by the administrative law judge who granted the benefits. No stay with respect to any medical treatment or rehabilitation authorized by the Office of Judges may be granted. If the decision is subsequently appealed and reversed in accordance with the procedures set forth in this article, and any overpayment of benefits occurs as a result of such reversal, any such overpayment may be recovered pursuant to the provisions of §23-4-1C(h) and §23-4-1D(d) of this code, as applicable.

(h) This section is of no force and effect after June 30, 2022.

§23-5-9a. Hearings on objections to Insurance Commissioner; private carrier, or self-insured employer decisions; mediation; remand; effective July 1, 2022.

(a) Objections to a decision of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, made pursuant to the provisions of §23-5-1a of this code, shall be filed with the Workers' Compensation Board of Review. Upon receipt of an objection, the Workers' Compensation Board of Review shall notify the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, and all other parties of the filing of the objection. The Workers' Compensation Board of Review shall establish by rule, promulgated in accordance with the provisions of §23-5-11a(m) of this code, an adjudicatory process that enables parties to present evidence in support of their positions and provides an expeditious resolution of the objection. The employer, the claimant, the Insurance Commissioner, the private carrier, or the self-insured employer, whichever is applicable, shall be notified of any hearing at least 10 days in advance.

(b) The chair of the Workers' Compensation Board of Review shall assign, on a rotating basis, a member of the Board of Review to preside over the review process and issue a decision in each objection that is properly filed with the Board of Review. The member of the Workers' Compensation Board of Review assigned to an objection shall review evidence, conduct proceedings, and develop a record as is necessary for a full and thorough review of the objection: *Provided*, That the board member may delegate such duties to a hearing examiner employed by the Board of Review, pursuant to §23-5-8a and §23-5-11a(n) of this code: *Provided, however*, That any order or decision of the Board of Review must be issued and signed by the member of the Board assigned to the objection, as provided in subsection (e) of this section: *Provided further*, That a time frame order, continuance order, show cause order, failure to prosecute order, or other interlocutory order as permitted by the Workers' Compensation Board of Review's procedural rules may be issued and signed by a hearing examiner only, and is not subject to the general requirement that orders be issued and signed by a member of the board.

(c) The Workers' Compensation Board of Review shall establish a program for mediation to be conducted in accordance with the requirements of Rule 25 of the West Virginia Trial Court Rules. The parties may agree that the result of the mediation is binding. A case may be referred to mediation by the Board of Review member assigned to the objection on his or her own motion, on motion of a party, or by agreement of the parties. Upon issuance of an order for mediation, the Workers' Compensation Board of Review shall assign a mediator from a list of qualified mediators maintained by the West Virginia State Bar.

(d) The Workers' Compensation Board of Review shall keep full and complete records of all proceedings concerning an objection. Subject to the rules of practice and procedure promulgated pursuant to §23-5-11a(m) of this code, the record upon which the matter shall be decided shall include any evidence submitted by a party to the Workers' Compensation Board of Review and evidence taken at hearings conducted by the Board of Review. The record may include evidence or documents submitted in electronic form or other appropriate medium in accordance with the rules of practice and procedure. The Workers' Compensation

Board of Review is not bound by the usual common law or statutory rules of evidence.

(e) All hearings shall be conducted as determined by the Workers' Compensation Board of Review according to the rules of practice and procedure promulgated pursuant to §23-5-11a(m) of this code. If a hearing examiner reviews an objection, the hearing examiner shall, at the conclusion of the review process, submit the designated record to the member of the Workers' Compensation Board of Review to whom the objection is assigned, along with the hearing examiner's recommendation of a decision affirming, reversing, or modifying the action that was subject to the objection. Upon consideration of the designated record and, if applicable, the recommendation of the hearing examiner, the member of the Workers' Compensation Board of Review assigned to the objection shall, based on the determination of the facts of the case and applicable law, render a decision affirming, reversing, or modifying the action that was subject to the objection. The decision shall contain findings of fact and conclusions of law, shall be signed by the member of the Workers' Compensation Board of Review rendering the decision, and shall be mailed to all parties.

(f) The Workers' Compensation Board of Review may remand a claim to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, for further development of the facts or administrative matters as, in the opinion of the member of the board of review assigned to the objection, may be necessary for a full and complete disposition of the case. The member of the Workers' Compensation Board of Review assigned to the objection shall establish a time within which the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, must report back to the board of review.

(g) The decision of the Workers' Compensation Board of Review regarding any objections to a decision of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, is final, and benefits shall be paid or denied in accordance with the decision, unless an order staying the payment of benefits is specifically entered by a court with appellate jurisdiction over the decision or by the member of the Office of Judges who granted the benefits. A stay with respect to any medical treatment or rehabilitation authorized by the Workers' Compensation Board of Review may not be granted. If the decision is subsequently appealed and reversed in accordance with the procedures set forth in this article, and any overpayment of benefits occurs as a result of the reversal, the overpayment may be recovered pursuant to the provisions of §23-4-1c(h) or §23-4-1d(d) of this code, as applicable.

(h) This section becomes effective on July 1, 2022.

§23-5-10. Appeal from administrative law judge decision to appeal board; effective until June 30, 2022.

(a) The employer, claimant, Workers' Compensation Commission, the successor to the commission, other private insurance carriers and self-insured employers, whichever is applicable, may appeal to the appeal board created in §23-11-1 *et seq*. of this code for a review of a decision by an administrative law judge. No appeal or review shall lie unless application therefor be made within thirty days of receipt of notice of the administrative law judge's final action or in any event within 60 days of the date of such final action, regardless of notice and, unless the application for appeal or review is filed within the time specified, no such appeal or review shall be allowed, such time limitation being hereby declared to be a condition of the right of such appeal or review and hence jurisdictional.

(b) This section is of no force and effect after June 30, 2022.

§23-5-10a. Appeal from a Workers' Compensation Board of Review decision to the Intermediate Court of Appeals; effective July 1, 2022.

(a) The employer, claimant, Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, may appeal to the West Virginia Intermediate Court of Appeals, created by §51-11-1 *et seq*. of this code, for a review of a decision by the Workers' Compensation Board of Review. No appeal or review shall lie unless application is made within 30 days of receipt of notice of the Workers' Compensation Board of Review's final action or in any event within 60 days of the date of such final action, regardless of notice and, unless the application for appeal or review is filed within the time specified, no such appeal or review shall be allowed, such time limitation being hereby declared to be a condition of the right of such appeal or review and hence jurisdictional.

(b) This section becomes effective on July 1, 2022.

§23-5-11. Workers' Compensation Board of Review generally; administrative powers and duties of the board; effective until June 30, 2022.

(a) On January 31, 2004, the Workers' Compensation Appeal Board heretofore established in this section is hereby abolished.

(b) There is created the "Workers' Compensation Board of Review", which may also be referred to as "the Board of Review" or "the board". Effective February 1, 2004, the Board of Review shall exercise exclusive jurisdiction over all appeals from the Workers' Compensation Office of Judges including any and all appeals pending with the board of Appeals on January 31, 2004.

(c) The board consists of three members.

(d) The Governor shall appoint, from names submitted by the "Workers' Compensation Board of Review Nominating Committee", with the advice and consent of the Senate, three qualified attorneys to serve as members of the Board of Review. If the Governor does not select a nominee for any vacant position from the names provided by the nominating committee, he or she shall notify the nominating committee of that circumstance and the committee shall provide additional names for consideration by the Governor. A member of the Board of Review may be removed by the Governor for official misconduct, incompetence, neglect of duty, gross immorality, or malfeasance, and then only after notice and opportunity to respond and present evidence. No more than two of the members of the board may be of the same political party. The members of the Board of Review shall be paid an annual salary of $85,000: *Provided*, That on and after July 1, 2008, the Governor shall set the salary of the members of the board: *Provided, however*, That the annual salary of a member of the Board of Review shall not exceed $110,000. Members are entitled to be reimbursed for actual and necessary travel expenses incurred in the discharge of official duties in a manner consistent with the guidelines of the Travel Management Office of the Department of Administration.

(e) The nominating committee consists of the following members: (1) The President of the West Virginia State Bar who serves as the chairperson of the committee; (2) an active member of the West Virginia State Bar Workers' Compensation Committee selected by the major trade association representing employers in this state; (3) an active member of the West Virginia State Bar Workers' Compensation Committee selected by the highest ranking officer of the major employee organization representing workers in this state; (4) the Dean of the West Virginia University School of Law; and (5) the Chairman of the Judicial Investigation Committee.

(f) The nominating committee is responsible for reviewing and evaluating candidates for possible appointment to the Board of Review by the Governor. In reviewing candidates, the nominating committee may accept comments from and request information from any person or source.

(g) Each member of the nominating committee may submit up to three names of qualified

candidates for each position on the Board of Review: *Provided*, That the member of the nominating committee selected by the major trade organization representing employers of this state shall submit at least one name of a qualified candidate for each position on the board who either is, or who represents, small business employers of this state. After careful review of the candidates, the committee shall select a minimum of one candidate for each position on the board.

(h) Of the initial appointments, one member shall be appointed for a term ending December 31, 2006; one member shall be appointed for a term ending December 31, 2008; and one member shall be appointed for a term ending December 31, 2010. Thereafter, the appointments shall be for six-year terms.

(i) A member of the Board of Review must, at the time he or she takes office and thereafter during his or her continuance in office, be a resident of this state, be a member in good standing of the West Virginia State Bar, have a minimum of 10 years' experience as an attorney admitted to practice law in this state prior to appointment and have a minimum of five years' experience in preparing and presenting cases or hearing actions and making decisions on the basis of the record of those hearings before administrative agencies, regulatory bodies, or courts of record at the federal, state, or local level.

(j) No member of the Board of Review may hold any other office, or accept any appointment or public trust, nor may he or she become a candidate for any elective public office or nomination thereto. Violation of this subsection requires the member to vacate his or her office. No member of the Board of Review may engage in the practice of law during his or her term of office.

(k) A vacancy occurring on the board other than by expiration of a term shall be filled in the manner original appointments were made, for the unexpired portion of the term.

(l) The board shall designate one of its members in rotation to be chairman of the board for as long as the board may determine by order made and entered of record. In the absence of the chairman, any other member designated by the members present shall act as chairman.

(m) The Board of Review shall meet as often as necessary to hold review hearings, at such times and places as the chairman may determine. Two members shall be present in order to conduct review hearings or other business. All decisions of the board shall be determined by a majority of the members of the board.

(n) The Board of Review shall make general rules regarding the pleading, including the form of the petition and any responsive pleadings, practice, and procedure to be used by the board.

(o) The Board of Review may hire a clerk and other professional and clerical staff necessary to carry out the requirements of this article. It is the duty of the clerk of the Board of Review to attend in person, or by deputy, all the sessions of the board, to obey its orders and

directions, to take care of and preserve in an office, kept for the purpose, all records and papers of the board, and to perform other duties as prescribed by law or required of him or her by the board. All employees of the board serve at the will and pleasure of the board. The board's employees are exempt from the salary schedule or pay plan adopted by the Division of Personnel. All personnel of the Board of Review are under the supervision of the chairman of the Board of Review.

(p) If considered necessary by the board, the board may, through staffing or other resources, procure assistance in review of medical portions of decisions.

(q) Upon the conclusion of any hearing, or prior thereto with concurrence of the parties, the board shall promptly determine the matter and make an award in accordance with its determination.

(r) The award shall become a part of the commission file. A copy of the award shall be sent forthwith by mail to all parties in interest.

(s) The award is final when entered. The award shall contain a statement explaining the rights of the parties to an appeal to the Board of Review and the applicable time limitations involved.

(t) The board shall submit to the Insurance Commissioner a budget sufficient to adequately provide for the administrative and other operating expenses of the board.

(u) The board shall report monthly to the Industrial Council on the status of all claims on appeal.

(v) Effective upon termination of the commission, the Board of Review shall be transferred to the Insurance Commissioner which shall have the oversight and administrative authority heretofore provided to the executive director and the board of managers.

(w) This section is of no force and effect after June 30, 2022.

§23-5-11a. Workers' Compensation Board of Review generally; administrative powers and duties of the board; effective July 1, 2022.

(a) The "Workers' Compensation Board of Review", which may also be referred to as "the Board of Review" or "the board" is hereby continued and granted exclusive jurisdiction over all objections to decisions of the Insurance Commissioner, private carriers, and self-insured employers, whichever is applicable, including any and all matters pending before the Office of Judges after September 30, 2022.

(b) The board consists of five members.

(c) The Governor shall appoint, with the advice and consent of the Senate, five attorneys qualified in accordance with subsection (f) of this section to serve as members of the Board of Review. A member of the Board of Review may be removed by the Governor for official misconduct, incompetence, neglect of duty, gross immorality, or malfeasance and then only after notice and opportunity to respond and present evidence. No more than three of the members of the board may be of the same political party. The Governor shall set the salary of the members of the board: *Provided*, however, That the annual salary of a member of the Board of Review shall not exceed $125,000. Members are entitled to be reimbursed for actual and necessary travel expenses incurred in the discharge of official duties in a manner consistent with the guidelines of the Travel Management Office of the Department of Administration.

(d) Of the initial appointments of the two additional seats created during the 2021 Regular Session, one member shall be appointed for a term ending December 31, 2025; one member shall be appointed for a term ending December 31, 2027. Thereafter, The appointments shall be for six-year terms.

(e) A member of the Board of Review must, at the time he or she takes office and thereafter during his or her continuance in office, be a resident of this state, be a member in good standing of the West Virginia State Bar, have a minimum of 10 years' experience as an attorney admitted to practice law in this state prior to appointment and have a minimum of five years' experience in preparing and presenting cases or hearing actions and making decisions on the basis of the record of those hearings before administrative agencies, regulatory bodies, or courts of record at the federal, state, or local level.

(f) No member of the Board of Review may hold any other office, or accept any appointment or public trust, nor may he or she become a candidate for any elective public office or nomination thereto. Violation of this subsection requires the member to vacate his or her office. No member of the Board of Review may engage in the practice of law during his or her term of office.

(g) A vacancy occurring on the board other than by expiration of a term shall be filled in the manner original appointments were made, for the unexpired portion of the term.

(h) The board shall designate one of its members in rotation to be chair of the board for as long as the board may determine by order made and entered of record. In the absence of the chair, any other member designated by the members present shall act as chair.

(i) The Board of Review shall meet as often as necessary to conduct the board's administrative business and make rules of practice and procedure, at such times and places as the chair may determine. Two members shall be present in order to conduct administrative business and make rules of practice and procedure. All decisions of the board upon administrative matters, pursuant to this section, shall be determined by a majority of the members of the board.

(j) The Board of Review shall, from time to time, promulgate rules of practice and procedure for the review and determination of all objections filed with the board. The board does not have the power to initiate or to promulgate legislative rules as that phrase is defined in §29A-3-1 *et seq*. of this code. Any rules adopted pursuant to this section which are applicable to the provisions of this article are not subject to §29A-3-9 through §29A-3-16 of this code. The board shall follow the remaining provisions of chapter 29A of this code for giving notice to the public of its actions and the holding of hearings or receiving of comments on the rules.

(k) The Board of Review may hire a clerk, hearing examiners, and other professional and clerical staff necessary to carry out the requirements of this article. It is the duty of the clerk of the Board of Review to attend in person, or by deputy, all the sessions of the board, to obey its orders and directions, to take care of and preserve in an office, kept for the purpose, all records and papers of the board and to perform other duties as prescribed by law or required of him or her by the board. All employees of the board serve at the will and pleasure of the board. The board's employees are exempt from the salary schedule or pay plan adopted by the Division of Personnel: *Provided*, That for the purpose of any applicable Division of Personnel Class Specifications, hearing examiners must be classified under a class with "attorney" in the class title. All personnel of the Board of Review are under the supervision of the chair of the Board of Review.

(l) The administrative expenses of the Board of Review shall be included within the annual budget of the Insurance Commissioner, and the Insurance Commissioner shall have administrative authority and oversight over the Board of Review.

(m) The amendments to this section made during the 2021 Regular Session of the Legislature shall become effective on July 1, 2022: *Provided*, That the board is authorized to promulgate rules and hire staff, pursuant to subsection (k) and (l) of this section respectively, prior to July 1, 2022, to the extent necessary to comply with the requirements of this article that shall become effective on that date.

§23-5-12. Appeal to board; procedure; remand and supplemental hearing; effective until June 30, 2022.

(a) Any employer, employee, claimant, or dependent who shall feel aggrieved at any final action of the administrative law judge taken after a hearing held in accordance with the provisions of §23-5-9 of this code shall have the right to appeal to the board created in §23-11-1 of this code for a review of such action. The Workers' Compensation Commission, the successor to the commission, other private insurance carriers and self-insured employers, whichever is applicable, shall likewise have the right to appeal to the board any final action taken by the administrative law judge. The aggrieved party shall file a written notice of appeal with the Board of Review, with a copy to the Office of Judges, within 30 days after receipt of notice of the action complained of or, in any event, regardless of notice, within 60 days after the date of the action complained of, and unless the notice of appeal is filed within the time specified, no appeal shall be allowed, the time limitation is a condition of the right to appeal and hence jurisdictional. The board shall notify the other parties immediately upon the filing of a notice of appeal. The notice of appeal shall state the ground for review and whether oral argument is requested. The Office of Judges, after receiving a copy of the notice of appeal, shall forthwith make up a transcript of the proceedings before the Office of Judges and certify and transmit it to the board. The certificate shall incorporate a brief recital of the proceedings in the case and recite each order entered and the date thereof.

(b) The board shall set a time and place for the hearing of arguments on each claim and shall notify the interested parties thereof. The review by the board shall be based upon the record submitted to it and such oral argument as may be requested and received. The board may affirm, reverse, modify, or supplement the decision of the administrative law judge and make such disposition of the case as it determines to be appropriate. Briefs may be filed by the interested parties in accordance with the rules of procedure prescribed by the board. The board may affirm the order or decision of the administrative law judge or remand the case for further proceedings. It shall reverse, vacate, or modify the order or decision of the administrative law judge if the substantial rights of the petitioner or petitioners have been prejudiced because the administrative law judge's findings are:

(1) In violation of statutory provisions; or

(2) In excess of the statutory authority or jurisdiction of the administrative law judge; or

(3) Made upon unlawful procedures; or

(4) Affected by other error of law; or

(5) Clearly wrong in view of the reliable, probative, and substantial evidence on the whole record; or

(6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted

exercise of discretion.

(c) After a review of the case, the board shall issue a written decision and send a copy by mail to the parties.

(1) All decisions, findings of fact and conclusions of law of the Board of Review shall be in writing and state with specificity the laws and facts relied upon to sustain, reverse, or modify the administrative law judge's decision.

(2) Decisions of the Board of Review shall be made by a majority vote of the Board of Review.

(3) A decision of the Board of Review is binding upon the executive director and the commission and the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, with respect to the parties involved in the particular appeal. The executive director, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, shall have the right to seek judicial review of a board of review decision irrespective of whether or not he or she appeared or participated in the appeal to the Board of Review.

(d) Instead of affirming, reversing, or modifying the decision of the administrative law judge, the board may, upon motion of any party or upon its own motion, for good cause shown, to be set forth in the order of the board, remand the case to the chief administrative law judge for the taking of such new, additional, or further evidence as in the opinion of the board may be necessary for a full and complete development of the facts of the case. In the event the board shall remand the case to the chief administrative law judge for the taking of further evidence, the administrative law judge shall proceed to take new, additional, or further evidence in accordance with any instruction given by the board within 30 days after receipt of the order remanding the case. The chief administrative law judge shall give to the interested parties at least 10 days' written notice of the supplemental hearing, unless the taking of evidence is postponed by agreement of parties, or by the administrative law judge for good cause. After the completion of a supplemental hearing, the administrative law judge shall, within 60 days, render his or her decision affirming, reversing, or modifying the former action of the administrative law judge. The decision shall be appealable to and proceeded with by the Board of Review in the same manner as other appeals. In addition, upon a finding of good cause, the board may remand the case to the Workers' Compensation Commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, for further development. Any decision made by the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, following a remand shall be subject to objection to the Office of Judges and not to the board. The board may remand any case as often as in its opinion is necessary for a full development and just decision of the case.

(e) All appeals from the action of the administrative law judge shall be decided by the board at the same session at which they are heard, unless good cause for delay thereof be shown

and entered of record.

(f) In all proceedings before the board, any party may be represented by counsel.

(g) This section is of no force and effect after June 30, 2022.

§23-5-12a. Appeal of board decisions to the Intermediate Court of Appeals; procedure; remand and supplemental hearing; effective July 1, 2022.

(a) Any employer, employee, claimant, or dependent who shall feel aggrieved by a decision of the Workers' Compensation Board of Review shall have the right to appeal to the West Virginia Intermediate Court of Appeals, created by §51-11-1 *et seq*. of this code, for a review of such action. The Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, shall likewise have the right to appeal to the Intermediate Court of Appeals any final action taken by the Workers' Compensation Board of Review. The aggrieved party shall file a written notice of appeal with the Intermediate Court of Appeals, with a copy to the Workers' Compensation Board of Review, within 30 days after receipt of notice of the action complained of or, in any event, regardless of notice, within 60 days after the date of the action complained of: *Provided*, That unless the notice of appeal is filed within the time specified, no appeal shall be allowed: *Provided, however*, That the time limitation is a condition of the right to appeal and hence jurisdictional. The board shall notify the other parties immediately upon the filing of a notice of appeal. The notice of appeal shall state the grounds for review and whether oral argument is requested. The Workers' Compensation Board of Review, after receiving a copy of the notice of appeal, shall forthwith make up a transcript of any proceedings before the board of review and certify and transmit it to the Intermediate Court of Appeals. The certificate shall incorporate a brief recital of the proceedings in the matter and recite each order entered or decision issued and the date thereof.

(b) The Intermediate Court of Appeals shall set a time and place for the hearing of arguments on each claim and shall notify the interested parties thereof. The review by the court shall be based upon the record submitted to it and such oral argument as may be requested and received. The Intermediate Court of Appeals may affirm, reverse, modify, or supplement the decision of the Workers' Compensation Board of Review and make such disposition of the case as it determines to be appropriate. Briefs may be filed by the interested parties in accordance with the rules of procedure prescribed by the court. The Intermediate Court of Appeals may affirm the order or decision of the Workers' Compensation Board of Review or remand the case for further proceedings. It shall reverse, vacate, or modify the order or decision of the Workers' Compensation Board of Review, if the substantial rights of the petitioner or petitioners have been prejudiced because the Board of Review's findings are:

(1) In violation of statutory provisions;

(2) In excess of the statutory authority or jurisdiction of the Board of Review;

(3) Made upon unlawful procedures;

(4) Affected by other error of law;

(5) Clearly wrong in view of the reliable, probative, and substantial evidence on the whole

record; or

(6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(c) After a review of the case, the Intermediate Court of Appeals shall issue a written decision and send a copy by mail to the parties.

(1) All decisions, findings of fact, and conclusions of law of the Intermediate Court of Appeals shall be in writing and state with specificity the laws and facts relied upon to sustain, reverse, or modify the Board of Review's decision.

(2) A decision of the Intermediate Court of Appeals is binding upon the Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, with respect to the parties involved in the particular appeal. The Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, shall have the right to seek judicial review of a final decision of the Intermediate Court of Appeals, pursuant to §51-11-10 of this code, irrespective of whether the party appeared or participated in the appeal to the Intermediate Court of Appeals.

(d) Instead of affirming, reversing, or modifying the decision of the Workers' Compensation Board of Review, the Intermediate Court of Appeals may, upon motion of any party or upon its own motion, for good cause shown, to be set forth in the order of the court, remand the case to the Board of Review for the taking of such new, additional, or further evidence as in the opinion of the court considers necessary for a full and complete development of the facts of the case. In the event the Intermediate Court of Appeals shall remand the case to the Board of Review for the taking of further evidence, the Board of Review shall proceed to take new, additional, or further evidence in accordance with any instruction given by the court within 30 days after receipt of the order remanding the case. The Workers' Compensation Board of Review shall give to the interested parties at least 10 days' written notice of the supplemental hearing, unless the taking of evidence is postponed by agreement of parties, or by the Board of Review for good cause. After the completion of a supplemental hearing, the Workers' Compensation Board of Review shall, within 60 days, render its decision affirming, reversing, or modifying the former action of the Workers' Compensation Board of Review. The decision shall be appealable to, and proceeded with, by the Intermediate Court of Appeals in the same manner as other appeals. In addition, upon a finding of good cause, the court may remand the case to the Insurance Commissioner, other private insurance carriers, or self-insured employers, whichever is applicable, for further development. Any decision made by the Insurance Commissioner, other private insurance carriers, or self-insured employers, whichever is applicable, following a remand, shall be subject to objection to the Workers' Compensation Board of Review and not to the Intermediate Court of Appeals. The Intermediate Court of Appeals may remand any case as often as, in its opinion, is necessary for a full development and just decision of the case.

(e) In all proceedings before the Intermediate Court of Appeals, any party may be

represented by counsel.

(f) This section becomes effective on July 1, 2022.

§23-5-13. Continuances and supplemental hearings; claims not to be denied on technicalities; effective until June 30, 2022.

(a) It is the policy of this chapter that the rights of claimants for workers' compensation be determined as speedily and expeditiously as possible to the end that those incapacitated by injuries and the dependents of deceased workers may receive benefits as quickly as possible in view of the severe economic hardships which immediately befall the families of injured or deceased workers. Therefore, the criteria for continuances and supplemental hearings "for good cause shown" are to be strictly construed by the chief administrative law judge and his or her authorized representatives to prevent delay when granting or denying continuances and supplemental hearings. It is also the policy of this chapter to prohibit the denial of just claims of injured or deceased workers or their dependents on technicalities.

(b) This section is of no force and effect after June 30, 2022.

§23-5-13a. Continuances and supplemental hearings; claims not to be denied on technicalities; effective July 1, 2022.

(a) It is the policy of this chapter that the rights of claimants for workers' compensation be determined as speedily and expeditiously as possible to the end that those incapacitated by injuries and the dependents of deceased workers may receive benefits as quickly as possible in view of the severe economic hardships which immediately befall the families of injured or deceased workers. Therefore, the criteria for continuances and supplemental hearings "for good cause shown" are to be strictly construed by the Workers' Compensation Board of Review and its authorized representatives to prevent delay when granting or denying continuances and supplemental hearings. It is also the policy of this chapter to prohibit the denial of just claims of injured or deceased workers or their dependents on technicalities.

(b) This section becomes effective on July 1, 2022.

§23-5-14. Disqualification of board members.

In any appeal wherein a board member is a party, or is interested in the results thereof otherwise than as a general subscriber to the compensation fund, or he or she is connected with a contributor therein, or is a beneficiary therein, or is connected with a beneficiary therein, he or she shall be disqualified from participating in the hearing and determination of such appeal.

§23-5-15. Appeals from final decisions of board to Supreme Court of Appeals of West Virginia prior to July 1, 2022; procedure; costs.

(a) As provided in §23-5-8b of this code, the provisions of this section do not apply to any decision issued by the Workers' Compensation Board of Review after June 30, 2022.

(b) Review of any final decision of the board, including any order of remand, may be prosecuted by either party or by the Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, to the Supreme Court of Appeals within 30 days from the date of the final order by filing a petition therefor with the court against the board and the adverse party or parties as respondents. Unless the petition for review is filed within the 30-day period, no appeal or review shall be allowed, such time limitation is a condition of the right to such appeal or review and hence jurisdictional. The clerk of the Supreme Court of Appeals shall notify each of the respondents and the Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, of the filing of such petition. The board shall, within 10 days after receipt of the notice, file with the clerk of the court the record of the proceedings had before it, including all the evidence. The court or any judge thereof in vacation may thereupon determine whether or not a review shall be granted. If review is granted to a nonresident of this state, he or she shall be required to execute and file with the clerk before an order or review shall become effective, a bond, with security to be approved by the clerk, conditioned to perform any judgment which may be awarded against him or her. The board may certify to the court and request its decision of any question of law arising upon the record, and withhold its further proceeding in the case, pending the decision of court on the certified question, or until notice that the court has declined to docket the same. If a review is granted or the certified question is docketed for hearing, the clerk shall notify the board and the parties litigant or their attorneys and the Insurance Commissioner, other private insurance carriers, and self-insured employers, whichever is applicable, of that fact by mail. If a review is granted or the certified question docketed, the case shall be heard by the court in the same manner as in other cases, except that neither the record nor briefs need be printed. Every review granted or certified question docketed prior to 30 days before the beginning of the term, shall be placed upon the docket for that term. The Attorney General shall, without extra compensation, represent the board in such cases. The court shall determine the matter brought before it and certify its decision to the board and to the commission. The cost of the proceedings on petition, including a reasonable attorney's fee, not exceeding $30 to the claimant's attorney, shall be fixed by the court and taxed against the employer if the latter is unsuccessful. If the claimant, or the commission (in case the latter is the applicant for review) is unsuccessful, the costs, not including attorney's fees, shall be taxed against the commission, payable out of the Workers' Compensation Fund, or shall be taxed against the claimant, in the discretion of the court: But there shall be no cost taxed upon a certified question.

(c) In reviewing a decision of the Board of Review, the Supreme Court of Appeals shall consider the record provided by the board and give deference to the board's findings,

reasoning, and conclusions, in accordance with subsections (d) and (e) of this section.

(d) If the decision of the board represents an affirmation of a prior ruling by both the commission and the Office of Judges that was entered on the same issue in the same claim, the decision of the board may be reversed or modified by the Supreme Court of Appeals only if the decision is in clear violation of constitutional or statutory provision, is clearly the result of erroneous conclusions of law, or is based upon the board's material misstatement or mischaracterization of particular components of the evidentiary record. The court may not conduct a de novo reweighing of the evidentiary record. If the court reverses or modifies a decision of the board pursuant to this subsection, it shall state with specificity the basis for the reversal or modification and the manner in which the decision of the board clearly violated constitutional or statutory provisions, resulted from erroneous conclusions of law, or was based upon the board's material misstatement or mischaracterization of particular components of the evidentiary record.

(e) If the decision of the board effectively represents a reversal of a prior ruling of either the commission or the Office of Judges that was entered on the same issue in the same claim, the decision of the board may be reversed or modified by the Supreme Court of Appeals only if the decision is in clear violation of constitutional or statutory provisions, is clearly the result of erroneous conclusions of law, or is so clearly wrong based upon the evidentiary record that even when all inferences are resolved in favor of the board's findings, reasoning, and conclusions, there is insufficient support to sustain the decision. The court may not conduct a de novo reweighing of the evidentiary record. If the court reverses or modifies a decision of the board pursuant to this subsection, it shall state with specificity the basis for the reversal or modification and the manner in which the decision of the board clearly violated constitutional or statutory provisions, resulted from erroneous conclusions of law, or was so clearly wrong based upon the evidentiary record that even when all inferences are resolved in favor of the board's findings, reasoning, and conclusions, there is insufficient support to sustain the decision.

§23-5-16. Fees of attorney for claimant; unlawful charging or receiving of attorney fees; effective until June 30, 2022.

(a) An attorney's fee in excess of 20 percent of any award granted may not be charged or received by an attorney for a claimant or dependent. In no case may the fee received by the attorney of the claimant or dependent be in excess of 20 percent of the benefits to be paid during a period of 208 weeks. The interest on disability or dependent benefits as provided in this chapter may not be considered as part of the award in determining the attorney's fee. However, any contract entered into in excess of 20 percent of the benefits to be paid during a period of 208 weeks, as herein provided, is unlawful and unenforceable as contrary to the public policy of this state and any fee charged or received by an attorney in violation thereof is an unlawful practice and renders the attorney subject to disciplinary action.

(b) On a final settlement an attorney may charge a fee not to exceed 20 percent of the total value of the medical and indemnity benefits: *Provided*, That this attorney's fee, when combined with any fees previously charged or received by the attorney for permanent partial disability or permanent total disability benefits may not exceed 20 percent of an award of benefits to be paid during a period of 208 weeks.

(c) Except attorney's fees and costs recoverable pursuant to §23-2C-21(c) of this code, an attorney's fee for successful recovery of denied medical benefits may be charged or received by an attorney, and paid by the private carrier or self-insured employer, for a claimant or dependent under this section. In no event may attorney's fees and costs be awarded pursuant to both this section and §23-2C-21(c) of this code.

(1) If a claimant successfully prevails in a proceeding relating to a denial of medical benefits brought before the commission, successor to the commission, other private carrier, or self-insured employer, whichever is applicable, as a result of utilization review, arbitration, mediation, or other proceedings, or a combination thereof, relating to denial of medical benefits before the Office of Judges, Board of Review, or court, there shall additionally be charged against the private carriers or self-insured employers, whichever is applicable, the reasonable costs and reasonable hourly attorney fees of the claimant. Following the successful resolution of the denial in favor of the claimant, a fee petition shall be submitted by the claimant's attorney to the Insurance Commissioner or his or her successors, arbitrators, mediator, the Office of Judges, the Board of Review, or court, whichever enters a final decision on the issue. An attorney representing a claimant must submit a claim for attorney fees and costs within 30 days following a decision in which the claimant prevails and the order becomes final.

(2) The Insurance Commissioner or his or her successors, arbitrators, mediator, the Office of Judges, the Board of Review, or court shall enter an order within 30 days awarding reasonable attorney fees not to exceed $125 per hour and reasonable costs of the claimant to be paid by the private carriers or self-insured employers, whichever is applicable, which shall be paid as directed. In no event may an award of the claimant's attorney's fees under this subsection exceed $500 per litigated medical issue, not to exceed $2,500 in a claim.

(3) In determining the reasonableness of the attorney fees to be awarded, the Insurance Commission, arbitrator, mediator, Office of Judges, Board of Review, or court shall consider the experience of the attorney, the complexity of the issue, the hours expended, and the contingent nature of the fee.

(d) This section is of no force and effect after June 30, 2022.

§23-5-16a. Fees of attorney for claimant; unlawful charging or receiving of attorney fees.

(a) An attorney's fee in excess of 20 percent of any award granted may not be charged or received by an attorney for a claimant or dependent. In no case may the fee received by the attorney of the claimant or dependent be in excess of 20 percent of the benefits, to be paid during a period of 208 weeks. The interest on disability or dependent benefits, as provided in this chapter, may not be considered as part of the award in determining the attorney's fee. However, any contract entered into in excess of 20 percent of the benefits to be paid during a period of 208 weeks, as herein provided, is unlawful and unenforceable as contrary to the public policy of this state and any fee charged or received by an attorney in violation thereof is an unlawful practice and renders the attorney subject to disciplinary action.

(b) On a final settlement an attorney may charge a fee not to exceed 20 percent of the total value of the medical and indemnity benefits: *Provided*, That this attorney's fee, when combined with any fees previously charged or received by the attorney for permanent partial disability or permanent total disability benefits may not exceed 20 percent of an award of benefits to be paid during a period of 208 weeks.

(c) Except attorney's fees and costs recoverable pursuant to §23-2C-21(c) of this code, an attorney's fee for successful recovery of denied medical benefits may be charged or received by an attorney and paid by the private carrier or self-insured employer, for a claimant or dependent under this section. In no event may attorney's fees and costs be awarded pursuant to both this section and §23-2C-21(c) of this code.

(1) If a claimant successfully prevails in a proceeding relating to a denial of medical benefits brought before the Insurance Commissioner, other private carrier, or self-insured employer, whichever is applicable, as a result of utilization review, arbitration, mediation, or other proceedings, or a combination thereof, relating to denial of medical benefits before the Workers' Compensation Board of Review, or a court, there shall additionally be charged against the private carriers or self-insured employers, whichever is applicable, the reasonable costs and reasonable hourly attorney's fees of the claimant. Following the successful resolution of the denial in favor of the claimant, a fee petition shall be submitted by the claimant's attorney to the Insurance Commissioner or his or her successors, arbitrators, mediator, the Workers' Compensation Board of Review, or a court, whichever enters a final decision on the issue. An attorney representing a claimant must submit a claim for attorney's fees and costs within 30 days following a decision in which the claimant prevails and the order becomes final.

(2) The Insurance Commissioner or his or her successors, arbitrators, mediators, the Workers' Compensation Board of Review, or a court shall enter an order within 30 days awarding reasonable attorney's fees not to exceed $125 per hour and reasonable costs of the claimant to be paid by the private carriers or self-insured employers, whichever is applicable, which shall be paid as directed. In no event may an award of the claimant's attorney's fees under this subsection exceed $500 per litigated medical issue, not to exceed

$2,500 in a claim.

(3) In determining the reasonableness of the attorney's fees to be awarded, the Insurance Commissioner, arbitrator, mediator, Workers' Compensation Board of Review, or court shall consider the experience of the attorney, the complexity of the issue, the hours expended, and the contingent nature of the fee.

(d) This section becomes effective on July 1, 2022.

§23-5-17.

Repealed.

Acts, 2009 Reg. Sess., Ch. 222.

§23-5-18.

Repealed.

Acts, 2009 Reg. Sess., Ch. 222.

§23-5A-1. Discriminatory practices prohibited.

No employer shall discriminate in any manner against any of his present or former employees because of such present or former employee's receipt of or attempt to receive benefits under this chapter.

§23-5A-2. Discriminatory practices prohibited -- Medical insurance.

Any employer who has provided any type of medical insurance for an employee or his dependents by paying premiums, in whole or in part, on an individual or group policy shall not cancel, decrease his participation on behalf of the employee or his dependents, or cause coverage provided to be decreased during the entire period for which that employee during the continuance of the employer- employee relationship is claiming or is receiving benefits under this chapter for a temporary disability. If the medical insurance policy requires a contribution by the employee, that employee must continue to make the contribution required, to the extent the insurance contract does not provide for a waiver of the premium.

Nothing in this section shall prevent an employer from changing insurance carriers or cancelling or reducing medical coverage if the temporarily disabled employee and his dependents are treated with respect to insurance in the same manner as other similarly classified employees and their dependents who are also covered by the medical insurance policy.

This section provides a private remedy for the employee which shall be enforceable in an action by the employee in a circuit court having jurisdiction over the employer.

§23-5A-3. Termination of injured employees prohibited; reemployment of injured employees.

(a) It shall be a discriminatory practice within the meaning of section one of this article to terminate an injured employee while the injured employee is off work due to a compensable injury within the meaning of §23-4-1 *et seq*. of this code and is receiving or is eligible to receive temporary total disability benefits, unless the injured employee has committed a separate dischargeable offense. A separate dischargeable offense shall mean misconduct by the injured employee wholly unrelated to the injury or the absence from work resulting from the injury. A separate dischargeable offense shall not include absence resulting from the injury or from the inclusion or aggregation of absence due to the injury with any other absence from work.

(b) It shall be a discriminatory practice within the meaning of section one of this article for an employer to fail to reinstate an employee who has sustained a compensable injury to the employee's former position of employment upon demand made in writing and transmitted by the United States Postal Service, return receipt requested, to the employer's principal office for such reinstatement provided that the position in which the employee sustained the compensable injury is still available and the employee is not disabled from performing the duties of such position. If the former position is not available, the employee shall be reinstated to another comparable position which is available and which the employee is capable of performing. A comparable position for the purposes of this section shall mean a position which is comparable as to wages, working conditions and, to the extent reasonably practicable, duties to the position held at the time of injury. A written statement from a duly licensed physician that the physician approves the injured employee's return to his or her regular employment shall be prima facie evidence that the worker is able to perform such duties. In the event that neither the former position nor a comparable position is available, the employee shall have a right to preferential recall to any job which the injured employee is capable of performing which becomes open after the injured employee notifies the employer that he or she desired reinstatement. Said right of preferential recall shall be in effect for one year from the day the injured employee notifies the employer that he or she desires reinstatement: *Provided*, That the employee provides to the employer a current mailing address during this one-year period.

(c) For the preferential recall rights authorized by this section when an employee is employed by an employer defined by §30-42-3(d) of this code, the employee's right to preferential recall shall be no greater than 120 days from the date the employee is released by a duly licensed physician to return to his or her regular employment. It is the employee's obligation to continually seek the possibility of employment during the employee's preferential recall period under this subsection. The employee's right to preferential recall authorized by this subsection terminates once the employer offers the employee his or her former position or a comparable position.

(d) Any civil action brought under this section shall be subject to the seniority provisions of a valid and applicable collective bargaining agreement, or arbitrator's decision thereunder,

or to any court or administrative order applying specifically to the injured employee's employer, and shall further be subject to any applicable federal statute or regulation.

(e) Nothing in this section shall affect the eligibility of the injured employee to workers' compensation benefits under this chapter.

§23-5A-4. State employees to accrue increment pay during absence due to work-related injuries; legislative rules.

(a) All employees of the State of West Virginia shall continue to accrue increment pay during absences from work due to a work-related compensable injury.

(b) The director of the Division of Personnel shall propose rules for legislative approval to implement the provisions of this section.

§23-6-1. Severability.

If any provision of this chapter 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 chapter, and to this end the provisions of this chapter are declared to be severable.

§23-6-2. Legislative intent.

It is the intent of the Legislature in enacting the amendments to this chapter during the regular session of the Legislature in the year one thousand nine hundred ninety-nine relating to employee benefits that the compensation programs performance council consider employer rate reductions commensurate with the cost of such employee benefits.

§23-6-3. Operative date for particular enactment.

The amendments to this chapter effected by the enactment of Enrolled Committee Substitute for Senate Bill No. 579 during the 1999 regular session of the Legislature, become operative on July 1, 1999.