SB 537

WEST VIRGINIA LEGISLATURE

SEVENTY-NINTH LEGISLATURE

REGULAR SESSION, 2009

ENROLLED

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 537

(SENATORS MINARD AND MCCABE, *original sponsors*)

[Passed April 11, 2009; in effect ninety days from passage.]

ENROLLED

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 537

(SENATORS MINARD AND MCCABE, *original sponsors*)

[Passed April 11, 2009; in effect ninety days from passage.]

AN ACT to repeal §23-5-17 and §23-5-18 of the Code of West Virginia, 1931, as amended; to amend and reenact §23-2-1d of said code; to amend and reenact §23-2A-1 of said code; to amend and reenact §23-2C-8, §23-2C-15, §23-2C-17 and §23-2C-21 of said code; to amend and reenact §23-4-1c, §23-4-6b, §23-4-8, §23-4-8c and §23-4-15b of said code; to amend said code by adding thereto a new section, designated §23-4-8d; to amend and reenact §23-5-1, §23-5-3 and §23-5-16 of said code; and to amend and reenact §33-2-22 of said code, all relating to workers' compensation; eliminating obsolete sunset provisions; redefining the responsibility of prime contractors to injured employees of their subcontractors; clarifying subrogation rights with respect to employees injured by third parties; authorizing negotiation of amount to accept as subrogation in Old Fund

claims; deleting mandatory recovery fee to Insurance Commissioner in certain subrogation claims; providing for a unitary decision-making process in claims involving the Uninsured Employer Fund; changing date on which governmental bodies may purchase workers' compensation insurance in the private market and on which the employers' mutual insurance company may nonrenew such bodies; awarding attorney fees and costs if workers' compensation temporary disability benefits claim is unreasonably denied; extending the scope of permissible remedies to include those in the general insurance code; permitting the recovery of administrative costs in certain actions; authorizing expedited review by the Office of Judges when a request to reopen temporary total benefits is denied; eliminating mandatory allocation in hearing loss claims; providing that claims for medical benefits in occupational pneumoconiosis claims may be made at any time; clarifying that a sixty-day period applies to various protests; extending the jurisdiction of the Office of Judges to hear certain protests; clarifying permissible method of delivering payment of benefits; establishing reimbursement for certain claimant travel expenses; authorizing award of attorney fees in certain final settlements; clarifying licensing requirements for third-party administrators; mandating conditional payments in certain instances; authorizing the Insurance Commissioner to compromise and settle claims for moneys due the Old Fund and Uninsured Employer Fund; and requiring report to Legislature regarding settlements.

Be it enacted by the Legislature of West Virginia:

That §23-5-17 and §23-5-18 of the Code of West Virginia, 1931, as amended, be repealed; that §23-2-1d of said code be amended and reenacted; that §23-2A-1 of said code be amended and reenacted; that §23-2C-8, §23-2C-15, §23-2C-17 and §23-2C-21 of said code be amended and reenacted; that §23-4-1c, §23-4-6b, §23-4-8, §23–4-8c and §23-4-15b of said code be amended and reenacted; that said code be amended by adding

thereto a new section, designated §23-4-8d; that §23-5-1, §23-5-3 and §23-5-16 of said code be amended and reenacted; and that §33-2-22 of said code be amended and reenacted, all to read as follows:

CHAPTER 23. WORKERS' COMPENSATION.

ARTICLE 2. EMPLOYERS AND EMPLOYEES SUBJECT TO CHAPTER; EXTRATERRITORIAL COVERAGE.

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

(a) For the exclusive purposes of this section, the term "employer" as defined in section one of this article includes any primary contractor who regularly subcontracts with other employers for the performance of any work arising from or as a result of the primary contractor's own contract: *Provided,* That a subcontractor does not include one providing goods rather than services. For purposes of this subsection, extraction of natural resources is a provision of services. In the event that a subcontracting employer defaults on its obligations to make payments to the commission, then the primary contractor is liable for the payments. However, nothing contained in this section shall extend or except to a primary contractor or subcontractors the provisions of section six, six-a or eight of this article. This section is applicable only with regard to subcontractors with whom the primary contractor has a contract for any work or services for a period longer than sixty days: *Provided, however,* That this section is also applicable to contracts for consecutive periods of work that total more than sixty days. It is not applicable to the primary contractor with regard to sub-subcontractors. However, a subcontractor for the purposes of a contract with the primary contractor can itself become a primary contractor with regard to other employers with whom it subcontracts. It is the intent of the Legislature that no contractor, whether a primary contractor, subcontractor or sub-subcontractor, escape or avoid liability for

any workers' compensation premium, assessment or tax. The executive director shall propose for promulgation a rule to effect this purpose on or before December 31, 2003.

(b) A primary contractor may avoid initial liability under subsection (a) of this section if it obtains from the executive director, prior to the initial performance of any work by the subcontractor's employees, a certificate that the subcontractor is in good standing with the Workers' Compensation Fund.

(1) Failure to obtain the certificate of good standing prior to the initial performance of any work by the subcontractor results in the primary contractor being equally liable with the subcontractor for all delinquent and defaulted premium taxes, premium deposits, interest and other penalties arising during the life of the contract or due to work performed in furtherance of the contract: *Provided,* That the commission is entitled to collect only once for the amount of premiums, premium deposits and interest due to the default, but the commission may impose other penalties on the primary contractor or on the subcontractor, or both.

(2) In order to continue avoiding liability under this section, the primary contractor shall request that the commission inform the primary contractor of any subsequent default by the subcontractor. In the event that the subcontractor does default, the commission shall notify the primary contractor of the default by placing a notice in the certified United States mail, postage prepaid, and addressed to the primary contractor at the address furnished to the commission by the primary contractor. The mailing is good and sufficient notice to the primary contractor of the subcontractor's default. However, the primary contractor is not liable under this section until the first day of the calendar quarter following the calendar quarter in which the notice is given and then the liability

is only for that following calendar quarter and thereafter and only if the subcontract has not been terminated: *Provided,* That the commission is entitled to collect only once for the amount of premiums, premium deposits and interest due to the default, but the commission may impose other penalties on the primary contractor or on the subcontractor, or both.

(c) In any situation where a subcontractor defaults with regard to its payment obligations under this chapter or fails to provide a certificate of good standing as provided in this section, the default or failure is good and sufficient cause for a primary contractor to hold the subcontractor responsible and to seek reimbursement or indemnification for any amounts paid on behalf of the subcontractor to avoid or cure a workers' compensation default, plus related costs, including reasonable attorneys' fees, and to terminate its subcontract with the subcontractor notwithstanding any provision to the contrary in the contract.

(d) The provisions of this section are applicable only to those contracts entered into or extended on or after January 1, 1994.

(e) The commission may take any action authorized by section five-a of this article in furtherance of its efforts to collect amounts due from the primary contractor under this section.

(f) Effective upon termination of the commission, subsections (a) through (e), inclusive, of this section shall be applicable only to unpaid premiums due the commission or the Old Fund as provided in article two-c of this chapter.

(g) 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.

(h) On after the effective date of the reenactment of this section in 2009, 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, is 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.

(i) 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 sections six and six-a of this article;

(2) May be held liable to an injured employee pursuant to the provisions of section eight of this article; and

(3) Is the designated employer for the purposes of any "deliberate intention" action brought by the injured worker pursuant to the provisions of section two, article four of this chapter.

(j) 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 and verifying a subcontractor's maintenance of insurance coverage, than the

prime contractor is not liable for any claim made hereunder against the subcontractor.

ARTICLE 2A. SUBROGATION.

§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 subsection (a) of this section, 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 and the successor to the commission 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 commissioner or self-insured employer as subrogation to medical benefits expended on behalf of the injured or deceased worker shall not exceed fifty 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 subdivisions (1) and (2) of this subsection, 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 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.

ARTICLE 2C. EMPLOYERS' MUTUAL INSURANCE COMPANY.

§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 section one-d, article two of this chapter, either reject or conditionally accept the claim. An aggrieved party may file a protest with 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 article five of this chapter: *Provided,* That in any proceeding before the Office of Judges 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 section thirteen, article two of this chapter.

(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 subdivision (1) of this subsection. 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 Workers' Compensation Uninsured Employer Fund.

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

(a) Effective upon termination of the commission, all subscriber policies with the commission shall novate to the company and all employers shall purchase workers' compensation insurance from the company unless permit-

ted to self-insure their obligations. The company shall assume responsibility for all new fund obligations of the subscriber policies which novate to the company or which are issued thereafter. Each subscriber whose policy novates to the company shall also have its advanced deposit credited to its account with the company. Each employer purchasing workers' compensation insurance from the company has the right to designate a representative or agent to act on its behalf in any and all matters relevant to coverage and claims administered by the company.

(b) Effective July 1, 2008, an employer may elect to: (1) Continue to purchase workers' compensation insurance from the company; (2) purchase workers' compensation insurance from another 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: *Provided,* That all state and local governmental bodies, including, but not limited to, all counties and municipalities and their subdivisions and including all boards, colleges, universities and schools, shall continue to purchase workers' compensation insurance from the company through June 30, 2010: *Provided, however*, That the company may not cancel or refuse to renew a policy of a state or local governmental body prior to July 1, 2011, except for failure of consideration to be paid by the policyholder or for refusal to comply with a premium audit. The company and other 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 thirty-three of this code.

(c) Every employer shall post a notice upon its premises in a conspicuous place identifying its workers' compensa-

tion 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. The employer shall at all times maintain the notice provided for the information of his or her employees. Release of employer policy information and status by the Industrial Council and the Insurance Commissioner shall be governed by section four, article one of this chapter.

(d) 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.

(e) Effective January 1, 2009, the company may decline to offer coverage to any applicant. Private carriers and, effective January 1, 2009, the company, may cancel a policy upon the issuance of thirty days' written advance notice to the policyholder and may refuse to renew a policy upon the issuance of sixty 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 ten days' advance written notice of cancellation to the policyholder.

(f) Every private carrier shall notify the Insurance Commissioner as follows: (1) Of the issuance or renewal of insurance coverage, within thirty 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 ten days prior to the effective date of the termination; and (3)

of a termination of coverage by an employer, within ten 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.

(g) For the purposes of subsections (e) and (f) of this section, 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-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-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 thirty-three of this code.

(b) Any administrative fines or remedies provided in this chapter or chapter thirty-three of this code or rules promulgated by the Workers' Compensation Commission or 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 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.

ARTICLE 4. DISABILITY AND DEATH BENEFITS.

§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 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.

§23-4-6b. 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 Speech Discrimination	**% of Permanent** 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.

§23-4-8. 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 proce-

dures 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.

§23-4-8c. 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.

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

§23-4-15b. 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.

ARTICLE 5. REVIEW.

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

(a) The Insurance Commissioner, private carriers and self-insured employers may determine all questions within their jurisdiction. In matters arising under subsection (c), section eight, article two-c of this chapter, and under articles three and four of this chapter, 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 dependants, and the employer, and with respect to claims involving funds created in article two-c of this chapter 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 section sixteen, article four of this chapter, 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 sixty days after the receipt of such decision unless a protest is filed within the sixty-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 sections eight and nine of this article. 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 article two-c of this chapter or decisions entered pursuant to subdivision (1), subsection (c), section seven-a, article four of this chapter.

(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 provi-

sions 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 article two-c of this chapter, or decisions entered pursuant to subdivision (1), subsection (c), section seven-a, article four of this chapter, 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.

§23-5-3. Refusal to reopen claim; notice; objection.

If it appears to the Insurance Commissioner, private insurance carriers and self-insured employers, whichever is applicable, that an application filed under section two of this article 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 sixty days after receipt of the notice, object in writing to the finding. Unless the objection is filed within the sixty-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 section nine of this article.

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

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

(b) On a final settlement an attorney may charge a fee not to exceed twenty 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 twenty percent of an award of benefits to be paid during a period of two hundred eight weeks.

CHAPTER 33. INSURANCE.

ARTICLE 2. INSURANCE COMMISSIONER.

§33-2-22. Authority of Insurance Commissioner regarding employers in default to workers' compensation funds; injunctions against defaulting employers.

(a) Upon termination of the Workers' Compensation Commission, all of the powers and authority previously conferred upon the Workers' Compensation Commission pursuant to article two, chapter twenty-three of this code, relating to employers in default to the Workers' Compensation Fund, are hereby transferred to the Insurance Commissioner and shall be applied by the commissioner to those employers in default to the Old Fund or having liability to the Uninsured Employer Fund or who are in policy default or fail to maintain mandatory workers' compensation coverage, all as defined in article two-c, chapter twenty-three of this code.

(b) In any case in which an employer is in default to the Old Fund or has liability to the Uninsured Employer Fund or who is in default on a policy or otherwise fails to maintain mandatory workers' compensation coverage, all as defined in article two-c, chapter twenty-three of this code, the commission may bring an action in the circuit court of Kanawha County to enjoin the employer from continuing to operate the employer's business: *Provided*, That the commissioner may, in his or her sole discretion, and as an alternative to this action pursuant to this subsection, require the employer to file a bond, in the form

prescribed by the commissioner, with satisfactory surety in an amount not less than one hundred fifty percent of the total payments, interest and penalties due.

(c) In any action instituted pursuant to subsection (b) of this section, the circuit court shall issue an injunction prohibiting the employer from operating the employer's business if the Insurance Commissioner proves by a preponderance of the evidence, that the employer is in default to the Old Fund or has liability to the uninsured fund or is in policy default or has otherwise failed to maintain mandatory workers' compensation coverage.

(d) Notwithstanding any provision of this code to the contrary, the commissioner shall have the authority to waive penalty and interest accrued on moneys due the Old Fund. The enactment of the provisions of this subsection shall be applied retrospectively to January 1, 2006, and may not be construed to require the commissioner to adjust or otherwise modify any agreements reached with regard to the payment of penalty or interest since that date.

(e) Notwithstanding any provision of this code to the contrary, the Insurance Commissioner may compromise and settle any claims for moneys due to the Old Fund or the Uninsured Employer Fund. Information regarding settlements is subject to chapter twenty-nine-b of this code. The commissioner shall submit to the President of the Senate, the Speaker of the House of Delegates and the Legislative Auditor an annual report summarizing the settlements into which he or she has entered pursuant to this subsection. The summary shall describe the parties involved, the total amount owed and portions paid, and the terms of the settlement.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

.....
Chairman Senate Committee

.....
Chairman House Committee

Originated in the Senate.

In effect ninety days from passage.

.....
Clerk of the Senate

.....
Clerk of the House of Delegates

.....
President of the Senate

.....
Speaker House of Delegates

The within is approved this the 7th

Day of May, 2009.

.....
Governor

PRESENTED TO THE
GOVERNOR

MAY 1 2009

Time 2:50 pm