

WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

ENROLLED

Committee Substitute

for

House Bill 5515

BY DELEGATES HALL, JEFFRIES, HOTT, AND ROHRBACH

[Passed March 14, 2026; in effect 90 days from
passage (June 12, 2026)]

FILED

2026 APR - 1 P 10:55

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

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1 AN ACT to amend and reenact §23-4-1a, §23-4-1b, §23-4-1c, §23-4-1d, §23-4-1e, §23-4-3, §23-
2 4-4, §23-4-5, §23-4-6, §23-4-6a, §23-4-6d, §23-4-7, §23-4-7a, §23-4-8a, §23-4-8b, §23-
3 4-8c, §23-4-9, §23-4-11, §23-4-12, §23-4-14, §23-4-15, §23-4-15a, §23-4-15b, §23-4-16,
4 §23-4-16a, §23-4-17, §23-4-18, §23-4-20, §23-4-23, §23-4-24, §23-4-25, §23-5-2, §23-5-
5 4, §23-5-7, §23-5-11a, and §23-5-14 of the Code of West Virginia, 1931, as amended;
6 and to repeal §23-4-3b, §23-4-3c, §23-4-22, §23-5-1, §23-5-3, §23-5-5, §23-5-6, §23-5-
7 8, §23-5-9, §23-5-10, §23-5-11, §23-5-12, §23-5-13, §23-5-15, and §23-5-16, relating to
8 modernizing and updating workers' compensation statutes; removing or revising
9 provisions made obsolete by prior legislation and regulatory revisions; standardizing
10 references to public offices and agencies; updating and correcting provisions and statutory
11 citations; removing entitlement of employer to notice of a request for permanent total
12 disability, to respond to a request, to submit information, to have a claimant examined,
13 and to submit and obtain reports from experts; removing consideration of vocational
14 standards as it relates to disability benefits; removing notification requirement to an
15 employer prior to ordering autopsy; modifying Board of Review membership from five to
16 at least three but no more than five members; and clarifying provisions as to Board of
17 Review terms and votes on administrative matters.

Be it enacted by the Legislature of West Virginia:

ARTICLE 4. DISABILITY AND DEATH BENEFITS.

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

1 Every employee who sustains an injury subject to this chapter, or his or her representative,
2 shall immediately on the occurrence of the injury or as soon thereafter as practicable give or
3 cause to be given to the employer or any of the employer's agents a written notice of the
4 occurrence of the injury stating in ordinary language the name and address of the employer, the
5 name and address of the employee, the time, place, nature, and cause of the injury, and whether
6 temporary total disability has resulted from the injury. The notice shall be given personally to the

7 employer or any of the employer's agents, or may be sent by certified mail addressed to the
8 employer at the employer's last known residence or place of business.

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

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

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

1 (a) In any claim for benefits under this chapter, the Insurance Commissioner, private
2 carrier, or self-insured employer, whichever is applicable, shall determine whether the claimant

3 has sustained a compensable injury within the meaning of §23-4-1 of this code and enter an order
4 giving all parties immediate notice of the decision.

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

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

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

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

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

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

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

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

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

54 parties immediate notice of any order granting temporary total disability or medical benefits. When
55 an order granting temporary total disability benefits is made, the claimant's return-to-work
56 potential shall be assessed. The Insurance Commissioner, private carrier, or self-insured
57 employer, whichever is applicable, may schedule medical and vocational evaluation of the
58 claimant and assign appropriate personnel to expedite the claimant's return to work as soon as
59 reasonably possible.

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

70 (d) Upon receipt of the first report of injury in a claim, the Insurance Commissioner, private
71 carrier, or self-insured employer, whichever is applicable, shall request from the employer or
72 employers any wage information necessary for determining the rate of benefits to which the
73 employee is entitled. If an employer does not furnish this information within 15 days from the date
74 the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable,
75 received the first report of injury in the case, the employee shall be paid temporary total disability
76 benefits for lost time at the rate the Insurance Commissioner obtains from reports made pursuant
77 to §23-2-2(b) of this code. If no wages have been reported, the Insurance Commissioner, private
78 carrier, or self-insured employer, whichever is applicable, shall make the payments at the rate the
79 Insurance Commissioner, private carrier, or self-insured employer finds would be justified by the

80 usual rate of pay for the occupation of the injured employee. The rate of benefits shall be adjusted
81 both retroactively and prospectively upon receipt of proper wage information. The Insurance
82 Commissioner shall have access to all wage information in the possession of any state agency.

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

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

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

97 (h) In the event that an employer files a timely objection to any order of the Insurance
98 Commissioner, private carrier, or self-insured employer, whichever is applicable, with respect to
99 compensability, or any order denying an application for modification with respect to temporary
100 total disability benefits, or with respect to those expenses outlined in §23-4-3(a) of this code, the
101 Insurance Commissioner, private carrier, or self-insured employer shall continue to pay to the
102 claimant such benefits and expenses during the period of such disability. When the employer has
103 protested the compensability or applied for modification of a temporary total disability benefit
104 award or expenses and the final decision in that case determines that the claimant was not entitled
105 to the benefits or expenses, the disputed amount of benefits or expenses is considered an

106 overpayment. The Insurance Commissioner, private carrier, or self-insured employer, whichever
107 is applicable, may recover the overpayment by withholding, in whole or in part, future benefits
108 payable to the individual in the same or other claims and credit the amount against the
109 overpayment until it is repaid in full.

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

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

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

1 (a) If the Insurance Commissioner, private carrier, or self-insured employer, whichever is
2 applicable, makes an award for permanent partial or permanent total disability, the Insurance
3 Commissioner, private carrier, or self-insured employer shall start payment of benefits by mailing
4 or delivering the amount due directly to the employee within 15 working days from the date of the
5 award: *Provided*, That the Insurance Commissioner, private carrier, or self-insured employer may

withhold payment of the portion of the award that is the subject of subsection (b) of this section until 77 days have expired without an objection being filed.

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

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

(d) If a timely protest to the award is filed, as provided in §23-5-1a or §23-5-9a of this code, benefits shall continue to be paid to the claimant during the period of the disability unless it is subsequently found that the claimant was not entitled to receive the benefits or any part thereof. If the final decision in any case determines that a claimant was not lawfully entitled to benefits paid to him or her pursuant to a prior decision, the amount of benefits paid shall be considered an overpayment and the Insurance Commissioner, private carrier, or self-insured employer,

32 whichever is applicable, may only recover that amount by withholding, in whole or in part, future
33 benefits payable to the individual in the same or other claims and credit the amount against the
34 overpayment until it is repaid in full.

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

38 (f) If a claimant is receiving benefits paid through a retirement plan, wage replacement
39 plan, salary continuation plan, or other benefit plan provided by the employer to which the
40 employee has not contributed, and that plan does not provide an offset for permanent total
41 disability benefits to which the claimant is also entitled under this chapter as a result of the same
42 injury or disease, the employer shall notify the Insurance Commissioner, private carrier, or self-
43 insured employer, whichever is applicable, of the duplication of the benefits paid to the claimant.
44 Upon receipt of the notice, the Insurance Commissioner, private carrier, or self-insured employer,
45 whichever is applicable, shall reduce the permanent total disability benefits provided under this
46 chapter by an amount sufficient to ensure that the claimant does not receive monthly benefits in
47 excess of the amount provided by the employer's plan or the permanent total disability benefit,
48 whichever is greater: *Provided*, That this subsection does not apply to benefits being paid under
49 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.**

1 (a) Notwithstanding any provision of this code to the contrary, no person shall be
2 jurisdictionally entitled to temporary total disability benefits for that period of time in excess of
3 three days during which that person is confined in a state correctional facility or jail: *Provided*,
4 That confinement shall not affect the claimant's eligibility for payment of expenses: *Provided*,
5 *however*, That this subsection is applicable only to injuries and diseases incurred prior to any

6 period of confinement. Upon release from confinement, the payment of benefits for the remaining
7 period of temporary total disability shall be made if justified by the evidence and authorized by
8 order of the Insurance Commissioner, private carrier, or self-insured employer, whichever is
9 applicable.

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

**§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.**

1 (a) The Insurance Commissioner shall establish and alter from time to time, as he or she
2 determines appropriate, a schedule of the maximum reasonable amounts to be paid to health
3 care providers, providers of rehabilitation services, providers of durable medical and other goods,

4 providers of other supplies and medically related items, or other persons, firms, or corporations
5 for the rendering of treatment or services to injured employees under this chapter.

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

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

23 (2) Payment for health care services, rehabilitation services, durable medical and other
24 goods and other supplies, and medically related items authorized under this subsection may be
25 made to the injured employee or to the person, firm, or corporation who or which has rendered
26 the treatment or furnished health care services, rehabilitation services, durable medical or other
27 goods or other supplies and items, or who has advanced payment for them, as the Insurance
28 Commissioner, private carrier, or self-insured employer, whichever is applicable, considers
29 proper, but no payments shall be made unless duly verified statements have been filed within six

30 months after the rendering of the treatment or the delivery of such goods, supplies, or items or
31 within 90 days of a subsequent compensability ruling if a claim is initially rejected: *Provided*, That
32 no payment under this section shall be made unless a verified statement shows a charge for the
33 treatment or with respect to any of the items specified in this subdivision has been or will be made
34 against the injured employee or any other person, firm, or corporation. When an employee
35 covered under the provisions of this chapter is injured in the course of and as a result of his or
36 her employment and is accepted for health care services, rehabilitation services, or the provision
37 of durable medical or other goods or other supplies or medically related items, the person, firm,
38 or corporation rendering the treatment may not make any charge or charges for the treatment or
39 with respect to the treatment against the injured employee or any other person, firm, or corporation
40 which would result in a total charge for the treatment rendered in excess of the maximum amount
41 in the fee schedule set forth in this subsection.

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

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

54 (A) In the event of an emergency where there is an urgent need for immediate medical
55 attention in order to prevent the death of a claimant or to prevent serious and permanent harm to

56 the claimant, if the claimant receives the emergency care from an out-of-state health care provider
57 who refuses to accept as full payment the scheduled amount, the claimant is not personally liable
58 for the difference between the amount scheduled and the amount demanded by the health care
59 provider. Upon the claimant's attaining a stable medical condition and being able to be transferred
60 to either a West Virginia health care provider or an out-of-state health care provider who has
61 agreed to accept the scheduled amount of fees as payment in full, if the claimant refuses to seek
62 the specified alternative health care providers, he or she is personally liable for the difference in
63 costs between the scheduled amount and the amount demanded by the health care provider for
64 services provided after attaining stability and being able to be transferred.

65 (B) In the event that there is no health care provider reasonably near to the claimant's
66 home who is qualified to provide the claimant's needed medical services who is either located in
67 the State of West Virginia or who has agreed to accept as payment in full the scheduled amounts
68 of fees, the Insurance Commissioner, private carrier, or self-insured employer, whichever is
69 applicable, upon application by the claimant, may authorize the claimant to receive medical
70 services from another health care provider. The claimant is not personally liable for the difference
71 in costs between the scheduled amount and the amount demanded by the health care provider.

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

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

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

108 (d) The Insurance Commissioner, private carrier, or self-insured employer, whichever is
109 applicable, may engage in and contract for medical cost containment programs, pharmacy
110 benefits management programs, medical case management programs, and utilization review
111 programs. Payments for these programs shall be made from the Workers' Compensation Old
112 Fund, by the private carrier, or by the self-insured employer, whichever is applicable. Any order
113 issued pursuant to the program shall be interlocutory in nature until an objecting party has
114 exhausted all review processes provided for by the Insurance Commissioner, private carrier, or
115 self-insured employer, whichever is applicable.

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

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

1 [Repealed.]

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

1 [Repealed.]

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

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

7 (b) A funeral director or any person who furnished the services and supplies associated
8 with the funeral or cemetery expenses, or a person who has advanced payment for the services
9 and supplies, is prohibited from making any charge or charges against the employee's

dependents for funeral expenses which would result in a total charge for funeral expenses in excess of the amount fixed by the Insurance Commissioner, unless:

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

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

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

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

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

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

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

(a) The terms "average weekly wage earnings, wherever earned, of the injured employee, at the date of injury" and "average weekly wage in West Virginia", as used in this chapter, have the meaning and shall be computed as set forth in §23-4-14 of this code except for the purpose

6 of computing temporary total disability benefits for part-time employees pursuant to the provisions
7 of §23-4-6d of this code.

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

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

injury for a period exceeding 104 weeks from the effective date of the amendment and reenactment of this section in the year 2003.

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

permanent disability award benefit rate shall be computed at the highest benefit rate justified by any of the compensable injuries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

133 (g) If a claimant to whom has been made a permanent partial award dies from sickness
134 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 §23-4-6b of this code, the degree of permanent disability other than permanent total disability shall be determined exclusively by the degree of whole body medical impairment that a claimant has suffered. For those injuries provided for in subdivision (f) of this section and §23-4-6b of this code, the degree of disability shall be determined exclusively by the provisions of said subdivision and said section. The Occupational Pneumoconiosis Board created pursuant to §23-4-8a of this code shall premise its decisions on the degree of pulmonary function impairment that claimants suffer solely upon whole body medical impairment. The Insurance Commissioner shall adopt standards for the evaluation of claimants and the determination of a claimant's degree of whole body medical impairment. Once the degree of medical impairment has been determined, that degree of impairment shall be the degree of permanent partial disability that shall be awarded to the claimant. This subdivision is applicable to all injuries incurred and diseases with a date of last exposure on or after February 2, 1995, to all applications for an award of permanent partial disability made on and after that date and to all applications for an award of permanent partial disability that were pending before the former workers' compensation commission or pending in litigation but not yet submitted for decision on and after that date. The prior provisions of this subdivision remain in effect for all other claims.

(j) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall establish a reviewing body to review applications for permanent total disability.

160 The reviewing bodies shall employ or otherwise engage adequate resources, including medical
161 professionals.

162 (1) The Insurance Commissioner shall establish requirements for the proper completion
163 and support for an application for permanent total disability benefits, and no issue of permanent
164 total disability may be referred to a reviewing body unless a properly completed and supported
165 application for permanent total disability benefits has been first filed. Prior to a reviewing body's
166 adjudication of a permanent total disability application, the reviewing body shall conduct
167 examinations of the claimant that it finds necessary and obtain all pertinent records concerning
168 the claimant's medical history and reports of examinations. The claimant may furnish all pertinent
169 information to the reviewing body and shall furnish to the reviewing body any information
170 requested. The claimant may submit no more than one report and opinion regarding each issue
171 present in a claim. The reviewing body may request that those persons who have furnished
172 reports and opinions regarding a claimant provide it with additional information considered
173 necessary. The claimant may submit or obtain reports from experts challenging or supporting the
174 other reports in the record regardless of whether or not the expert examined the claimant or relied
175 solely upon the evidence of record.

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

182 (3) A reviewing body shall state its initial recommendations in writing with an explanation
183 for each recommendation setting forth the reasons for each. The recommendations shall be
184 served upon the claimant and the claimant shall be afforded a 30-day opportunity to respond in
185 writing to the reviewing body regarding its recommendations. The reviewing body shall review

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

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

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

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

Loss of both eyes or the sight thereof.

Loss of both hands or the use thereof.

Loss of both feet or the use thereof.

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

(n)(1) Other than for those injuries specified in subdivision (m) of this section, in order to be eligible to apply for an award of permanent total disability benefits for all injuries incurred and all diseases, including occupational pneumoconiosis, regardless of the date of last exposure, on and after the effective date of the amendment and reenactment of this section during the year 2003, a claimant: (A) Must have been awarded the sum of 50 percent in prior permanent partial disability awards; (B) must have suffered a single occupational injury or disease which results in a finding that the claimant has suffered a medical impairment of 50 percent; or (C) has sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section. Upon filing an application, the claim will be reevaluated by the reviewing body pursuant to subdivision (i) of this section to determine if the claimant has suffered a whole body medical impairment of 50 percent or more resulting from either a single occupational injury or occupational disease or a combination of occupational injuries and occupational diseases or has sustained a 35 percent

238 statutory disability pursuant to the provisions of subdivision (f) of this section. A claimant whose
239 prior permanent partial disability awards total 85 percent or more shall also be examined by the
240 reviewing body and must be found to have suffered a whole body medical impairment of 50
241 percent in order for his or her request to be eligible for further review. The reviewing body shall
242 review the claim as provided for in subdivision (j) of this section. If the claimant has not suffered
243 whole body medical impairment of at least 50 percent or has sustained a 35 percent statutory
244 disability pursuant to the provisions of subdivision (f) of this section, the request shall be denied.
245 Upon a finding that the claimant has a 50 percent whole body medical impairment or has
246 sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this
247 section, the review of the application continues as provided for in the following paragraph of this
248 subdivision. Those claimants whose prior permanent partial disability awards total 85 percent or
249 more and who have been found to have a whole body medical impairment of at least 50 percent
250 or have sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of
251 this section are entitled to the rebuttable presumption created pursuant to subdivision (d) of this
252 section for the remaining issues in the request.

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

made after the amendment and reenactment of this section in the year 2003, permanent total disability benefits shall cease at the age of 70 years.

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

(A) 80 percent for the first year;

(B) 70 percent for the second year;

(C) 60 percent for the third year; and

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

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

(A) No percent of whole body medical impairment existing as the result of carpal tunnel syndrome for which a claim has been made under this chapter may be included in the aggregation of permanent disability under the provisions of this subsection or subsection (d) of this section; and

(B) No percent of whole body medical impairment existing as the result of any occupational disease, the diagnosis of which is based solely upon symptoms rather than specific, objective,

289 and measurable medical findings, and for which a claim has been made under this chapter may
290 be included in the aggregation of permanent disability under the provisions of this subsection or
291 subsection (d) of this section.

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

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

1 If an employee is found to be permanently disabled due to occupational pneumoconiosis
2 as defined in §23-4-1 of this code, the percentage of permanent disability is determined by the
3 degree of medical impairment that is found by the Occupational Pneumoconiosis Board. The
4 Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall
5 enter an order setting forth the findings of the Occupational Pneumoconiosis Board with regard
6 to whether the claimant has occupational pneumoconiosis and the degree of medical impairment,
7 if any, resulting therefrom. That order is the final decision of the Insurance Commissioner, private
8 carrier, or self-insured employer, whichever is applicable, for purposes of §23-5-1a of this code.
9 If a decision is objected to, the Board of Review shall affirm the decision of the Occupational
10 Pneumoconiosis Board made following hearing unless the decision is clearly wrong in view of the
11 reliable, probative, and substantial evidence on the whole record. Compensation is paid therefor

12 in the same manner and at the same rate as is provided for permanent disability under the
13 provisions of §23-4-6 of this code: *Provided*, That for any employee who applies for occupational
14 pneumoconiosis benefits whose award was granted on or after the effective date of the
15 amendment and reenactment of this section during the year 2003, there shall be no permanent
16 partial disability awarded based solely upon a diagnosis of occupational pneumoconiosis, it being
17 the intent of the Legislature to eliminate any permanent partial disability awards for occupational
18 pneumoconiosis without a specific finding of measurable impairment.

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

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

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

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

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

9 (b) For purposes of establishing temporary total disability weekly benefits pursuant to §23-
10 4-6(b) of this code for part-time employees, the "average weekly wage earnings, wherever
11 earned, of the injured person at the date of injury" shall be computed based upon the best average
12 weekly gross pay, wherever earned, which is received by the employee during the best quarter
13 of wages out of the preceding four quarters of wages as reported to the Insurance Commissioner
14 pursuant to §23-2-2(b) of this code: *Provided*, That for part-time employees who have been
15 employed less than two months but more than one week prior to the date of injury or any employee
16 whose wages have not yet been reported to the Insurance Commissioner, the average weekly
17 wage earnings shall be calculated based upon the average gross earnings in the weeks actually
18 worked: *Provided, however*, That for part-time employees who have been employed one week or
19 less, the average weekly wage earnings shall be calculated based upon the average weekly wage
20 prevailing for the same or similar part-time employment at the time of injury except that when an
21 employer has agreed to pay a certain hourly wage to a part-time employee, the average weekly
22 wage shall be computed by multiplying the hourly wage by the regular numbers of hours
23 contracted to be worked each week: *Provided further*, That notwithstanding any provision of this
24 article to the contrary, no part-time employee shall receive temporary total disability benefits
25 greater than his or her average weekly wage earnings as so calculated.

26 (c) Notwithstanding any other provisions of this article to the contrary, benefits payable to
27 a part-time injured employee for any permanent disability shall be computed and paid on the same
28 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.**

1 (a) The Legislature hereby finds and declares that two of the primary objectives of the
2 workers' compensation system established by this chapter are to provide benefits to an injured
3 claimant promptly and to effectuate his or her return to work at the earliest possible time; and that

4 the prompt dissemination of medical information to the employer as to diagnosis, treatment, and
5 recovery is essential if these two objectives are to be achieved.

6 (b) In view of the foregoing findings, a claimant irrevocably agrees by the filing of his or
7 her application for benefits that any physician may release to and orally discuss with the claimant's
8 employer, or its representative, or with a representative of the Insurance Commissioner, private
9 carrier, or self-insured employer, whichever is applicable, from time to time, the claimant's medical
10 history and any medical reports pertaining to the occupational injury or disease and to any prior
11 injury or disease of the portion of the claimant's body to which a medical impairment is alleged
12 containing detailed information as to the claimant's condition, treatment, prognosis, and
13 anticipated period of disability and dates as to when the claimant will reach or has reached his or
14 her maximum degree of improvement or will be or was released to return to work. For the
15 exclusive purposes of this chapter, the patient-physician privilege of confidentiality is waived with
16 regard to the physician's provision of this medical information pursuant to this section. Whenever
17 a copy of any medical report is obtained by the employer or its representative and the physician
18 has not also forwarded a copy of the medical report to the Insurance Commissioner, private
19 carrier, or self-insured employer, whichever is applicable, the employer shall forward a copy of
20 the medical report to the Insurance Commissioner, private carrier, or self-insured employer within
21 10 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; medical evaluations; temporary
total disability benefits and the termination thereof; mandatory action; additional
authority; suspension of benefits.**

1 (a) The Legislature hereby finds and declares that injured claimants should receive the
2 type of treatment needed as promptly as possible; that overpayments of benefits with the resultant
3 hardship created by the requirement of repayment should be minimized; and that to achieve these
4 two objectives it is essential that the Insurance Commissioner, private carriers, and self-insured

5 employers establish and operate a systematic program for the monitoring of injury claims where
6 the disability continues longer than might ordinarily be expected.

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

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

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

29 (2) If, however, the authorized treating physician recommends a permanent partial
30 disability award in excess of 15 percent, or recommends a permanent total disability award, the

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

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

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

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

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

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

(4) When other evidence submitted or otherwise obtained justifies a finding that the claimant has engaged or is engaging in abuse, including, but not limited to, physical activities inconsistent with his or her compensable workers' compensation injury.

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

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

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

104 (g) The provisions of this section are in addition to and in no way in derogation of the
105 power and authority vested in the Insurance Commissioner, private carrier, or self-insured
106 employer, whichever is applicable, by other provisions of this chapter or vested in the employer

107 to have a claimant examined by a physician or physicians of the employer's selection and at the
108 employer's expense, or vested in the claimant or employer to file a protest, under other provisions
109 of this chapter.

110 (h) All evaluations and examinations performed by physicians shall be performed in
111 accordance with the protocols and procedures established by rule of the Insurance
112 Commissioner: *Provided*, That the physician may exceed these protocols when additional
113 evaluation is medically necessary.

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

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

1 The Occupational Pneumoconiosis Board shall consist of five licensed physicians who
2 shall be appointed by the Insurance Commissioner. No person shall be appointed as a member
3 of the board, or as a consultant thereto, who has not by special study or experience, or both,
4 acquired special knowledge of pulmonary diseases. All members of the Occupational
5 Pneumoconiosis Board shall be physicians of good professional standing admitted to practice
6 medicine and surgery in this state. Two members shall be roentgenologists. One member of the
7 board shall be designated annually as chairman by the Insurance Commissioner. The term of
8 office of each member of the board shall be six years. Any member of the board may be appointed
9 to any number of terms. The function of the board is to determine all medical questions relating
10 to cases of compensation for occupational pneumoconiosis under the direction and supervision
11 of the Insurance Commissioner. Any three members of the board constitute a quorum for the
12 transaction of its business if at least one of the members present is a roentgenologist. The
13 Insurance Commissioner, shall, from time to time, fix the compensation to be paid each member

14 of the board. Members are also entitled to reasonable and necessary traveling and other
15 expenses incurred while actually engaged in the performance of their duties. In fixing the
16 compensation of board members, the Insurance Commissioner shall take into consideration the
17 number of claimants a member of the board actually examines, the actual time spent by members
18 in discharging their duties, and the recommendation of the Governor as to reasonable
19 reimbursement per unit of time expended based on comparative data for physicians within the
20 state in the same medical specialties.

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

1 The Occupational Pneumoconiosis Board, upon reference to it by an appropriate party of
2 a case of occupational pneumoconiosis, shall notify the employee, or in case he or she is dead,
3 the claimant, and the employer, as well as the Insurance Commissioner, private carrier, or self-
4 insured employer, whichever is applicable, to appear before the board at a time and place stated
5 in the notice. If the employee is living, he or she shall appear before the board at the time and
6 place specified and submit to the examination, including clinical and X-ray examinations, required
7 by the board. If a physician licensed to practice medicine in the state makes an affidavit that the
8 employee is physically unable to appear at the time and place designated by the board, the board
9 shall, on notice to the proper parties, change the place and time as may reasonably facilitate the
10 hearing or examination of the employee or may appoint a qualified specialist in the field of
11 respiratory disease to examine the claimant on behalf of the board. The employee, or in case he
12 or she is dead, the claimant, and employer shall also produce as evidence to the board all reports
13 of medical and X-ray examinations which may be in their respective possession or control,
14 showing the past or present condition of the employee. If the employee is dead, the notice of the
15 board shall further require that the claimant produce necessary consents and permits so that an
16 autopsy may be performed, if the board so directs. When in the opinion of the board an autopsy
17 is considered necessary to accurately and scientifically ascertain and determine the cause of
18 death, the autopsy examination shall be ordered by the board, which shall designate a duly

19 licensed physician, a pathologist, or any other specialists determined necessary by the board, to
20 make the examination and tests to determine the cause of death and certify his or her or their
21 written findings, in triplicate, to the board. The findings shall be public records. In the event that a
22 claimant for compensation for the death refuses to consent and permit the autopsy to be made,
23 all rights for compensation are forfeited.

24 The employee, or if he or she be dead, the claimant, and the employer, shall be entitled
25 to be present at all examinations conducted by the board and to be represented by attorneys and
26 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.**

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

11 (b) If it can be shown that the claimant or deceased employee has been exposed to the
12 hazard of inhaling minute particles of dust in the course of and resulting from his or her
13 employment for a period of 10 years during the 15 years immediately preceding the date of his or
14 her last exposure to such hazard and that the claimant or deceased employee has sustained a
15 chronic respiratory disability, it shall be presumed that the claimant is suffering or the deceased

employee was suffering at the time of his or her death from occupational pneumoconiosis which arose out of and in the course of his or her employment. This presumption is not conclusive.

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

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

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

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

(d) If either party objects to the whole or any part of the findings and conclusions of the Occupational Pneumoconiosis Board, the party shall file with the Board of Review, within 60 days from receipt of the copy to that party, unless for good cause shown the Board of Review extends the time, the party's objections to the findings and conclusions of the Occupational Pneumoconiosis Board in writing, specifying the particular statements of the Occupational Pneumoconiosis Board's findings and conclusions to which such party objects. The filing of an objection within the time specified is a condition of the right to litigate the findings and therefore jurisdictional. After the time has expired for the filing of objections to the findings and conclusions of the Occupational Pneumoconiosis Board, the Board of Review shall proceed to act as provided in this chapter. If, after the time has expired for the filing of objections to the findings and conclusions of the Occupational Pneumoconiosis Board, no objections have been filed, the report of a majority of the Occupational Pneumoconiosis Board of its findings and conclusions on any medical question shall be taken to be plenary and conclusive evidence of the findings and conclusions stated in the report. If objection has been filed to the findings and conclusions of the

Occupational Pneumoconiosis Board, notice of the objection shall be given to the board. The members of the Occupational Pneumoconiosis Board joining in the findings and conclusions shall appear at the time fixed by the Board of Review for the hearing to submit to examination and cross-examination in respect to the findings and conclusions. At the hearing, evidence to support or controvert the findings and conclusions of the Occupational Pneumoconiosis Board shall be limited to examination and cross-examination of the members of the board and to the taking of testimony of other qualified physicians and roentgenologists.

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

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

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

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

16 (b) In cases where an employee has sustained a permanent disability, or has sustained
17 an injury likely to result in temporary disability as determined by the Insurance Commissioner,
18 private carrier, or self-insured employer, whichever is applicable, the Insurance Commissioner,
19 private carrier, or self-insured employer shall at the earliest possible time determine whether the
20 employee would be assisted in returning to remunerative employment with the provision of
21 rehabilitation services and if it is determined that the employee can be physically and vocationally
22 rehabilitated and returned to remunerative employment by the provision of rehabilitation services
23 including, but not limited to, vocational or on-the-job training, counseling, assistance in obtaining
24 appropriate temporary or permanent work site, work duties, or work hours modification, by the
25 provision of crutches, artificial limbs, or other approved mechanical appliances, or medicines,
26 medical, surgical, dental, or hospital treatment or other services which the Insurance

27 Commissioner, private carrier, or self-insured employer in its sole discretion determines will
28 directly assist the employee's return to employment, the Insurance Commissioner, private carrier,
29 or self-insured employer shall immediately develop a rehabilitation plan for the employee and,
30 after due notice to the employer, expend an amount necessary for that purpose: *Provided*, That
31 the expenditure for vocational rehabilitation shall not exceed \$20,000 for any one injured
32 employee: *Provided, however*, That no payment shall be made for such vocational rehabilitation
33 purposes as provided in this section unless authorized by the Insurance Commissioner, private
34 carrier, or self-insured employer prior to the rendering of the physical or vocational rehabilitation,
35 except that payments shall be made for reasonable medical expenses without prior authorization
36 if sufficient evidence exists which would relate the treatment to the injury and the attending
37 physician or physicians have requested authorization prior to the rendering of the treatment:
38 *Provided further*, That payment for physical rehabilitation, including the purchase of prosthetic
39 devices and other equipment and training in use of the devices and equipment, are considered
40 expenses within the meaning of §23-4-3 of this code and are subject to the provisions of §23-4-3
41 of this code. The provision of any rehabilitation services may be pursuant to a rehabilitation plan
42 to be developed and monitored by a rehabilitation professional for each injured employee or by
43 such other provider as determined by the Insurance Commissioner, private carrier, or self-insured
44 employer, whichever is applicable. Notwithstanding any other provision of this section to the
45 contrary, the Insurance Commissioner may determine by rule that a rehabilitation plan or any
46 component thereof is not appropriate for an injured employee.

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

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

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

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

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

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

§23-4-12. Application of benefits.

1 The dependent or person to whom benefits are paid shall apply the benefits to the use of
2 the several beneficiaries of the benefits according to their respective claims upon the decedent

for support, in compliance with the finding and direction of the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable.

§23-4-14. Computation of benefits.

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

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

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

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

(2) On and after July 1, 1994, the expression "average weekly wage earnings, wherever earned, of the injured person, at the date of injury", within the meaning of this chapter, shall be computed based upon the daily rate of pay at the time of the injury or upon the weekly average derived from the best quarter of wages out of the preceding four quarters of wages as reported to

24 the Insurance Commissioner pursuant to §23-2-2(b) of this code, whichever is most favorable to
25 the injured employee, except for the purpose of computing temporary total disability benefits for
26 part-time employees pursuant to the provisions of §23-4-6d of this code.

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

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

§23-4-15. Application for benefits.

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

11 (b) To entitle any employee to compensation for occupational pneumoconiosis under the
12 provisions of this subsection, the application for compensation shall be made on the form or forms

13 prescribed by the Insurance Commissioner, and filed with the Insurance Commissioner, private
14 carrier, or self-insured employer, whichever is applicable, within three years from and after the
15 last day of the last continuous period of 60 days or more during which the employee was exposed
16 to the hazards of occupational pneumoconiosis or within three years from and after a diagnosed
17 impairment due to occupational pneumoconiosis was made known to the employee by a physician
18 and unless filed within the three-year period, the right to compensation under this chapter is
19 forever barred, such time limitation being hereby declared to be a condition of the right and hence
20 jurisdictional, or, in the case of death, the application shall be filed by the dependent of the
21 employee within two years from and after the employee's death, and such time limitation is a
22 condition of the right and hence jurisdictional.

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

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

1 Notwithstanding any other provisions of this chapter, nonresident alien beneficiaries are
2 entitled to the same benefits as citizens of the United States: *Provided*, That the Insurance

3 Commissioner, private carrier, or self-insured employer, whichever is applicable, in its discretion
4 may make, and the beneficiary shall accept, commutation of the benefits into a lump sum
5 settlement and payment. Nonresident alien beneficiaries within the meaning of this section means
6 persons not citizens of the United States residing outside of the territorial limits of the United
7 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.**

1 If a claim for occupational pneumoconiosis benefits is filed by an employee within three
2 years from and after the last day of the last continuous period of 60 days' exposure to the hazards
3 of occupational pneumoconiosis, the Insurance Commissioner, private carrier, or self-insured
4 employer, whichever is applicable, shall determine whether the claimant was exposed to the
5 hazards of occupational pneumoconiosis for a continuous period of not less than 60 days while
6 in the employ of the employer within three years prior to the filing of his or her claim, whether in
7 the State of West Virginia the claimant was exposed to such hazard over a continuous period of
8 not less than two years during the 10 years immediately preceding the date of his or her last
9 exposure to the hazard and whether the claimant was exposed to the hazard over a period of not
10 less than 10 years during the 15 years immediately preceding the date of his or her last exposure
11 to the hazard. If a claim for occupational pneumoconiosis benefits is filed by an employee within
12 three years from and after the employee's occupational pneumoconiosis was made known to the
13 employee by a physician, the Insurance Commissioner, private carrier, or self-insured employer,
14 whichever is applicable, shall determine whether the claimant filed his or her application within
15 that period and whether in the State of West Virginia the claimant was exposed to the hazard over
16 a continuous period of not less than two years during the 10 years immediately preceding the
17 date of last exposure to the hazard and whether the claimant was exposed to the hazard over a
18 period of not less than 10 years during the 15 years immediately preceding the date of last
19 exposure to the hazard. If a claim for occupational pneumoconiosis benefits is filed by a

20 dependent of a deceased employee, the Insurance Commissioner, private carrier, or self-insured
21 employer, whichever is applicable, shall determine whether the deceased employee was exposed
22 to the hazards of occupational pneumoconiosis for a continuous period of not less than 60 days
23 while in the employ of the employer within 10 years prior to the filing of the claim, whether in the
24 State of West Virginia the deceased employee was exposed to the hazard over a continuous
25 period of not less than two years during the 10 years immediately preceding the date of his or her
26 last exposure to the hazard and whether the claimant was exposed to the hazard over a period
27 of not less than 10 years during the 15 years immediately preceding the date of his or her last
28 exposure to the hazard. The Insurance Commissioner, private carrier, or self-insured employer,
29 whichever is applicable, shall also determine other nonmedical facts that, in the opinion of the
30 Insurance Commissioner, private carrier, or self-insured employer, are pertinent to a decision on
31 the validity of the claim.

32 The Insurance Commissioner, private carrier, or self-insured employer, whichever is
33 applicable, shall enter an order with respect to nonmedical findings within 90 days following
34 receipt by the Insurance Commissioner, private carrier, or self-insured employer of both the
35 claimant's application for occupational pneumoconiosis benefits and the physician's report filed
36 in connection with the claimant's application and shall give each interested party notice in writing
37 of these findings with respect to all the nonmedical facts. The findings and actions of the Insurance
38 Commissioner, private carrier, or self-insured employer, whichever is applicable, are final unless
39 the employer, employee, claimant, or dependent, within 60 days after receipt of the notice, objects
40 to the findings and, unless an objection is filed within the 60-day period, the findings are forever
41 final, the time limitation is a condition of the right to litigate the findings and therefore jurisdictional.
42 Upon receipt of an objection, the Board of Review shall set a hearing as provided in §23-5-9a of
43 this code. In the event of an objection to the findings by the employer, the claim shall,
44 notwithstanding the fact that one or more hearings may be held with respect to the objection,
45 mature for reference to the Occupational Pneumoconiosis Board with like effect as if the objection

46 had not been filed. If the Board of Review concludes after the objection hearings that the claim
47 should be dismissed, a final order of dismissal shall be entered. The final order is subject to appeal
48 in accordance with the provisions of §23-5-10a and §23-5-12a of this code. If the Board of Review
49 concludes after the objection hearings that the claim should be referred to the Occupational
50 Pneumoconiosis Board for its review, the order entered shall be interlocutory only and may be
51 appealed only in conjunction with an appeal from a final order with respect to the findings of the
52 Occupational Pneumoconiosis Board.

**§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.**

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

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

12 (2) Except as stated below, in any claim in which an award of permanent disability was
13 made, any request must be made within five years of the date of the initial award. During that time
14 period, only two requests may be filed. With regard to those occupational diseases, including
15 occupational pneumoconiosis, which are medically recognized as progressive in nature, if any

16 such request is granted by the Insurance Commissioner, private carrier, or self-insured employer,
17 whichever is applicable, a new five-year period begins upon the date of the subsequent award.

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

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

28 (b) In any claim in which an injured employee makes application for a further period of
29 temporary total disability, if the application is in writing and filed within the applicable time limit
30 stated above, the Insurance Commissioner, private carrier, or self-insured employer, whichever
31 is applicable, shall pass upon the request within 30 days of the receipt of the request. If the
32 decision is to grant the request, the order shall provide for the receipt of temporary total disability
33 benefits. In any case in which an injured employee makes application for a further award of
34 permanent partial disability benefits or for an award of permanent total disability benefits, if the
35 application is in writing and filed within the applicable time limit as stated above, the Insurance
36 Commissioner, private carrier, or self-insured employer, whichever is applicable, shall pass upon
37 the request within 30 days of its receipt and, if the Insurance Commissioner, private carrier, or
38 self-insured employer determines that the claimant may be entitled to an award, the Insurance
39 Commissioner, private carrier, or self-insured employer shall refer the claimant for further
40 examinations that are necessary.

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

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

53 (1) The Insurance Commissioner, private carrier, or self-insured employer, whichever is
54 applicable, shall continuously monitor permanent total disability awards and may, from time to
55 time, after due notice to the claimant, reopen a claim for reevaluation of the continuing nature of
56 the disability and possible modification of the award. At such times as the Insurance
57 Commissioner, private carrier, or self-insured employer, whichever is applicable, may determine,
58 the Insurance Commissioner, private carrier, or self-insured employer may require the claimant
59 to provide documents and other information, including, but not limited to, tax returns, financial
60 records, and affidavits demonstrating level of income, recreational activities, work activities,
61 medications used, and physicians or other medical or rehabilitation providers treating or
62 prescribing medication or other services for the claimant; require the claimant to appear under
63 oath and answer questions; and suspend or terminate any benefits of a claimant who willfully fails
64 to provide the information or appear as required. The Insurance Commissioner, private carrier, or
65 self-insured employer, whichever is applicable, may reopen a claim for reevaluation when, in its
66 sole discretion, it concludes that there exists good cause to believe that the claimant no longer

67 meets the eligibility requirements under §23-4-6(n) of this code. The eligibility requirements,
68 including any vocational standards, shall be applied as those requirements are stated at the time
69 of a claim's reopening.

70 (2) Upon reopening a claim under this subsection, the Insurance Commissioner, private
71 carrier, or self-insured employer, whichever is applicable, may take evidence, have the claimant
72 evaluated, make findings of fact and conclusions of law, and shall vacate, modify, or affirm the
73 original permanent total disability award as the record requires. In the event the claimant retains
74 his or her award following the reevaluation, the claimant's reasonable attorneys' fees incurred in
75 defending the award shall be paid by the Insurance Commissioner, private carrier, or self-insured
76 employer, whichever is applicable. In addition, the Insurance Commissioner, private carrier, or
77 self-insured employer, whichever is applicable, shall reimburse a prevailing claimant for his or her
78 costs in obtaining one evaluation on each issue during the course of the reevaluation.

79 (3) This subsection shall not be applied to awards made under the provisions of §23-4-
80 6(m) of this code. The claimant may seek review of the final order as otherwise provided in §23-
81 5-1 *et seq.* of this code for review of orders granting or denying permanent disability awards.

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

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

§23-4-16a. Interest on benefits.

1 Whenever any award of temporary total, permanent partial, or permanent total disability
2 benefits or dependent benefits is made on or after July 1, 1971, and a protest is filed to the award
3 or an appeal is taken from the award by an employer only and not by the claimant or dependent
4 and the award is not ultimately denied or reduced following the protest or appeal, the Insurance
5 Commissioner, private carrier, or self-insured employer, whichever is applicable, shall add interest

6 to the award at the simple rate of six percent per annum from the date the award would have
7 been payable had the protest or appeal not been filed or taken, exclusive of any period for which
8 a continuance was granted upon motion of any party other than the protesting or appealing
9 employer.

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

1 The Insurance Commissioner, private carrier, or self-insured employer, whichever is
2 applicable, under special circumstances and when it is considered advisable, may commute
3 periodical benefits to one or more lump-sum payments. Upon the application of any claimant who
4 has received an award of partial or total disability, who is not a citizen of the United States and
5 desires to reside permanently beyond the territorial limits of the United States, or upon the
6 application of an alien dependent of a deceased employee with respect of whose death award of
7 compensation has been made, the dependent residing in the territorial limits of the United States
8 at the time of the decedent's death, and desiring to reside permanently beyond the territorial limits
9 of the United States, the Insurance Commissioner, private carrier, or self-insured employer,
10 whichever is applicable, may commute into one lump-sum payment the periodical payments to
11 which the claimant or dependent would be entitled, but at the rate of one-half the amount that
12 would be payable to a citizen of the United States under like circumstances. The lump-sum
13 payment at the rate specified in this section discharges all liability with respect to the award, but
14 in no event shall the award be paid until the claimant or dependent has actually arrived and
15 domiciled himself or herself outside the territorial limits of the United States, except a sufficient
16 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.

1 Except as provided by this section, compensation shall be paid only to the employees or
2 their dependents and is exempt from all claims of creditors and from any attachment, execution
3 or assignment other than compensation to counsel for legal services, under the provisions of, and

4 subject to the limitations contained in §23-5-16a of this code, and other than for the enforcement
5 of orders for child or spousal support entered pursuant to the provisions of chapter 48 of this code.
6 Payments may be made in the periodic installments determined by the Insurance Commissioner,
7 private carrier, or self-insured employer, whichever is applicable, in each case, but in no event
8 less frequently than semimonthly for any temporary award and monthly for any permanent award.
9 Payments for permanent disability shall be paid on or before the third day of the month in which
10 they are due. In all cases where compensation is awarded or increased, the amount of
11 compensation shall be calculated and paid from the date of disability.

§23-4-20. Postmortem examinations.

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

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

1 [Repealed.]

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

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

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

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

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

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

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

26 (e) If any portion of this section or any application of this section is subsequently found to
27 be unconstitutional or in violation of applicable law, it shall not affect the validity of the remainder
28 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.**

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

13 (b) The Insurance Commissioner, private carrier, or self-insured employer, whichever is
14 applicable, has the sole and exclusive jurisdiction to initially hear and decide any claim or request
15 pertaining, in whole or in part, to §23-4-6(d) or (n) of this code. Any claim or request for permanent
16 total disability benefits arising under said subdivisions shall first be presented as part of the initial
17 claim filing or by way of an application for modification or adjustment pursuant to §23-4-16 of this
18 code. The Board of Review may consider a claim only after the Insurance Commissioner, private
19 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.

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

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

ARTICLE 5. REVIEW.

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

1 [Repealed.]

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

1 In any case where an injured employee makes application in writing for a further
2 adjustment of his or her claim under the provisions of §23-4-16 of this code and the application
3 discloses cause for a further adjustment, the Insurance Commissioner, private carrier, or self-
4 insured employer, whichever is applicable, shall make the modifications or changes with respect
5 to former findings or orders in the claim that are justified. Any party dissatisfied with any
6 modification or change made by the Insurance Commissioner, private carrier, or self-insured
7 employer, whichever is applicable, is, upon proper and timely objection, entitled to a hearing, as
8 provided in §23-5-9a of this code.

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

1 [Repealed.]

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

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

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

1 [Repealed.]

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

1 [Repealed.]

§23-5-7. Compromise and settlement.

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

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

27 (c) The amendments to this section enacted during the regular session of the Legislature,
28 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.**

1 [Repealed.]

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

1 [Repealed.]

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

1 [Repealed.]

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

1 [Repealed.]

**§23-5-11a. Workers' Compensation Board of Review generally; administrative powers and
duties of the board.**

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

6 (b) The board shall consist of at least three members and not exceed a total of five
7 members.

8 (c) The Governor shall appoint, with the advice and consent of the Senate, attorneys
9 qualified in accordance with subsection (f) of this section to serve as members of the Board of
10 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. If the board consists of five members, no more than three of the members may be of the same political party. If the board consists of three or four members, no more than two of the members may be of the same political party. The Governor shall set the salary of the members of the board: *Provided*, 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. Notwithstanding any other provision of this code to the contrary, the term of a member shall expire pursuant to this subsection unless the member is reappointed by the Governor as set forth in subsection (c) of this section.

(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.

36 No member of the Board of Review may engage in the practice of law during his or her term of
37 office.

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

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

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

49 (j) The Board of Review shall, from time to time, promulgate rules of practice and
50 procedure for the review and determination of all objections filed with the board. The board does
51 not have the power to initiate or to promulgate legislative rules as that phrase is defined in §29A-
52 3-1 *et seq.* of this code. Any rules adopted pursuant to this section which are applicable to the
53 provisions of this article are not subject to §29A-3-9 through §29A-3-16 of this code. The board
54 shall follow the remaining provisions of chapter 29A of this code for giving notice to the public of
55 its actions and the holding of hearings or receiving of comments on the rules.

56 (k) The Board of Review may hire a clerk, hearing examiners, and other professional and
57 clerical staff necessary to carry out the requirements of this article. It is the duty of the clerk of the
58 Board of Review to attend in person, or by deputy, all the sessions of the board, to obey its orders
59 and directions, to take care of and preserve in an office, kept for the purpose, all records and
60 papers of the board and to perform other duties as prescribed by law or required of him or her by
61 the board. All employees of the board serve at the will and pleasure of the board. The board's

62 employees are exempt from the salary schedule or pay plan adopted by the Division of Personnel:
63 *Provided*, That for the purpose of any applicable Division of Personnel class specifications,
64 hearing examiners must be classified under a class with "attorney" in the class title. All personnel
65 of the Board of Review are under the supervision of the chair of the Board of Review.

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

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

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

1 [Repealed.]

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

1 [Repealed.]

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

1 In any matter wherein a member of the Workers' Compensation Board of Review is a
2 party, or is personally interested in the results thereof, or is a beneficiary therein, or is connected
3 with a beneficiary therein, he or she shall be disqualified from participating in the hearing and
4 determination of any objection to decisions of the Insurance Commissioner, private carrier, or self-
5 insured employer, whichever is applicable.

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

Enr CS for HB 5515

1 [Repealed.]

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

1 [Repealed.]

The Clerk of the House of Delegates and the Clerk of the Senate hereby certify that the foregoing bill is correctly enrolled.

Jim Pack

Clerk of the House of Delegates

Joe Levin

Clerk of the Senate

FILED
2016 APR -1 P 10:56
OFFICE OF THE CLERK OF THE SENATE
SECRETARY OF STATE

Originated in the House of Delegates.

In effect 90 days from passage.

Ben Haskew

Speaker of the House of Delegates

Randy Smith

President of the Senate

The within is approved this the 1st
Day of April, 2026.

PATRICK MORISSEY
Governor

PRESENTED TO THE GOVERNOR

Time 3:30pm