State of Wisconsin
2021 - 2022 LEGISLATURE

LRB-0117/1
MIM&MED:amn

2021 SENATE BILL 11

January 21, 2021 – Introduced by Senators JACQUE, WANGGAARD, BEWLEY, AGARD, BALLWEG, NASS, PFAFF, RINGHAND and L. TAYLOR, cosponsored by Representatives HORLACHER, EMERSON, ALLEN, BRANDTJEN, CALLAHAN, DITTRICH, EDMING, KERKMAN, KUGLITSCH, LOUDENBECK, MILROY, MURSAU, NOVAK, PETRYK, RAMTHUN and THIESFELDT. Referred to Committee on Labor and Regulatory Reform.

AN ACT ***to renumber and amend*** 102.17 (4) and 102.58; ***to amend*** 102.04 (2m), 102.13 (2) (a), 102.29 (6m) (a) 3., 102.315 (1) (c), 102.315 (2), 102.42 (1), 102.49 (5) (b), 102.49 (5) (c) and 102.49 (5) (e); and ***to create*** 102.04 (2g), 102.17 (9), 102.29 (6m) (a) 1m., 102.315 (2e), 102.315 (2m), 102.315 (2s), 102.42 (1p), 102.44 (7) and 102.49 (5) (cm) of the statutes; **relating to:** various changes to the worker's compensation law.

Analysis by the Legislative Reference Bureau

This bill makes various changes to the worker's compensation law, as administered by the Department of Workforce Development and the Division of Hearings and Appeals in the Department of Administration (DHA).

PAYMENT OF BENEFITS; OTHER PAYMENTS

Liability for public safety officers

This bill makes changes to the conditions of liability for worker's compensation benefits for a law enforcement officer or a fire fighter (public safety officer) who is diagnosed with post-traumatic stress disorder (PTSD).

The bill provides that if a public safety officer is diagnosed with PTSD by a licensed psychiatrist or psychologist and the mental injury that resulted in that diagnosis is not accompanied by a physical injury, that public safety officer can bring a claim for worker's compensation benefits if the conditions of liability are proven by

a preponderance of the evidence and the mental injury is not the result of a good–faith employment action by the person's employer. Under current law, an injured employee who does not have an accompanying physical injury must demonstrate a diagnosis based on unusual stress of greater dimensions than the day–to–day emotional strain and tension experienced by all employees as required under *School District No. 1 v. DILHR*, 62 Wis. 2d 370, 215 N.W.2d 373 (1974). Under the bill, such an injured public safety employee is not required to demonstrate a diagnosis based on that standard, and instead must demonstrate a diagnosis based on the new standard.

The bill also limits liability for treatment for a mental injury that is compensable under the bill's provisions to no more than 32 weeks after the injury is first reported. Under the bill, a public safety officer is restricted to compensation for a mental injury that is not accompanied by a physical injury and that results in a diagnosis of PTSD three times in his or her lifetime irrespective of a change of employer or employment.

Payments in cases of injuries resulting in death

Current law provides that, in each case of an injury resulting in death leaving no person dependent for support or leaving one or more persons partially dependent for support, the employer or insurer must pay into the work injury supplemental benefit fund (WISBF) the amount of the death benefit otherwise payable. This bill does the following:

1. Allows such amounts due to be paid in advance of when they would otherwise be due, including as a single, lump–sum payment. If an employer or insurer makes an advance or lump–sum payment, the bill requires DWD to give the employer or the insurer an interest credit, computed as otherwise provided under current law. Current law requires, in the case of a death leaving no dependents, that the payments be made in five equal annual installments.

2. Provides that, in the case of a violation of an employer policy against drug or alcohol use that is causal to an employee's injury resulting in death who leaves no person dependent for support or leaving one or more persons partially dependent for support, no payment is required to be made to WISBF. Current law provides that, in the case of such a violation, then neither the employee nor the employee's dependents may receive any compensation under the worker's compensation law for that injury, other than costs for treating the injury, but does not exempt the employer or insurer from the payment to WISBF.

Furnishing of billing statements

This bill requires a health care provider to furnish to the representative or agent of a worker's compensation insurer a complete billing statement for treatment of an injury for which an employee claims compensation upon request.

COVERAGE; LIABILITY

Leased employees

Under current law, employee leasing companies are generally liable for injuries to their leased employees under the worker's compensation law. This bill provides that a client of an employee leasing company may instead assume the liability for

leased employees under an employee leasing agreement. The bill also provides that if a client terminates or otherwise does not provide worker's compensation insurance coverage for the leased employees, the employee leasing company is liable for injuries to those leased employees under the worker's compensation law.

Statute of limitations

This bill clarifies that for worker's compensation claims the statute of limitations applies to an individual's employer, the employer's insurance company, and any other named party.

For further information see the state and local fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 102.04 (2g) of the statutes is created to read:

102.04 **(2g)** Liability under s. 102.03 with respect to a leased employee, as defined in s. 102.315 (1) (g), shall be determined as provided in s. 102.315 (2) or (2m) (c), whichever is applicable.

SECTION 2. 102.04 (2m) of the statutes is amended to read:

102.04 **(2m)** ~~A~~ Except as otherwise provided in an employee leasing agreement that meets the requirements of s. 102.315 (2m), a temporary help agency is the employer of an employee whom the temporary help agency has placed with or leased to another employer that compensates the temporary help agency for the employee's services. ~~A~~ Except as provided in s. 102.315 (2m) (c), a temporary help agency is liable under s. 102.03 for all compensation and other payments payable under this chapter to or with respect to that employee, including any payments required under s. 102.16 (3), 102.18 (1) (b) 3. or (bp), 102.22 (1), 102.35 (3), 102.57, or 102.60. Except as permitted under s. 102.29, a temporary help agency may not seek or receive reimbursement from another employer for any payments made as a result of that liability.

SECTION 3. 102.13 (2) (a) of the statutes is amended to read:

102.13 **(2)** (a) An employee who reports an injury alleged to be work–related or files an application for hearing waives any physician–patient, psychologist–patient, or chiropractor–patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding ss. 51.30 and 146.82 and any other law, any physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, worker's compensation insurer, department, or division, or its representative, provide that person with any information or written material reasonably related to any injury for which the employee claims compensation. If the request is by a representative of a worker's compensation insurer for a billing statement, the physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, hospital, or health care provider shall, within 30 days after receiving the request, provide that person with a complete copy of an itemized billing statement or a billing statement in a standard billing format recognized by the federal government.

SECTION 4. 102.17 (4) of the statutes is renumbered 102.17 (4) (a) and amended to read:

102.17 **(4)** (a) Except as provided in this subsection and s. 102.555 (12) (b), in the case of occupational disease, the right of an employee, the employee's legal representative, ~~or~~ a dependent, the employee's employer or the employer's insurance company, or other named party to proceed under this section shall not extend beyond 12 years after the date of the injury or death or after the date that compensation,

other than for treatment or burial expenses, was last paid, or would have been last payable if no advancement were made, whichever date is latest, and in the case of traumatic injury, that right shall not extend beyond 6 years after that date.

(b) In the case of occupational disease; a traumatic injury resulting in the loss or total impairment of a hand or any part of the rest of the arm proximal to the hand or of a foot or any part of the rest of the leg proximal to the foot, any loss of vision, or any permanent brain injury; or a traumatic injury causing the need for an artificial spinal disc or a total or partial knee or hip replacement, there shall be no statute of limitations, except that benefits or treatment expense for an occupational disease becoming due 12 years after the date of injury or death or last payment of compensation, other than for treatment or burial expenses, shall be paid from the work injury supplemental benefit fund under s. 102.65 and in the manner provided in s. 102.66 and benefits or treatment expense for such a traumatic injury becoming due 6 years after that date shall be paid from that fund and in that manner if the date of injury or death or last payment of compensation, other than for treatment or burial expenses, is before April 1, 2006.

(c) Payment of wages by the employer during disability or absence from work to obtain treatment shall be considered payment of compensation for the purpose of this section if the employer knew of the employee's condition and its alleged relation to the employment.

SECTION 5. 102.17 (9) of the statutes is created to read:

102.17 **(9)** (a) In this subsection:

1. "Fire fighter" means any person employed on a full–time basis by the state or any political subdivision as a member or officer of a fire department, including the 1st class cities and state fire marshal and deputies.

2. "Post–traumatic stress disorder" means that condition, as described in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

(b) Subject to par. (c), in the case of a mental injury that is not accompanied by a physical injury and that results in a diagnosis of post–traumatic stress disorder in a law enforcement officer, as defined in s. 23.33 (1) (ig), or a fire fighter, the claim for compensation for the mental injury, in order to be compensable under this chapter, is subject to all of the following:

1. The mental injury must satisfy all of the following conditions:

a. The diagnosis of post–traumatic stress disorder is made by a licensed psychiatrist or psychologist.

b. The conditions of liability under s. 102.03 (1) are proven by the preponderance of the evidence.

2. The mental injury may not be a result of any of the following actions taken in good faith by the employer:

a. A disciplinary action.

b. A work evaluation.

c. A job transfer.

d. A layoff.

e. A demotion.

f. A termination.

3. The diagnosis does not need to be based on unusual stress of greater dimensions than the day–to–day emotional strain and tension experienced by similarly situated employees.

(c) No individual may receive compensation for a claim of mental injury under this subsection more than 3 times in his or her lifetime. The limitation under this paragraph applies irrespective of whether the individual becomes employed by a different employer or in a different position with the same employer.

SECTION 6. 102.29 (6m) (a) 1m. of the statutes is created to read:

102.29 **(6m)** (a) 1m. The employee leasing company that employs the leased employee.

SECTION 7. 102.29 (6m) (a) 3. of the statutes is amended to read:

102.29 **(6m)** (a) 3. Any employee of the client ~~or~~, any employee of ~~that other~~ an employee leasing company described in subd. 2., or the employee leasing company that employs the leased employee, unless the leased employee who has the right to make a claim for compensation would have a right under s. 102.03 (2) to bring an action against the employee of the client, the employee leasing company that employs the leased employee, or the leased employee of the ~~other~~ employee leasing company described in subd. 2., if the employees and leased employees were coemployees.

SECTION 8. 102.315 (1) (c) of the statutes is amended to read:

102.315 **(1)** (c) "Divided workforce" means a workforce in which some of the employees of a client are leased employees and some of the employees of the client are not leased employees, but does not include a workforce with respect to a client that has elected to provide insurance coverage for leased employees under sub. (2m).

SECTION 9. 102.315 (2) of the statutes is amended to read:

102.315 **(2)** EMPLOYEE LEASING COMPANY LIABLE. ~~An~~ Except as otherwise provided in an employee leasing agreement that meets the requirements of sub. (2m), an employee leasing company is liable under s. 102.03 for all compensation

payable under this chapter to a leased employee, including any payments required under s. 102.16 (3), 102.18 (1) (b) 3. or (bp), 102.22 (1), 102.35 (3), 102.57, or 102.60. If a client that makes an election under sub. (2m) (a) terminates the election, fails to provide the required coverage, or allows coverage to lapse, the employee leasing company is liable under s. 102.03 as set forth in this subsection. Except as ~~permitted~~ allowed under s. 102.29, an employee leasing company may not seek or receive reimbursement from another employer for any payments made as a result of that liability. An employee leasing company is not liable under s. 102.03 for any compensation payable under this chapter to an employee of a client who is not a leased employee.

SECTION 10. 102.315 (2e) of the statutes is created to read:

102.315 **(2e)** TERMINATION OF EMPLOYEE LEASING AGREEMENT. If an employee leasing company terminates an employee leasing agreement with a client that has made an election under sub. (2m) (a), the company shall provide notice of the termination of an employee leasing agreement to the department and the client, on a form prescribed by the department, at least 30 days before the termination of the employee leasing agreement. The notice provided under this subsection must contain all of the following information:

(a) The name, mailing address, and federal employer identification number of the employee leasing company.

(b) The name, mailing address, and federal employer identification number of the client.

(c) The effective date of the termination of the employee leasing agreement.

(d) The signatures of the authorized representatives of the client and the employee leasing company.

SECTION 11. 102.315 (2m) of the statutes is created to read:

102.315 **(2m)** CLIENT ELECTION TO PROVIDE INSURANCE COVERAGE. (a) A client may elect to provide insurance coverage under this chapter for leased employees. Such an election must be provided in an employee leasing agreement, and the leased employees must be insured in the voluntary market and not under a mandatory risk–sharing plan under s. 619.01.

(b) The client shall provide notice of an election or termination of an election under par. (a) to the department and the employee leasing company on a form prescribed by the department at least 30 days before the effective date of the election or termination of the election. The notice provided under this subsection must contain all of the following information:

1. The name, mailing address, and federal employer identification number of the client.

2. The name, mailing address, and federal employer identification number of the employee leasing company.

3. The effective date of the employee leasing agreement.

4. The signatures of the authorized representatives of the client and the employee leasing company.

(c) A client that elects to provide insurance coverage under par. (a) is liable under s. 102.03 for all compensation payable to a leased employee, including any payments required under s. 102.16 (3), 102.18 (1) (b) 3. or (bp), 102.22 (1), 102.35 (3), 102.57, or 102.60.

(d) If a client makes an election under par. (a), the employee leasing company shall include the client's federal employer identification number on any reports to the

department for the purposes of administering the worker's compensation program or the unemployment insurance program under ch. 108.

(e) The experience rating under the standards and criteria under ss. 626.11 and 626.12 remain with a client that makes an election under par. (a).

SECTION 12. 102.315 (2s) of the statutes is created to read:

102.315 **(2s)** CLAIM REPORTING. Any claim filed under this chapter for a leased employee shall include the client's federal employer identification number.

SECTION 13. 102.42 (1) of the statutes is amended to read:

102.42 **(1)** TREATMENT OF EMPLOYEE. ~~The~~ Subject to the limitations under sub. (1p), the employer shall supply such medical, surgical, chiropractic, psychological, podiatric, dental, and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances, and training in the use of artificial members and appliances, or, at the option of the employee, Christian Science treatment in lieu of medical treatment, medicines, and medical supplies, as may be reasonably required to cure and relieve from the effects of the injury, and to attain efficient use of artificial members and appliances, and in case of the employer's neglect or refusal seasonably to do so, or in emergency until it is practicable for the employee to give notice of injury, the employer shall be liable for the reasonable expense incurred by or on behalf of the employee in providing such treatment, medicines, supplies, and training. When the employer has knowledge of the injury and the necessity for treatment, the employer's failure to tender the necessary treatment, medicines, supplies, and training constitutes such neglect or refusal. The employer shall also be liable for reasonable expense incurred by the employee for necessary treatment to cure and relieve the employee from the effects of occupational disease prior to the time that the employee knew or should have known the nature

of his or her disability and its relation to employment, and as to such treatment subs. (2) and (3) shall not apply. The obligation to furnish such treatment and appliances shall continue as required to prevent further deterioration in the condition of the employee or to maintain the existing status of such condition whether or not healing is completed.

SECTION 14. 102.42 (1p) of the statutes is created to read:

102.42 **(1p)** LIABILITY FOR TREATMENT OF CERTAIN MENTAL INJURIES. The employer of an employee whose injury is a mental injury that is compensable under s. 102.17 (9) is liable for the employee's treatment of the mental injury for no more than 32 weeks after the injury is first reported.

SECTION 15. 102.44 (7) of the statutes is created to read:

102.44 **(7)** In the case of an employee whose injury is a mental injury that is compensable under s. 102.17 (9), the period of disability may not exceed 32 weeks after the injury is first reported.

SECTION 16. 102.49 (5) (b) of the statutes is amended to read:

102.49 **(5)** (b) In addition to the payment required under par. (a), in each case of injury resulting in death leaving no person dependent for support, the employer or insurer shall, except as provided in s. 102.58 (2), pay into the state treasury the amount of the death benefit otherwise payable, minus any payment made under s. 102.48 (1),. The payment under this paragraph shall, except as provided in par. (cm), be made in 5 equal annual installments, with the first installment due as of the date of death.

SECTION 17. 102.49 (5) (c) of the statutes is amended to read:

102.49 **(5)** (c) In addition to the payment required under par. (a), in each case of injury resulting in death, leaving one or more persons partially dependent for

support, the employer or insurer shall, except as provided in s. 102.58 (2), pay into the state treasury an amount which, when added to the sums paid or to be paid on account of partial dependency and under s. 102.48 (1), shall equal the death benefit payable to a person wholly dependent.

SECTION 18. 102.49 (5) (cm) of the statutes is created to read:

102.49 **(5)** (cm) The employer or insurer may make advance payments of amounts owed under par. (b) or (c), up to and including a lump sum payment of the entire amount owed. If an employer or insurer makes an advance payment, the department shall give the employer or the insurer an interest credit against its liability for payments made in excess of that required under par. (b) or (c). The credit shall be computed at 5 percent.

SECTION 19. 102.49 (5) (e) of the statutes is amended to read:

102.49 **(5)** (e) The adjustments in liability provided in ss. 102.57, 102.58 (1), and 102.60 do not apply to payments made under this section.

SECTION 20. 102.58 of the statutes is renumbered 102.58 (1) and amended to read:

102.58 **(1)** If injury is caused by the failure of the employee to use safety devices that are provided in accordance with any statute, rule, or order of the department of safety and professional services and that are adequately maintained, and the use of which is reasonably enforced by the employer, or if injury results from the employee's failure to obey any reasonable rule adopted and reasonably enforced by the employer for the safety of the employee and of which the employee has notice, the compensation and death benefit provided in this chapter shall be reduced by 15 percent, but the total reduction may not exceed $15,000.

(2) If an employee violates the employer's policy concerning employee drug or alcohol use and is injured, and if that violation is causal to the employee's injury, no compensation or death benefits shall be payable to the injured employee or a dependent of the injured employee and no payment under s. 102.49 (5) (b) or (c) shall be payable. Nothing in this ~~section~~ subsection shall reduce or eliminate an employer's liability for incidental compensation under s. 102.42 (1) to (8) or drug treatment under s. 102.425.

SECTION 21. Nonstatutory provisions.

(1) WORKER'S COMPENSATION INSURANCE; RATE APPROVAL; NOTICE. The commissioner of insurance shall submit to the legislative reference bureau for publication in the Wisconsin Administrative Register a notice of the effective date of new rates for worker's compensation insurance first approved by the commissioner after the effective date of this subsection.

SECTION 22. Initial applicability.

(1) The treatment of ss. 102.17 (9), 102.42 (1) and (1p), and 102.44 (7) first applies to injuries reported on the effective date of rate changes for worker's compensation insurance approved by the commissioner of insurance under s. 626.13 after the effective date of this subsection.

(END)

O'Malley, Jim T - DWD

From: DWD MB WC Advisory Council
Sent: Monday, December 07, 2020 3:07 PM
To: Peters, Steve M - DWD; O'Malley, Jim T - DWD; Dipko, John A - DWD
Cc: Brown, Patricia S - DWD (WC)
Subject: FW: WC Commentary

FYI: We received this comment for WCAC.

Kelly

From: Louis Busalacchi <louie@ltlserviceinc.com>
Sent: Friday, December 04, 2020 1:36 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: WC Commentary

Steven,

I would like to go on record asking the Wisconsin WC Advisory Committee to strongly consider adopting a set fee schedule for health care providers to use when treating work-related injuries. Specifically, it is important health care providers do not charge higher than normal fees for their services when examining or treating people seeking workers compensation coverage.

Our goal is to make sure employees are safe at all times while performing their duties. If an accident occurs, health care providers should not be using state WC fund as an opportunity to charge higher rates to treat patients. Rates charged for services should mirror a fee schedule adopted and agreed to by all parties involved – health care providers, employers, insurance companies and government officials. If parties cannot agree on what fair treatment cost should be, can we at least adopt a fee schedule similar to private sector coverages currently in place?

Thank you for taking time to consider my position.

Regards,
Louie

Louie Busalacchi
President
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LTL Service INC.

Kretz Lumber Co., Inc.

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12/8/2020

Steven Peters, Chair
Worker's Compensation Advisory Council
P.O. Box 7901
Madison, WI 53707-7901

Dear Administrator Peters:

As a Wisconsin citizen and employer, I continue to be concerned by our state's lack of meaningful control over the cost of medical treatment for work injuries. The most recent data from the Worker's Compensation Research Institute shows that Wisconsin still has the highest reimbursement rates for professional medical services for work injuries; and growth in those costs continues to outpace the rest of the nation. This is unsustainable for Wisconsin's business environment, which has suffered enough from the Coronavirus pandemic.

I am writing to insist that the Worker's Compensation Advisory Council include a fee schedule or other meaningful cost containment measure in the upcoming agreed bill. I further call upon the State Legislature to finally pass such a measure and give Wisconsin employers the relief they need from runaway medical costs.

Sincerely,

Troy Brown

Troy Brown, President

Kretz Lumber Co. Inc

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WISCONSIN COUNCIL OF SELF-INSURERS, INC
A Worker's Compensation Voice for Employers

December 9, 2020

Lynn A. Weinberger
Department of Workforce Development
201 East Washington Avenue
Madison, WI- 53703-2866

Via E-mail Lynn.Weinberger@dwd.wisconsin.gov

Dear Lynn:

The Wisconsin Council of Self-Insurers, Inc. (WCSI) is organized and operated as a non-profit business league within the meaning of Section 501(c)(6) of the Internal Revenue Code. Voting membership is open to public and private sector, self-insured employers, and those insured employers with retained, self-insured liability of at least $250,000 per worker's compensation claim. WCSI is affiliated with the National Council of Self-Insurers, Inc. Its purposes include advocating for the worker's compensation interests of self-insured employers in the legislative and regulatory rule-making processes; providing a clearinghouse for information as to pending worker's compensation legislation, changes in statutes and regulation, and significant court and agency decisions affecting the interests of self-insured employers; providing representation for self-insured employers at hearings and conferences pertaining to the operation, administration, and substance of Wisconsin worker's compensation law; and providing educational programs designed to assist self-insured employers in improving their loss experience within the Wisconsin worker's compensation system.

We have polled our membership for ideas and concerns to be addressed by the Advisory Council in negotiating the next Agreed Bill. The list we derived in our polling is set forth below. The WCSI has not developed an official, organization-wide position on any of the issues or suggestions identified below; our purpose at this point is to communicate the ideas and concerns of our members to those involved in the process.

Telephone (262) 522-0660
Facsimile (262) 522-0654
Web Site: wicouncilselfinsurers.com

N14W23833 Stone Ridge Drive
Suite 444
Waukesha, Wisconsin 53188

Our list:

(1) Medical Cost Control/Fee Schedule – Wisconsin is an outlier, nationally speaking, as far as the rates paid for medical treatment in worker's compensation claims is concerned. Rates paid in Wisconsin worker's compensation claims greatly exceed the rates paid for identical medical services by non-industrial health insurance or governmental benefit programs such as Medicaid or Medicare. The significantly higher rates paid by Wisconsin employers in worker's compensation cases give health care providers an incentive to characterize non-industrial conditions as being work-related. Many of our members have expressed the belief that a medical fee schedule is necessary to bring medical costs under control in Wisconsin worker's compensation claims.

(2) Anti-PPD-Stacking Measure – The Labor and Industry Review Commission and courts have held that the minimum awards set forth in Wis. Admin. Code § DWD 80.32 can be "stacked" for each surgical procedure necessitated by the same injury. *DaimlerChrysler v. LIRC*, 2007 WI 40, 300 Wis.2d 133, 729 N.W.2d 212 (2007). This leads to absurd results, which frequently contradict the uncontroverted medical opinions of treating and examining physicians as far as the assessment of permanent partial disability is concerned. For example, where an employee has undertaken two total left knee arthroplasties, the second with good results, leaving the employee with a fully functional left leg, he is nevertheless awarded 100% disability at the left knee (50% per procedure), as if his left leg has been amputated at the knee. This is true even if he is assessed as having a total of just 50% permanency by treating and examining physicians. Permanent disability in Wisconsin should be based upon function as assessed by qualified medical experts, and not upon an unfortunate interpretation of the Administrative Code, and many of our members feel that "stacking" should not be permitted.

(3) Eliminate Wage Expansion for Part-Time Workers – Primary compensation benefits should be paid based upon the injured employee's actual wage at the time of injury, whether the employee was working full time or part-time. Wisconsin's practice of expanding the wage of injured part-time employees to that of full-time employees in calculating average weekly wage is based upon an unfounded assumption that the employee is working part-time because he or she is unable to find full time work; in reality, for many varied personal reasons, Wisconsin employees routinely seek out and accept part-time employment, particularly in our emerging service-oriented economy. When part-time wage is expanded to the equivalent of full-time wage in calculating average weekly wage, injured employees are not infrequently paid non-taxable temporary total disability benefits at a rate in excess of the taxable part-time wages they were being paid when injured. This serves as a disincentive to a prompt return to work. The only case in which wage expansion is appropriate is one in which the part-time employee is employed elsewhere at the time of injury, and unable to perform his or her other employment because of the work injury.

(4) Revision of Vocational Retraining Law – Wisconsin's vocational retraining law must be simplified and revised to reflect good vocational science. In the past, an injured employee would consult with a qualified professional counselor in the Division of Vocational Rehabilitation (DVR), who based upon the employee's residual work capabilities, vocational attributes and interests, would develop a rehabilitation plan for that employee. DVR policy required that before the employee was placed into a retraining program, the counselor was required to attempt to place the employee into work with his or

her employer of injury, and failing such placement, into suitable employment in the general labor market. If placement could not be thus achieved, then the counselor was required to find a suitable retraining program which would restore the employee's earning capacity most efficiently, i.e., return the employee to the general labor market as soon as possible, to minimize wage loss. In the aftermath of *Massachusetts Bonding & Ins. Co. v. Industrial Commission*, 275 Wis. 2d 505, 512 (1957), this DVR-mandated, sound approach to retraining was felt (in part) to justify a presumption for worker's compensation purposes in favor of the retraining program developed by the counselor for the injured employee, and the employee's presumed entitlement to maintenance benefits and incidental expense for the duration of the program could be rebutted only with a showing that DVR policy had been violated. Since then, the DVR has adopted a "consumer choice" decision-making process, in which the professional input of the counselor is minimized, and the injured worker decides what he or she is going to do. As things stand, there is no reason that any deference should be given in the worker's compensation system to a "consumer-choice" driven DVR retraining program, such that any presumption favoring that program should exist. The current presumption that 80 weeks of maintenance benefits are required to complete a two-year retraining program is erroneous, as institutions of higher learning usually operate with two, 15-week semesters per year, meaning that if a two-year presumption exists, it should consist of 60 and not 80 weeks. Retraining provisions added to the Act in the past because of then-existing funding shortfalls in the Division of Vocational Rehabilitation ("the order of selection process") are extraordinarily complicated, inconsistent with other provisions, and should be eliminated.

(5) Permanent, Total Disability Age-Out Measure – Wisconsin currently awards permanent, total disability benefits for life. Wisconsin is a wage loss state. Permanent, total disability benefits should end when the injured employee reaches 65 years of age, the usual retirement date, at which point he or she would no longer be expected to earn wages, regardless of injury.

(6) Limit WC Compensability to Cases Where Work Exposure is the *Predominant* Cause – Attorneys representing injured employees in Wisconsin are currently telling treating physicians they have asked to complete reports for their clients' worker's compensation claims that work exposure need contribute but 5% to the overall cause of a condition to make that condition compensable. Many of our members feel that for a condition to be compensable, work exposure should be the *predominant* (51% or more) cause of the condition.

(7) Compel Re-Examination of Presumptive Ratings for Permanency Under the Administrative Code – members feel that the presumptive permanency ratings set forth in the Administrative Code are not consistent with good medical science and urge that they be re-examined and revised. Presumptive ratings should not preempt hands-on assessments by qualified medical experts.

(8) Retain "Extraordinary Stress" Legal Standard for *All* Non-Traumatic Mental Stress Claims, *Including* Those of First Responder and Protective Service Employees – For policy reasons laid out by the court in *School District No. 1 v. DILHR*, 62 Wis. 2d 370, 377-78 (1974), a finding that an employee has been exposed to extraordinary stress as compared with other employees in the same or similar occupation or profession should be required before worker's compensation benefits are paid for non-traumatic mental stress, regardless of occupation or profession. The contributions of all employees are appreciated,

including those of first responders and other protective service employees, but there is no reason that employees within those categories of employment should be treated differently from all others.

(9) Group Self-Insurance – Several of our members are interested in legislation permitting group self-insurance for worker's compensation in Wisconsin. Group self-insurance allows businesses of related industries to join together selectively to self-insure their worker's compensation liability as a group. Members of a self-insured group seek greater control and improved efficiencies managing their worker's compensation costs. A Board of Trustees conducts oversight of the program. The expectation is that through limiting membership to employers with a strong culture of safety and commitment to loss control, the group will enjoy better loss experience and lower rates than the industry as a whole. Prospective members undergo a thorough underwriting process before an offer of membership is extended. Agency regulation is required, as it is with individual self-insured employers. Excess and aggregate insurance coverage may be provided by an insurance carrier.

We ask that the Advisory Council consider these ideas and concerns as the process of negotiating the Agreed Bill begins. Thank you.

WISCONSIN COUNCIL OF SELF-INSURERS, INC.

Ronald S. Aplin
Acting Executive Director

Healthe SYSTEMS

Transforming healthcare.

December 14, 2020

Steve Peters, Administrator
Worker's Compensation Advisory Council
P.O. Box 7901
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WCAdvisoryCouncil@dwd.wisconsin.gov

RE: Statute and Rule Change Input | Worker's Compensation Act

Dear Mr. Peters,

Healthesystems is a pharmacy and ancillary medical benefits manager supporting large national carriers, regional insurers, self-insureds, and third-party administrators in the state of Wisconsin. We want to thank you for the opportunity to provide input on possible statute and rule changes to the Wisconsin Worker's Compensation Act. Our comments will center around the ongoing challenges associated with opioid prescribing and management, physician dispensing, compounds and co-packaged drug kits and an update to drug pricing data sources by reference.

Opioid Prescribing and Management

Inappropriate opioid utilization is a leading indicator of prolonged disability duration and delayed recovery. We note that Wisconsin's Medical Examining Board published Opioid Prescribing Guidelines in April 2018; however, these are not contained within the agency rules and are non-binding on workers' compensation claims.[1] Implementing these same recommendations which relate to opioid supply limits and morphine equivalent thresholds at 50 MED would be a step in the right direction for injured workers in Wisconsin. With these kinds of policies in place, already vetted and accepted by the Medical Board, we could see significant reductions in opioid overutilization and improvement in overall patient outcomes and return to work.

Physician Dispensing

For many years, the Workers' Compensation Advisory Council (WCAC) has debated the need to place some controls on physician dispensed drugs. We acknowledge physician dispensing is convenient for the injured worker, yet there are many more benefits to the injured worker in obtaining medications through a pharmacy. A number of states have placed limits on the days' supply or post-accident timeframes for physicians to receive reimbursement for dispensed medications in order to overcome excessive markups on physician dispensed medications compared with identical medications dispensed in a retail pharmacy setting. Physician dispensing may make sense in very specific situations such as when a patient lives in a rural area or there is an emergency that cannot be otherwise fulfilled in time to treat the patient; however, these are the exceptions rather than the rule. With more than 1300 pharmacies in the state, injured workers have no shortage of places to get their medications. For these reasons, we would like to propose the following policies:

[1] https://dsps.wi.gov/Documents/BoardCouncils/MED/20180321MEBGuidelinesv8.pdf accessed December 10, 2020

1. Require prior authorization for physician dispensed medication in an outpatient setting.
2. Permit physician dispensing only during the initial visit within 10 days following a work injury.
3. Limit the days' supply for any physician dispensed medication to 7 days which allows the patient ample time to visit a retail pharmacy.

Many states such as Arizona, Colorado, Oklahoma, Tennessee and Texas have adopted these policies to help improve patient care and reduce costs.

Repackaged Drugs

Physician dispensing of repackaged medications has been an industry concern for many years. Trade publications and industry groups have reported extensively on these often-inflated costs which are associated with repackaged pharmaceuticals. Repackaged drugs are often subject to a significant mark-up from the original labelers' and therefore, most states have adopted some legislation, regulation or guidance to help stamp out abusive billing and reimbursement of repackaged drugs. We would like to recommend that WCAC adopt a policy that will help to clarify and explicitly state how repackaged drugs should be reimbursed. This change could help serve the payer and provider communities by reducing payment disputes and administrative costs associated with resubmissions and appeals on repackaged medication bills. We would like to recommend same or similar language originally proposed in AB-711 WC Agreed Bill for 2014 that states:

"If a prescription drug dispensed for outpatient use by an injured employee is a repackaged prescription drug, the liability of the employer or insurer for the cost of the repackaged prescription drug is limited to the average wholesale price of the prescription drug set by the original manufacturer of the prescription drug. If the National Drug Code number of a repackaged drug cannot be determined from the billing statement submitted to the employer or insurer, that liability is limited to the average wholesale price of the lowest-priced therapeutic equivalent. That limitation of liability, however, does not apply to a repackaged prescription drug dispensed from a retail, mail-order, or institutional pharmacy."

Compounds

The primary concern with compounds is that they are not FDA approved and are not tested for safety or efficacy, and in workers' compensation claims, they are sometimes prescribed to patient without medical justification. These factors present risks to patients and why compounds are never recommended as a first line treatment. All private, public and government health plans including BadgerCare, specifically exclude compounded drugs from coverage where there is a commercially manufactured drug product available. It is well documented in reports from WCRI and NCCI studies on workers' compensation medical costs, that compounded products are excessively priced in comparison to their FDA-approved equivalents and are an unnecessary cost driver.

Convenience Packs and Kits

Convenience Packs and kits are another highly marked-up item which is being exploited by a lack of guidance. They are not the same as a repackaged drug which is already found in drug compendiums; however, they are similar because they begin with one or more "original" medications and are placed into a new box, called a convenience pack or a kit. They can be paired with a medical supply or a second medication. Once they are newly packaged, they are assigned a NEW NDC and a new marked-up AWP and often this new price is 200-1000% above the cost of the two items inside the box. Some physicians are prescribing medications which are packaged into these kits, for example a $120 tube of Diclofenac (NSAID) along with a $20 tube of Capsaicin (pain reliever) can be placed into a new package or box,

assigned a new NDC by the packager priced at $3,600. Sometimes, a single lower priced medication is packaged with application swabs or sterile gauze pads, with a new NDC and a high price tag. While this practice does not violate any pharmacy or medical board rules, the few individuals who are engaged in this are adding costs to our system by exploiting a loophole in the reimbursement and utilization rules.

Recommendation

For these reasons, we recommend requiring prescribers to seek preauthorization for any compounded, co-packaged or convenience pack medications. When medically necessary, they would be reimbursable at no more than the fee schedule rate which would be applicable to the individual products contained therein. Ingredients with no NDC, and supplies that are incidental to the package, such as gloves, gauze, bandages and syringes would not be integral to the medication itself and should not be separately reimbursable.

Workers' compensation agencies both across the nation and regionally have adopted similar preauthorization and reimbursement rules for these types of drugs without any reported delays or adverse impact to patient care. Healthesystems does recognize that some injured workers may have unique medical needs which might require them to use a compounded or convenience packaged kit; and with a preauthorization requirement, these injured employees will still be able to get those medically necessary drugs with the appropriate upfront authorization from the carrier.

Prescription Drug Pricing Source

Wisconsin §102.425 Prescription and nonprescription drug treatment of the Worker's Compensation Act, limits the liability cost of an employer/insurer to the Average Wholesale Price (AWP) as quoted in Red Book. While we support the use of RedBook, this language has not been updated in many years and we recommend the citation be updated to reflect the current name and publisher; Micromedex RedBook Online, published by Truven Health Analytics. We also recommend including MediSpan PriceRx, published by Wolters Kluwer as an authorized data source for AWP pricing. Because AWP data is self-reported from the manufacturer to both of these publishers, the drug prices are identical between the two sources. However, MediSpan is more widely used by pharmacies, PBMs and bill review systems for claim adjudication and clinical support. MediSpan has a proprietary generic product indicator which helps PBMs and pharmacies to standardize drugs by class, provides support for generic and therapeutic substitutions as is required in §102.425 (2)(a) and other clinical utilization management tools used by both the pharmacist and the payer. For this reason, Healthesystems recommends the inclusion of Medi-Span Drug PriceRx and RedBook Online as the official data source for AWP.

Healthesystems supports the Workers' Compensation Advisory Council's agreed-bill process and its mission to ensure a fair and balanced system which serves injured workers, employers and the stakeholders who facilitate the injured workers' treatment needs. We appreciate your consideration of our recommendations.

Sincerely,

Sandy Shtab

Sandy Shtab
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December 15, 2020

Mr. Steve Peters, Chair
Worker's Compensation Advisory Council
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Madison WI 53702

by email only: Stevem.Peters@dwd.wisconsin.gov

Dear Mr. Peters:

Please present the following proposals to the Worker's Compensation Advisory Council, at their next scheduled meeting, for their consideration in the development of their upcoming agreed bill.

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1. Due to the unprecedented failure of our Wisconsin legislature to adopt and pass multiple WCAC *Agreed Bills* over the past decade, a system should be put in place to *automatically increase benefits* that currently require active legislative involvement for routine increases. Adjusting those benefits after losing expected increases to reach what would have been their expected / usual and customary increase after the fact may have an aggregate 'leveling effect', but that is of little consequence to the actual workers who are financially injured by our legislature's failures. Specifically, the *maximum ppd rate* has been stuck at $362 since January 2017, and the sec. 102.44(1) *Supplemental Benefits* dollar index has been stuck at $669 since April 2016. Seeing that these benefits are fairly increased in the new agreed bill is only one part of the solution. The addition of a process of automatic increases for these benefits should also be programmed into the law.

The WCAC should develop a plan to have these benefits automatically increased at a fair rate.

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2. Claims to Medicare and Medicaid generally must be submitted within 12 months of the date of service. This forces many providers on contested worker's compensation claims to choose to take a huge discount on their bills that follows from submitting a claim to Medicare/Medicaid or risk not receiving any money at all.

The LIRC currently takes the policy position that, upon a litigated finding in favor of the applicant, that the workers compensation carrier gets the benefit of that substantial discount and that the carrier need only reimburse Medicare/Medicaid the amount they paid and the medical providers lose what they would have received if the case had not been contested. See, *Larry v. Harley Davidson*; http://lirc.wisconsin.gov/wcdecsns/1662.htm.

According to the Wisconsin Hospital Association, "Wisconsin's Medicaid reimbursement resulted in **$1.14 billion in unpaid costs in 2017**. These unpaid costs are shifted to Wisconsin businesses – a situation known as Wisconsin's "Hidden Health Care Tax" – which drives up health insurance premiums for everyone else."
https://www.wha.org/HealthCareTopics/M/Medicaid-(1)

Because medical costs now often carry the bulk of the 'value' of many worker's compensation cases, it is hardly unusual to see carriers on a previously conceded case, right before a scheduled surgery/expensive procedure, advise the worker and provider that they will deny payment for such care until an IME is had. And all too often, and to no one's surprise, the IME provides the carrier with its first and only defense to the proposed care. In those cases, medical care is either abandoned because of an inability to pay for it by the worker (group health often having run out because of the worker's time off work/worker' inability to afford COBRA payments) or the medical provider has to take a substantial discount from Medicare or Medicaid for that care. That discount is eventually made up through higher charges for care by the rest of the population who pay for their medical care with their own cash (deductibles and co-pays) and commercial insurance.

Whether the care is abandoned or finally had, but paid for by the government after the provider is forced to take a huge discount, finding a way to get Medicare or Medicaid to initially pay for an injured worker's care, is a great and more frequently used strategy to reduce the carrier's overall exposure, while the rest of society pays for what is later found to be the carrier's responsibility. Carriers are paid substantial premiums to pay for needed medical care of injured workers. There is no reason to allow them to shift that burden to our government, our citizens, and other businesses of this state.

The WCAC should develop a law that requires a carrier, upon a finding of liability for the medical care, to not only repay Medicare/Medicaid, but to pay the medical provider the remaining amount of any bill that has been written off as a result of accepting Medicare or Medicaid. Providing a 20% fee be paid on that repaid 'balance' amount to the successful attorney whose time, efforts, and skill produced that additional money for the medical provider would be fair while also acting as an incentive to combating this clear inequity.

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3. It is time to eliminate the bizarre interest credit found in sec 102.32(6m), that allows carriers to reduce PPD/LOEC [PPD] benefit amounts that are paid before their scheduled release. When a PPD percentage is determined, it becomes a set and fixed liability of the carrier. The PPD money should be regarded as the injured worker's money that is being *held in trust* by the carrier solely for the purpose of paying it out slowly over time to preclude the injured worker from wasting a lump sum payout due to potential financial imprudence. There is just as good an argument that the carriers should be paying some money for interest to the worker for being allowed to hold the worker's money.

The fairest solution is to just eliminate a claim to ownership or interest by either the worker or carrier. The WCAC should eliminate the interest credit found in sec 102.32(6m).

Thank you for your kind consideration.

Sincerely,

John B. Edmondson
je@ntd.net

cc (by email) James Buchen james@buchenpublicaffairs.com
Stephanie Bloomingdale sbloomingdale@wisaflcio.org

March 23rd, 2021

Dear Advisory Council,

Thank you for taking under review a concern regarding patients who present for treatment under Workers Compensation. A case which illustrates this issue involves a patient who was walking in to work on [redacted] and fell. She sought medical attention that day and filed for WC. I performed her surgery in the days that followed and submitted claims for care to [redacted] for processing. [redacted] denied compensability and declined claim processing. Ms. [redacted] disputed this determination and during this dispute asked her group health to cover her bills. We also advise workers with denied WC claims to have group health process claims since most group health plans have a 90 day timely filing clause after which they will reject submission. With legal assistance and several year's effort, the worker prevailed in the determination of WC coverage.

The issue I bring forth is the handling of her claims following the recent determination of WC coverage. Upon notification, our medical practice process has always been to refund the group health plan and submit claims to the WC carrier for processing. I will also typically call the patient back for examination in order to complete a disability exam and generate a WC-16 form for submission. In this patient's case, however, I was informed that [redacted] would not be accepting claims for processing, but rather would [redacted] would directly reimburse her group health carrier. I believe this method of settlement has three unintended consequences:

1. The group health carrier, despite being paid outside the normal claims processing path, may seek inappropriate recoupment from medical providers in the future. My practice has seen this multiple times where years following care, the insurance carrier 'reprocesses' old claims using an algorithm they have internally developed to scrub claims for any that may have been wrongly paid. They then automatically recoups funds paid. We appeal these issues and bring forth documents that explain how these matters were correctly paid, however, our experience is that payments made outside of the normal flow of an insurance carrier's claims processing require months of dispute resolution. At times we have appealed these to the Insurance Commissioner of Wisconsin, however, most workers in Wisconsin are insured by self-funded plans where the Commissioner does not have jurisdiction. The Insurance Commissioner refers us to the Department of Labor in Washington D.C. who advises the patient and us to retain legal council to pursue these matters. The cost of such representation and engagement typically exceeds the cost of the medical bills.

2. The WC carrier is financially incentivized to deny claims of work-relatedness even when the injury is most likely related to employment. There is greater work involved in the treatment of injured workers. In this individual, I met with the WC nurse assigned by [redacted], discussed return to work issues and completed work notes, and responded to inquires and additional forms that are involved in treating injured workers. The WC fee schedule is higher than commercial insurance in most instances and balances this greater work involved in the good care of injured workers. By having [redacted] directly reimburse her commercial carrier and denying processing of medical claims directly, medical providers are not compensated for the additional work and are instead asked to accept a rate negotiated for group health claims. WC carriers are thus incentivized to deny care and obtain this lower rate.

3. The potential for a greater number of initial denials and subsequent appeals creates additional legal burden for those who must review disputed claims and at the same time distracts workers/patients from the process of healing and return to work.

I appreciate your consideration of asking Worker's Compensation carriers to accept medical provider claims for processing when injuries are deemed work related whether at the time of care, or as in this case in a delayed manner.

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March 24, 2021

Steve Peters, Administrator
Division of Workers Compensation
Department of Workforce Development
Madison, WI 53701

Dear Administrator Peters,

As the Workers Compensation Advisory Committee (WCAC) begins discussions of legislation for the 2021-2022 cycle, the Professional Fire Fighters of Wisconsin (PFFW) would like the Advisory Council to consider legislation that would apply the PTSD provisions found in SB-11 and AB-17 to some of the others holding EMS certification by Wisconsin Department of Health Services.

SB-11 and AB-17 cover Law Enforcement Officers and career Fire Fighters. Many career Fire Fighters are also EMS providers so they are covered by this legislation. However, there are other holders of EMS certification that are not covered. Some of those are full time career providers that are not fire-based. In the public sector we call them "stand-alone EMS".

The PFFW is specifically seeking legislation giving stand-alone EMS the same PTSD provision in Workers Compensation that fire-based EMS is provided under SB-11 or AB-17. There are other EMS personnel not included in SB-11 and AB-17. These are volunteers, hospital based, and EMS what work for private sector employers.

I would like to request that the PFFW be given the opportunity to address the EMS-PTSD issue at the March 30th meeting of the WCAC.

Thank for you your consideration.

Sincerely

Mahlon Mitchell
State President