Legislative Proposals from the Public and Legislators for WCAC Consideration in 2025-2026 2.6.25

	Statute/Rule	Topic	Proposal	Source	Date
1.	102.17 (1) (d)	Advanced Practice Registered Nurses (APRN) & Physician Assistants (PA)	Authorize advanced practice registered nurses and physician assistants to give opinions on cause and extent of disability.	Phil McQuillen, Claims Manager, Sentry Insurance	e-mail message 6/5/24
2.	102.44 (1m)	Supplemental Benefits	1.Change the law to ensure that Supplemental Benefits are increased on a regular periodic basis and to regularly include additional employees into the Supplemental Benefit program. 2. Appoint an economist to study the value of the savings resulting from decreased worker's compensation insurance premiums over the last nine (9) years.	Brad Harrell Bob Hurley John Eiden Tim Moore	Letter 6/24/24
3.	102.44 (1m)	Supplemental Benefits	Provide cost of living adjustments (COLA) each year for employees receiving compensation for permanent total disability (PTD)	Robert Hurley	e-mail message 12/4/24

4.	102.17 (1) (d)	Doctor of Audiology (Au.D.)	Authorize Doctors of Audiology to sign WKC-16-B forms for worker's compensation hearing loss cases.	Dr. Veronica Heide Au.D., President, Wisconsin Academy of Audiology & Dr. Meredy Hase, Au.D., Board Member, Wisconsin Academy of Audiology	Letter 11/15/24 & Public Hearing 12/10/24
5.	102.44 (1) (ag) & 102.59 (1)	Supplemental Benefits	Change the law to authorize employees receiving compensation for permanent total disability (PTD) from the Second Injury Fund under s. 102.59 (1), Wis. Stats., to also receive supplemental benefits under s. 102.44 (1) (ag), Wis. Stats.	Barbara Wasmund & Attorney John D. Neal Stafford, Neal and Soule, Madison, WI	Letter 12/4/24
6.	102.175 (3)	Pre-Existing Conditions	Create protection for employers and worker's compensation insurance carriers from claims by employees with pre-existing conditions. Establish a legal process for hiring disclosures from employees to protect employers.	Stefan Benson	e-mail message 12/5/2024

7.	1. 102.13 (1)	1.Independent Medical Exams (IME)	1. *All IME examinations must be performed by doctors licensed in Wisconsin. * All doctors who perform IME examinations must practice at least 50% of their time in Wisconsin. *Prohibit file review IME evaluations or limit benefit denials. *Prohibit IME examinations for first 90 days following injury date. *Prohibit IME examinations more than 90 days after injured employee is released from care. *Authorize an employee's friend, family member or attorney to be present during IME examinations. *Limit charges for IME examinations and file reviews to $1,500. *Do not allow retroactive directives after IME examinations. *Benefit denials should only be allowed from the IME examination date going forward. *When the examining doctor's opinion denies benefit eligibility there should be a way for the employee to contest the opinion such as the State appointing a doctor under s. 102.13 (3), Wis. Stats. * When two (2) or more doctors have the same opinion, the preponderance of evidence controls over another doctor with a different opinion.	Dr. Kelly Von-Schilling Worth, Spine and Joint Institute	Public Hearing 12/10/24 & e-mail messages 1/4/25 & 1/8/25
	2. 102.44 (4m) & DWD 80.32	2. Minimum Permanent Partial Disability (PPD) Ratings	2. The updates to the minimum permanent partial disability (PPD) ratings developed by the Health Care Provider Advisory Committee (HCPAC) should be approved by the WCAC.		
	3. 102.42 (2)	3. Choice of Treating Practitioner	3.*Injured employees must be allowed to have the choice to select their own treating practitioner. Authorize letters of protection to be issued to providers. * Employees cannot be fired for preserving their right to see their own doctor. If this occurs the DWD or State appoints legal counsel for the employee, notice is issued to the employer, an investigation is conducted, employers are fined $10,000 for violations, and attorney fees will be paid by the employer.		

7.	3. 102.42 (2)	3. Choice of Treating Practitioner	*Employees cannot be fired for preserving their rights to file a worker's compensation claim. If this occurs the DWD or State appoints legal counsel for the employee, notice is issued to the employer, an investigation is conducted, a bad faith claim is filed, employers are fined $10,000, and attorney fees are paid by the employer. *Nurse case managers should not be allowed to self-direct treatment for injured employees. If this occurs sanctions for fines to be imposed such as $500 per violation. *Nurse case managers should not be allowed to visit injured employees at their homes, especially when visits are unannounced. *Claims adjusters cannot be permitted to direct treatment for injured employees. If this occurs based on evidence from voice mail messages, text or written statements from injured employees following an investigation, sanctions may be imposed under bad faith for a $5,000 penalty.	Dr. Kelly Von-Schilling Worth, Spine and Joint Institute	Public Hearing 12/10/24 & e-mail messages 1/4/25 & 1/8/25
	4. 102.16 (2m) & DWD 81	4. Worker's Compensation Treatment Guidelines	4. Establish worker's compensation treatment guidelines for lower extremities that the Health Care Provider Advisory Committee (HCPAC) has been working to develop.		
	5. 102.18 (1) (bp) & DWD 80.70	5. Bad Faith	5. Create a process for injured employees to dispute unreasonable denials of treatment and to have treatment resumed.		

8.	102.17 (9)	PTSD Coverage for EMS Personnel	EMS personnel should have the same worker's compensation coverage for PTSD that law enforcement and full-time firefighters received in 2021 Wis. Act 29.	Chanse Kaczmarski, Fitch-Rona EMS, Board of Directors, Wisconsin EMS	Public Hearing 12/10/24
9.	102.17 (9)	PTSD Coverage for EMS Personnel & Part-Time and Volunteer Firefighters	EMS personnel, part-time firefighters, and volunteer fire fighters should receive the same worker's compensation coverage for PTSD that full-time fire fighters were provided in 2012 Wis. Act 29.	Lt. Devan Anders, Deer-Grove EMS	Public Hearing 12/10/24
10.	102.17 (9)	PTSD Coverage for Volunteer EMT Personnel & Firefighters	Volunteer EMT personnel and volunteer fire fighters should receive the same worker's compensation coverage for PTSD as full-time fire fighters were provided in 2021 Wis. Act 29.	Ron Hampton, Chief, Cassville Volunteer Fire Department, and Board of Directors, Wisconsin State Fire Fighters Association	Public Hearing 12/10/24
11.	102.17 (9)	PTSD Coverage for EMS Personnel	All EMS personnel should receive the same worker's compensation coverage for PTSD as full-time fire fighters were provided in 2021 Wis. Act 29.	Alan De Young, Executive Director, Wisconsin Emergency Medical Services Association (WEMSA)	Public Hearing 12/10/24 e-mail message 12/11/24 & Letter 1/10/25
12.	No Current Statute or Rule	Medical Fee Schedule	Adopt a medical fee schedule to control health care costs within the worker's compensation system.	Willard T. Walker, CEO, Walker Forge, Inc.	e-mail message 12/18/24

13.	No Current Statute or Rule	Medical Fee Schedule	Decrease worker's compensation costs by lowering healthcare expenditures. A medical fee schedule could limit what providers can charge to treat injured workers.	Douglas Fearing, CEO, Fearing Audio Video Security	e-mail message 12/18/24
14.	No Current Statute or Rule	Medical Costs	Mitigate the high costs for health care and worker's compensation.	Rob Peaslee, CEO, Manitowoc Grey Iron Foundry	e-mail message 1/19/24
15.	102.17 (9)	PTSD Coverage for EMS Personnel & Other Public Safety Employees	Provide worker's compensation coverage for PTSD to emergency medical service practitioners and fire fighters regardless of their level of employment or volunteer status, dispatchers, corrections officers, medical examiners, and coroners as provided in 2021 SB-681 and 2024 SB-992.	Senator Andre Jacque, Wisconsin State Senate, District 1	Letter 1/3/25
16.	102.17 (9)	PTSD Coverage for EMS & All Firefighters	Extend worker's compensation coverage for PTSD to all emergency medical service (EMS) practitioners and firefighters, including volunteers.	Nicole Gullickson, NRP, CCEMT-P, EMS Director, Northwestern Municipal EMS, Inc.	Letter 1/6/25
17.	No Current Statute or Rule	Medical Costs	Control high costs from medical providers.	Bur Zeratsky, President, National Rivet	e-mail message 1/7/25
18.	No Current Statute or Rule	Medical Fee Schedule	Include a medical fee schedule in the Wisconsin Worker's Compensation system.	George Forish, VP, Precision Pattern Co.	e-mail message 1/7/25

19.	1. No Current Statute or Rule	1. Opioid Prescribing Guidelines	1. Limit physician dispensed opioids at the lowest effective dose to a seven (7) day supply per claim. Opioids dispensed beyond this limit should be deemed unnecessary treatment under s. 102.16 (2m), Wis. Stats.	Tiffany Grzybowski, Analyst, Advocacy and Compliance, Healthe Systems	Letter 1/9/25
	2. No Current Statute or Rule	2. Opioid Prescribing Guidelines	2. Encourage adherence to the Wisconsin Medical Board Guidelines for prescribing opioids.		
	3. No Current Statute or Rule	3. Education on Alternative Therapies	3. Educate injured workers about alternative therapies for chronic pain to supplement or replace opioids.		
	4. No Current Statute or Rule	4. Discontinuing Opioid Medications	4. Provide guidance on discontinuing opioid medications after an IME recommendation that opioids are no longer necessary.		
	5. No Current Statute or Rule	5. Physician Dispensing	5. Limit physician dispensed medications to a seven (7) day supply during the initial visit and within the first 10 days following a work-related injury; Require prior authorization for physician dispenses medications in outpatient settings.		
	6. No Current Statute or Rule	6. Limit Charges for Repackaged Drugs	6. Set Reimbursement at AWP of original manufacturer's NDC, or if unavailable, payment based on lowest priced therapeutic equivalent drug. Use language in 2014 AB-711.		
	7. No Current Statute or Rule	7. Compounded medications & Co-Packaged Drug Kits	7. Require preauthorization for compounded drugs and co-packaged kits; Limit reimbursement to rates established based on the original National Drug Code (NDC). Use language in 2014 AB-711.		
	8. No Current Statute or Rule	8. Average Wholesale price (AWP) Source	8. Amend s. 102.425 to include Medi-Span as another average wholesale price (AWP) pricing source.		
	9. No Current Statute or Rule	9. Durable Medical Equipment	9. Prohibit auto-shipping of Durable Medical Equipment (DME) related supplies and include the following language in a new section of ch. 102, "The auto-shipping of monthly DME supplies is prohibited. An affirmative request from the injured worker or prescribing provider is required."		

20.	102.17 (9)	PTSD Coverage for Volunteer Firefighters, Emergency Medical Personnel & First Responders	Extend worker's compensation coverage for PTSD to volunteer fire fighters, emergency medical personnel, and first responders as was provided to full-time fire fighters.	Chris Klahn, President, Wisconsin State Firefighters Association	e-mail message 1/9/25
21.	1. 102.44 (4m) 2. No Current Statute or Rule 3.102.44 (4M) 4. 102.16 & DWD 80.03 5. No Current Statute or Rule	1. Minimum Permanent Partial Disability (PPD) Ratings 2. End Date on Permanent Total Disability (PTD) Payments 3. Permanent Partial Disability (PPD) Ratings 4. Compromise Settlements 5. Utilization of Treatment Review Standard	1. Amend s. 102.44 (4m) (a) as follows, "~~At least once every 8 years~~ ~~t~~ The department shall review and revise those permanent partial disability ratings at the direction of the Worker's Compensation Advisory Council as necessary to reflect the advances in the science of medicine." 2. Set a limitation on the maximum number of weeks of eligibility or set a presumptive age of retirement (such as ending eligibility at "old age" Social Security) for ending compensation payments for PTD. 3. Use the American Medical Association (AMA) guidelines for permanent disability which are periodically updated, managed on a much broader scale and used by 40 states. 4. The parties that agree to a full and final compromise settlement should not be restricted by an unwritten threshold that a dispute exceeding 100 weeks is necessary to achieve approval of a full and final compromise settlement. The WCAC should act to establish language to codify a threshold in the statutes. 5. Adopt appropriate utilization of treatment standards to address outliers in the medical provider community. An example of utilization of review standards is Illinois 820 ILCS 305/8.7 that provides a workable solution.	Andrew Franken, President, Wisconsin Insurance Alliance	Letter 1/10/25

22.	No Current Statute or Rule	Medical Fee Schedule	A worker's compensation medical fee schedule should be adopted in Wisconsin.	Julie Schatz, Risk Management Consultant, Roberts & Crow, Inc.	e-mail message 1/9/25
23.	No Current Statute or Rule	Medical Fee Schedule	Establish a worker's compensation medical fee schedule.	Renae Langel, Vice President HR & Risk Management, Midwest Carriers	e-mail message 1/10/25
24.	No Current Statute or Rule	Medical Fee Schedule	Implement a worker's compensation medical fee schedule.	Rachael Lockwood, BSN, RN, Health Services & Benefits Manager, Waupaca Foundry, Inc.	e-mail message 1/10/25
25.	DWD 80.32 (2)	Minimum Permanent Partial Disability (PPD) Ratings	Amend s. DWD 80.32 (2) of the Wisconsin Administrative Code to remove the language from this subsection that allows for compensation for permanent partial disability (PPD) equivalent to amputation at the midpoint between the two (2) nearest joints where there is a functional prosthesis for upper or lower extremities.	Attorney William Sachse	e-mail message 2/6/25

From: Lake, Cathy A - DWD <CathyA.Lake@dwd.wisconsin.gov>
Sent: Monday, June 10, 2024 9:57 AM
To: Dipko, John A - DWD (WC) <john.dipko@dwd.wisconsin.gov>; O'Malley, Jim T - DWD <Jim.OMalley@dwd.wisconsin.gov>
Subject: FW: Clarification of 102.17

I responded to Phil about DWD's position. I asked him if he wanted his comments passed on to the WCAC. He would like you to make sure the WCAC knows that some carriers believe the statutory language should be expanded as to which providers can speak to causation and extent of disability. CAL

From: McQuillen Phil <Phillip.McQuillen@sentry.com>
Sent: Wednesday, June 5, 2024 9:40 AM
To: Lake, Cathy A - DWD <CathyA.Lake@dwd.wisconsin.gov>
Subject: Clarification of 102.17

Good Morning Judge Lake,

We are hoping to get the Department's current position on who can and cannot remove someone from work or give them work restrictions. Back in 2004 Judge Janell Knutson provided an opinion (see attached) regarding 102.17(1)(d), stating that PAs and APNP's are **not** authorized to impose work restrictions or remove injured employees from work while they are in the healing period. This opinion was given in close proximity to the law change, but she was very clear on the Department's position on the issue.

Quite a bit has changed since 2004. As you know, PA's and APNP's are much more on the forefront of medical care. Both are far more likely to be the primary treater for injured workers. Having an office visit with an actual MD is quite rare for the majority of injuries.

I am interested in the Department's current interpretation of the statute. Does the DWD take a different view now?

Thank you in advance for your help!

Phil McQuillen, AIC, AIC-M
Claims Manager | Workers' Compensation
715-346-9229 | 800-999-4642 FAX
phillip.mcquillen@sentry.com

Sentry Insurance
PO Box 8032
Stevens Point, WI 54481
Office: 800-473-6879

-----Original Message-----
From: Knutson, Janell [mailto:Janell.Knutson@dwd.state.wi.us]
Sent: Tuesday, May 11, 2004 12:13 PM
[redacted]
Subject: Latest Amendments to the WCA, effective 3/30/04

This is the department's official position:

Physician assistants and advance practice nurse prescribers are not competent to give opinions about whether injuries are work-related. They are also not authorized to impose work limitations/restrictions or take employees off from work.

The amendment to s. 102.17 (1) (d) effective 3/30/04 specifically provides that reports from these practitioners as well as dentists are not admissible on the cause and extent of disability. Cause of disability refers to whether it is work-related. Extent of disability refers to how much disability someone has and can be either temporary or permanent. Extent of disability covers return to work restrictions/limitations.

An insurance carrier is not required to pay disability benefits based on the opinion of a PA or an APNP. I cannot answer your question concerning whether the opinion of a PA or APNP is acceptable under the FMLA or ADA.

The change in our statute allows PA's and APNP's to be paid for providing treatment to injured workers. Some worker's compensation insurance carriers were not paying for treatment provided by PA's and APNP's because they were not listed as practitioners under the Worker's Compensation Act.

APNP's approached the Worker's Compensation Advisory Council and asked for a change in the law so they would be paid in cases where the employee suffered a compensable injury.

I hope I have adequately answered your question.

Janell M. Knutson
Administrative Law Judge
Section Chief, Madison Operations

Department of Workforce Development
Division of Worker's Compensation
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
Email: dwddwc@dwd.wisconsin.gov

STATE OF WISCONSIN
DWD
Department of Workforce Development

Tony Evers, Governor
Amy Pechacek, Secretary-designee

August 4, 2022

WC CLAIM NO: 2022-
INJURY DATE:
EMPLOYEE:
EMPLOYER:
INSURER NO:

IF YOU CALL OR WRITE US
PLEASE USE WC CLAIM NO.

We are in receipt of your hearing application, and I've reviewed the documents that you've submitted in support of your claim.

Prior to any case being scheduled for a prehearing conference or a hearing, the injured worker must file a certified report signed by a physician, chiropractor or podiatrist licensed to practice. I noted that the medial report you submitted is signed by APNP, Please be advised that § 102.17, Wis Stats., specifically provides that certified reports by physician assistants (and advanced practice nurse prescribers) are not admissible as evidence of the cause of an injury and the extent of the disability in worker's compensation claims. Therefore, you still need to file a medical report in your case.

Please have a doctor complete the enclosed practitioner's report form and return a copy to this office. Send a copy to all other parties as well. We can also accept the report from , APNP, provided it is co-signed by her supervising physician.

If we do not receive a reply to this letter, within 60 days, your application may be dismissed.

Sincerely,

Enclosed with original:
WKC-16-B

Brad Harrell, [redacted]

June 24, 2024

Governor Tony Evers
P.O. Box 7863
Madison, WI 53707

Re: Permanently and Totally Disable Workers of Wisconsin

Dear Governor Evers:

Thank you for declaring 2024 the *Year of the Worker in Wisconsin.*

We are a group of Wisconsin workers who were injured in industrial accidents who became permanently and totally disabled (PTD) because of our injuries. We seek your kind help in our quest to ensure that supplemental benefits for permanently and totally disabled workers are increased on a regular periodic basis, as well as regularly bringing in additional PTD workers into the Supplemental Benefit program. Supplemental benefits act similarly to standard cost of living increases. (Supplemental benefits are currently not available to someone who is PTD, unless their date of injury occurred prior to 2003.)

We understand that the Workers Compensation Advisory Council is the body that is primarily responsible for this type of legislation. In 2017, the Advisory Council produced an Agreed Upon Bill that created an increase for supplemental benefits and brought two more years' worth of PTD injured workers into the program. However, that bill never made it out of the legislature. Since that time, three additional Agreed Upon Bills have come out of the Advisory Council and none of them contained any increase for supplemental benefits that the Advisory Council had endorsed in 2017.

Why would that be? We conclude the issue must be money/the perceived cost to employers and their insurance carriers.

Thanks to your leadership, not only has the State of Wisconsin never been in a better fiscal position than in 2024, but the same can be said of Wisconsin employers regarding the premiums they pay for their workers compensation coverage. During the past eight years, Wisconsin workers compensation premiums have decreased, in an unprecedented fashion, for 8 consecutive years. During that time, the cumulative decrease has amounted to over a 40% reduction in premiums that employers pay for their workers compensation insurance coverage! Their savings, in Wisconsin's almost 2 billion dollar a year worker's compensation insurance industry, must have amounted to many hundreds of millions of dollars, if not a sum in excess of one billion dollars!

We have also just learned that according to the May 9th minutes of the Wisconsin Rating Committee meeting of the Wisconsin Compensation Rating Bureau, the rate recommendation for October 2024 will be for another reduction, but this one will be for the largest ever...at 10.5% decrease! That will bring a cumulative rate reduction of almost 47% over a nine year period. (See attached Circular Letter 3260, and chart.)

Governor Evers, what we beg of you is this: Would you please appoint an economist to calculate how much money Wisconsin employers have saved over the past 8 years/upcoming nine years in their workers compensation premiums due to the unprecedented decreases during those time periods (as compared to rates remaining static)?

That information will hopefully allow us to convince the management side of the Advisory Council that a regularly scheduled increase of supplemental benefits for permanently and totally disabled workers is certainly affordable by Wisconsin employers (and that apparently is only costing insurance carriers for 2023 just over 1.04 million dollars for the prior year. (See attached WC Insurance letter 542).

An economist's analysis should also produce information that your office can utilize to educate the citizens of Wisconsin, including Wisconsin employers (and the WMC), of another substantial benefit your office's leadership has provided to our state.

Thank you for your kind consideration of our request. We are sorry to burden you with our problem, but we cannot think of anyone else better who would likely care enough to help us. We know you are a strong supporter of the Advisory Council and would not wish to circumvent that process, but if there is anything else that you might be able to do to aid our cause, we would be forever and deeply grateful.

God bless you and thank you again for whatever you can do. We greatly look forward to hearing from you.

Kindest regards,

Brad Harrell
[redacted]

And on behalf of:

Bob Hurley
[redacted]

John Eiden
[redacted]

Tim Moore
[redacted]

Enclosures (see below):
Circular Letter 3260
Referenced rate reduction chart
WC Insurance Letter 542

1. Circular Letter 3260

https://www.wcrb.org/circulars/CircularLetters2024/CIRCULAR_LETTER_3260_2024_Rate_Change_Indication..pdf

CIRCULAR LETTER 3260—May 9, 2024
PROCEEDINGS OF THE WISCONSIN RATING COMMITTEE
TO: MEMBERS OF THE BUREAU

Minutes of the Wisconsin Rating Committee meeting held via teleconference from the premises of the Wisconsin Compensation Rating Bureau, 20700 Swenson Drive, Waukesha, WI 53186 on Thursday, May 9, 2024.

A Special Rating Committee meeting was called to discuss the October 1, 2024 rate filing. The following items were discussed:

- Trend factors recommended by the Actuarial Subcommittee.
- An overall decrease in rate level of 10.50%.
- No change to the current Expense Constant of $220.
- No change to the current Maximum Minimum Premium of $900.

The Governing Board and Rating Committee accepted the recommendation for filing with the Office of the Commissioner of Insurance

2. Referenced rate reduction chart

If the work comp premium a Wisconsin employer paid in 2015 was $100.00, the following shows how the aggregate rate decreases experienced over the following 9 years by businesses in Wisconsin would decrease that base premium amount. Over 9 years (including the now proposed rate for October of 2024 of a 10.5% decrease), rates will have decreased in aggregate by almost 47%!

YEAR	DECREASE	Premium Dollars Charged
2015	-(base)-	$100.00
2016	3.19%	$ 96.81
2017	8.46%	$ 88.62
2018	6.03%	$ 83.28
2019	8.84%	$ 75.92
2020	0.93%	$ 75.21
2021	5.44%	$ 71.12
2022	8.47%	$ 65.10
2023	8.39%	$ 59.63
2024	10.50%	$ 53.37

3. WC Insurance Letter 542

https://dwd.wisconsin.gov/wc/letters/insurance/ins-letter-542.htm

Insurance Letter 542
Purpose

To communicate to insurance carriers regarding the 2023 supplemental benefit reimbursement assessment rate. This includes information regarding deadlines and to remind insurance carriers that interest will accrue on all unpaid balances after 30 days. The Worker's Compensation Supplemental Benefit Reimbursement Assessment is issued annually.

The current supplemental benefit assessment is for reimbursement requests submitted to the Department in calendar year 2023 for payment on claims made in 2022. Insurance carriers were provided time to submit reimbursement requests through December 31, 2023, resulting in assessments being issued the following calendar year. This earlier, winter schedule is expected to continue going forward. For your planning purposes, the next annual WISBF assessment, covering 2023 reimbursement requests submitted through the end of calendar year 2024, will be issued by February of 2025.

Background

Under s. 102.44 (1) (c), Wis. Stats., as amended by 2015 Wis. Act 55, the Work Injury Supplemental Benefit Fund (WISBF) no longer makes reimbursement payments to insurance carriers and self-insured employers for injuries that occur on or after January 1, 2016.

Section 102.75 (1g), Wis. Stats., authorizes the Department to assess and collect costs for the reimbursement of supplemental benefits payments made on claims for injuries occurring on or before December 31, 2015.

The maximum amount the Department will assess and collect in a calendar year is $5,000,000. If the total amount reimbursable in a calendar year exceeds $5,000,000, the Department will collect the maximum payable of $5,000,000 that year and collect the excess in the next calendar year, (subject to the $5,000,000 maximum), or in subsequent calendar years until the total outstanding amount is zero.

The Department will approve and pay a claim for supplemental benefit reimbursement no later than 16 months after the end of the year in which the supplemental benefit reimbursement claim was received by the Department, subject to the $5,000,000 yearly maximum. Insurance carriers are required to file a claim for reimbursement with the Department, using the Supplemental Payments Reimbursement Request Form, WKC- 140-E, no later than 12 months after the end of the year in which the supplemental benefits were paid. This form can be found on our website.

All supplement benefit reimbursement claims that were pending as of May 14, 2013, the effective date of the reduction of reimbursement payments, and reimbursement claims received by the Department following that date are being paid in chronological order of receipt by the department, subject to the $5,000,000 yearly maximum, until the outstanding amount is zero.

The revenue funding supplemental benefit reimbursements is from annual assessments on each insurance carrier based on the same indemnity amount that is used for that insurer in the annual general assessment for the Department's operations fund. Each company's indemnity amount is determined by summing the amounts paid for each claim "first closed" in the previous calendar year. Indemnity includes payments for temporary total and partial disability, permanent total and partial disability, compromises, death benefits and funeral expenses, paid holidays, supplemental benefits, disfigurement, and vocational rehabilitation.

Each company's assessment amount is determined by multiplying its 2022 "first closed" claims total indemnity payments by the rate indicated. Each company's claim detail listing is available

by clicking "Assessment Reports" on the Administrative Assessments page. A DWD/WISCONSIN Logon Account ID and password is required to access the report.

The Worker's Compensation Supplemental Benefit Reimbursement Assessment rate is calculated by dividing the current total amount reimbursable (up to a maximum of $5,000,000) by the total indemnity payments from insurance carriers for claims "first closed" in the previous calendar year. **For 2023, the current total amount collectible is $1,043,819.98** divided by the total insurance carrier indemnity paid for 2022 "first closed" claims total of $242,704,622.00 generates a Supplemental Benefit Reimbursement Assessment rate of 0.00431, rounded up to avoid a shortfall

Action Requested

Payment of your organization's 2023 Supplemental Benefit Assessment invoice

.....

John Dipko, Chair
Wisconsin Workers Compensation Division
201 E Washington Ave
Madison, WI 53703
Phone: (608) 590-7868
john.dipko@dwd.wisconsin.gov

December 4, 2024

I am an individual that suffered an industrial accident/traumatic injury in Wisconsin on 9/17/1982; my L1 vertebrae was shattered. To date, I have had six back surgeries. I am now being **traumatized again** by this committee!

I have not received a cost-of-living adjustment (COLA) since 3/2016. *Every* member of this committee should be **ashamed** of themselves! I bet every member of this committee has had a regular COLA. The cost of living has risen 31.5% since 2016 – it's beyond brutal for those of us who have had **no increases** in our income in *over* **eight years!**

I am requesting that this board does its job and *protect*, not harm Wisconsin PTD workers. This board needs to immediately and unanimously vote a COLA for us. I also demand that we receive a COLA every year as TTD individuals do.

I understand you just became the chair of the WCAC; I hope you will look into this matter and rectify this. I will be writing to every member on this board, every person in the legislature and the governor. If this does not receive immediate attention, I will then contact every major news station across Wisconsin. This injustice has gone on far too long! I will be awaiting a direct response from you to the questions listed below.

1. What is your justification for not voting a COLA to PTD individuals?
2. How much in total does the supplemental benefit program cost Wisconsin? (I have been led to believe it only costs $1 Million per year)
3. How many PTD workers in Wisconsin receive supplemental benefits?
4. How can Employers/Management afford to give a COLA to individuals receiving supplemental benefits? (I will answer this this for you.) Via the $1 Billion dollars plus saved in the past 9 years of unprecedented Work Comp premium rate reductions. (Rates set by the state reflecting the cost to employers to pay the benefits required under WI law have consistently and substantially fallen during that 9-year period.)

Sincerely,

Robert G. Hurley

[redacted]

WISCONSIN ACADEMY OF AUDIOLOGY

To: Wisconsin Workers Compensation Division, John Dipko, Administrator and the Wisconsin Workers Compensation Advisory Council (WCAC)
From: Wisconsin Academy of Audiology (WAA)
Date: November 15, 2024
Re: Request to change Wisconsin Workers Compensation rules for approved signers on the Workers Compensation WKC-16-B form to include audiologists.

The Wisconsin Academy of Audiology asks that the Worker's Compensation Advisory Council authorize audiologists, Doctors of Audiology (Au.D), be allowed to sign WKC-16-B forms based upon their education, training, and professional experience. The Administrative Code DWD 80.25 Loss of hearing currently defines (c) "Licensed to practice in the same health care profession" as licensed to practice as a physician, psychologist, chiropractor, podiatrist or dentist." These, including audiologists, are all doctoring professions. We ask that audiologists be added to this listing.

We understand that it is a challenge to find physicians (MDs, including ENTs) to evaluate a claim for occupational deafness. Please know that often the examination that accompanies a report is obtained by a Doctor of Audiology (Au.D). It is not unusual for physicians to defer to the Doctor of Audiology's opinion.

Kindly add us to the agenda of the Workers Compensation Advisory Council Public Hearing on December 10. If the rules are changed to allow audiologists, Doctors of Audiology, to sign WKC-16-B forms, there will be an expanded statewide choice of providers for both Respondents and Applicants. This change provides Respondents and Applicants a greater choice of experts, be they MDs, or Au.Ds.

Respectfully.
Dr. Veronica Heide, President
Dr. Meredy Hase, Board Member
Doctors of Audiology

Attachment: Position Statement

STAFFORD, NEAL & SOULE, S.C.

Attorneys At Law
5930 Seminole Centre Court, Suite H
Madison, WI 53711
Phone: (608) 251-6045
Facsimile: (608) 251-6688
www.staffordneal.com

John D. Neal
Charles M. Soule

Practice Limited To
Worker's Compensation

December 4, 2024

John A. Dipko, Administrator
Wisconsin Worker's Compensation Division
201 East Washington Avenue
Madison, WI 53702

Dear Mr. Dipko:

Please consider the attached as a "public proposal" for consideration by the Worker's Compensation Advisory Council. You may wish to confirm with Jim O'Malley that Barbara Wasmund remains the only permanently and totally disabled person injured in the state of Wisconsin before January 1, 2003 who has not been given this benefit. Enclosed is a letter in support of this request by Barbara Wasmund. Thank you for giving this your consideration.

Very truly yours,

John D. Neal

JDN:so

Encs.

cc: Barbara Wasmund

Proposed Change to Section 102.59(1)

Add the following language at the end of the existing subsection of the statute:

> An employee receiving permanent total disability benefits pursuant to this statute shall also be eligible to receive supplemental benefits as provided in s. 102.44(1).

Explanation

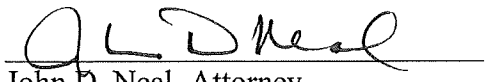
In extremely rare cases, an injured worker may be found eligible for permanent total disability benefits under s. 102.59(1) where they satisfy the statutory requirements, that is, that the work injury ("primary injury") results in "scheduled" permanent partial disability exceeding 200 weeks, and where, when considered with established pre-existing conditions, the employee is in fact permanently and total disabled as a combined result of both.

It is believed that at this time, only one individual in the State of Wisconsin is receiving such benefits. Her name is Barbara J. Wasmund. Her injury occurred on March 18, 1995. Her weekly wage at that time was $240 a week. Her claim number is: 1995-020271.

In July of 2006, the Fund conceded that based on all available evidence, Barbara Wasmund became entitled to receive permanent total disability benefits under s. 102.59(1) from the Fund commencing on August 2, 2005. As a result she has received $160 a week to the present.

It is respectfully suggested that the policy behind s. 102.44, that is, that there should be some cost-of-living help for individuals who are permanently and totally disabled because of a work injury, should apply equally to those receiving benefits from the employer or the worker's compensation insurance carrier as well as an individual like Barbara Wasmund, who receives the same benefit but from the Fund under s. 102.59(1).

Respectfully submitted,

By: 

John D. Neal, Attorney

Attachments

April 2, 2023

Steve Peters, Administrator
West Virginia Compensation Division

Dear Mr. Peters,

I had a severe right leg injury at work 28 years ago. Because of that, on top of earlier spinal and other issues, I've not been able to work. After a few years I stopped getting benefits from the insurance company for my leg injury and I began to receive benefits from the State of West Virginia. When I was injured in 1995, I was earning $6.00 per hour, so my wage was set at $240.00 per week. My weekly check was set at $160.00 per week. This is what I receive.

I am told other people who because of work injuries can no longer work have been given a Cost of living increase over the years, but because of the wording of some law I am not eligible for any increase. I was told you are in charge of the committee that has the power to include me in the group that gets some cost of living help from time to time. I am sincerely asking for your help in adding me to that group. I am grateful and appreciate getting my monthly check for $693 but it doesn't go very far these days.

Thank you kindly for any help you or your Committee can give me.

Barbara Hammond

[redacted]

From: Stefan Benson <sbenson@benson-ace.com>
Sent: Thursday, December 5, 2024 12:27 PM
To: wcwadvisorycouncil@dwd.wisconsin.gov <wcwadvisorycouncil@dwd.wisconsin.gov>
Subject: Workers comp insurance law comments.

My name is Stefan Benson. My family and I own two hardware stores in northwest Wisconsin. My comment/concern for the council review is in regards to the protection of the employer and workers comp insurer from claims from employees with pre-existing conditions. For example, an employee that has had a history of back or knee issues takes a new job and claims to have injured themselves at work so they can get their surgery paid for by the employer/insurer. In our case in particular we had a lady employed with us that had been having knee issues. She had been with us a while and discussed how her knees were bad and she was going to need surgery soon. One day she claimed to have twisted her knee in the office. We filled out an accident report. Next thing you know she is going to be getting that surgery she has been needing. Only now the workers comp insurer is picking up the tab and the employers insurance rates go way up. We notified the insurer and even sent them emails from the employee's physician stating to the fact that she had preexisting conditions. The insurer claimed it was better to pay the $60,000 claim than to fight it. So, insurance company gets screwed, employer gets screwed, and employee gets the surgery they need and then move on to another employer and start the process all over for another ailment.

My point is what protection system can be legally put in place to protect employers and insurance companies from fraudulent claims from employees with pre-existing conditions. Or is there a legal process in place for hiring disclosures that employers like myself should be using to protect from this happening.

Thanks for addressing this at your meeting.
Stefan Benson

Worker's Compensation Feedback Form (WKC-19603-E)

1/4/2025 10:47:44 AM

Worker's Compensation Feedback Form

Customer Feedback - Provide as much information about your claim or case as you would like to help us improve. :

Hello and thank you for reviewing my submission. Where this feedback box appears to be directly related to "customers" or injured worker's, I am a provider in Wisconsin who works mainly with work injured patients and have for 15 years and I am a voice for the people, specifically, the injured worker's of Wisconsin. I have worked in the worker's compensation field for over 35 years total in 3 different states. I have seen a lot of abuse on both sides of the fence, but in this State specifically, mainly on the side of the insurance/ employer side. Please let me continue... I recently appeared before the WCAC on 12/10/2024 with some of those challenges that we face as providers as well as the employee faces. I only scratched the surface. But I will be submitting detailed submission of those proposed changes as well as many others, where I feel something needs to be done. There is more abuse than your board members want to believe, that is going on, and I hate to say, it is abuse that goes beyond violations of the current laws and statutes even with worker's compensation here in Wisconsin. I have treated work injured patients for over 15 years just here in this State and I can say with boldness, that something must be done to stop the insurance companies and employers from their misdeeds and abuse to the employees or the very injured workers who make up our great State. The worker's who are supposed to be protected but are not and more often than you may realize, the insurance company and employer, deny benefits/claims for the injured worker based on most often, false information and lies. I have seen this happen over and over, where the injured worker comes to us for a second opinion, ie, and get fired for changing doctors...or their benefits are threatened because they switched providers from [redacted], the almighty company doctor, or [redacted]. "If they switch doctor's, they cannot guarantee that their TTD benefits will continue" or, "We did not authorize you to switch doctors...I am afraid we will have to discontinue your benefits" or the NCM shows up at their door "unannounced" and asks to come in. The patient allows to come in because it is an official person who works for the insurance company. She pulls out of her purse, a list of other facilities that they can guarantee payment, but you are going to a doctor "who has not been authorized as part of our network" or they go even as far as, "They are not licensed and certified to do workers compensation!" The list is endless and this goes on every day. Just this past 2 weeks, I have had "3" patient's come to me telling me that they were fired or let go. Two patients gave me their affidavits in writing that I will be submitting to the WCAC board members, the third who accepted the task of sitting down and giving us her testimony, ended up going "missing"! It appears I am out of time. I urge you to take these matters more serious and do something about this. More later! Thank you, Dr. Kelly

E-Mail (optional): [redacted]

To exit and delete this form without submitting it, click the back button on your browser.

From: Dr. Kelly Von-Schilling Worth <dr.kelly@injuryrehabcenters.com>
Sent: Wednesday, January 8, 2025 8:24 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>; Dipko, John A - DWD (WC) <john.dipko@dwd.wisconsin.gov>
Cc: Brown, Patricia S - DWD (WC) <PatriciaS.Brown@dwd.wisconsin.gov>; McCormick, Kelly M - DWD <KellyM.McCormick@dwd.wisconsin.gov>; Salvi, Frank J - DWD <Frank.Salvi@dwd.wisconsin.gov>
Subject: UPDATED 12/10/2024 WRITTEN COMMENTS SUBMISSION

Hello all and a very Happy New Year to everyone,

To the WCAC, especially John Dipko, this is Dr. Kelly. It was a pleasure meeting with all of you at the December 10, 2024, meeting in Madison. It was an interesting evening for sure.

As promised, I wanted to get my written comments in and the changes that I feel need to be addressed as soon as possible for the Worker's Compensation Act. I have attached Kelly McCormick, Frank Salvi and Patricia from the HealthCare Provider Advisory Committee that they may receive a copy of what I am turning in as these have been changes needed that I have wanted to submit to the HCPAC for a while to start working on but have not had the time. I am hoping that we can begin the process of looking at these few statutes and more formally work on submission, however, I wanted the WCAC to get a true firsthand feel of what is really going on in the arena of Worker's Compensation out there and get these proposed changes that perhaps you can get things done much faster and start thinking about the employees and providers more than the insurance companies and employers and make some of these changes immediately.

Enclosed or attached, you will find my 11-page document under LEGAL FORM SUBMISSION - WCAC that goes over mainly section 102.13 or the IME process and proposed changes. I further then discuss a few other sections, but that would be my main submission for the proposed change that needs to be addressed as soon as possible.

I have further attached affidavits of 4 patients that are actively treating in my office along with their first report of injury, so you have their information and injury report and injuries in detail. Also, just in case you wanted to reach out to them. All 4 got fired from their jobs for filing an injury claim. I attached their story in written and typed form because some of them are in Spanish. My legal historian assisted them with the type of written portion. I assure you these are real stories and not made up and I have hundreds more of the abuse that goes on of all different types through our workers' compensation system. I felt that 4 focused just on the firing would be perhaps enough to get all of your attention, especially those of you who represent the insurance and employer side of things, how abusive things truly are out there. I would have had 5 but the last girl got scared and not only did not give us her testimony but stopped coming in for care. She was fired, yet her job, "old job" called her and told her they would turn her into immigration if she pursued this further. She is Hispanic!

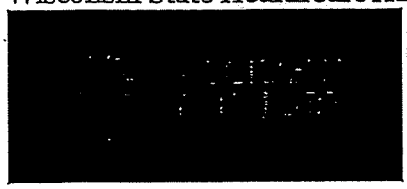
Now I can assure you, if you call the employer and try and discuss this with them, they will lie and say that the patient was insubordinate, or they went over their point system, or they came in late, etc, they will lie to your face. I have been doing this for 35 years and in this state for 15 so please trust me, when I tell you, that they cover it up, but this is exactly why they were fired and no other reason. [redacted], NEVER had a work injury, and after a decade or two working for his company, gets fired. This goes on...ALL the time!!! You don't see it because you are all in Madison in your ivory towers as they say, not truly seeing the reality of what is happening out there. [redacted], please read his details of

I have many, MANY more solutions to some of the challenges we face with the Worker's Compensation system here in Wisconsin that would benefit the State, the providers, the insurance companies, and most importantly, the employees. But I do feel that this is enough to start with and we can go from here and see how far this goes because this took a lot of time. I hope it was not wasted time and done in vain.

I thank all of you for your tender ear and hearts and really do hope that I was able to touch someone's heart here that we can do something about some of these things.

In much Respect,

Dr. Kelly Von-Schilling Worth, DC, DACAN, FIACN, FAFICC, DABCI, DABDA
Diplomate American Chiropractic Academy of Neurology
Board Certified Chiropractic Neurologist
Fellow of the International Academy of Chiropractic Neurology
Fellow of the American Forensic Industrial Chiropractic Consultants
Diplomate American Board of Chiropractic Internist
Board Certified Chiropractic Internist
Diplomate American Board of Disability Analyst
Board Certified Traditional Naturopathic Physician
Wisconsin State HealthCare Advisory Committee for Worker's Compensation



2500 W Lincoln Ave.
South Milwaukee, WI 53215
+1 (414) 643-9000
injuryrehabcenters.com
spineandjointinstitute.com

Spine and Joint Institute of Milwaukee, Inc

Wisconsin State, Board Member Review Committee of SJIM Appeals
Official Process of Review and Compliance
Medical Necessity of Treatment - URAC COMPLIANCE
2500 West Lincoln Ave.
Milwaukee, WI 53215
(414) 643-9000 ph
(414) 643-9004 fax

DATE: 12/31/2024

TO: DWD – Worker's Compensation Division
Worker's Compensation Advisory Council
201 East Washington Ave.
[redacted]
Madison, WI 53703
[redacted]

TO: Mr. John Dipko - Administrative Chairman and Committee Members

FROM: SPINE and JOINT INSTITUTE of MILWAUKEE, Inc
Clinic Director - Dr. Kelly Von-Schilling Worth
HealthCare Advisory Council Committee Member w/ DWD

RE: PROPOSED W/C LEGISLATIVE CHANGES and FOLLOW-UP to TESTIMONY and VERBAL SUBMISSION on 12/10/2024.

FORMAL SUBMISSION of PROPOSED WORKER'S COMPENSATION MATTERS RELATING TO CURRENT LAWS and STATUTES THAT NEED REFINING.

PROPOSED DISCUSSIONS for CHANGE ARE the FOLLOWING:

DWD – 102.13 EXAMINATION or the IME PROCESS – For the most part, most insurance companies adhere to the law and obtain an IME from a resourceful provider that lives and practices within the community and knows the laws of worker's compensation for Wisconsin and further, who provides a very thorough medical report as to the summation of the history of the events that have transpired with the patient, the history of care received up to that point and finally, their physical examination findings and conclusions. The problem is, that there are some insurance companies that do not follow this pattern and skirt the law and play in the grey areas where there are no laws or statutes. THIS is where we need clarity given and placed into the statutes as a subsection under perhaps section 102.13. Here are the items of concern that should be refined under this statue and discussed more thoroughly.

A) **ALL IME's MUST BE LICENSED IN THIS STATE** – All too often, there will be IME's performed by a doctor who does not practice here or that is even licensed in this State. I propose that any/all IME's performed in physical form should be done by a licensed Wisconsin Doctor.

B) **ALL IME's MUST PRACTICE at least 50% OR MORE IN WISCONSIN** – As well, there will be IME doctors who may be "licensed" within Wisconsin but fly in from a different State and will perform IME's literally in the same building as the insurance company who has hired them to perform these IME's, or they rent space in a Hotel for a day. With some insurance companies, they will rent out the suite in the same building *for them* to conveniently perform the IME's on their patient's, the doctor flies in for the day, performs 15-20 of them in 1-2 days and then flies right back out. This would be the [redacted] as well as other IME's that are very well known in the community of IME's. The report is always the same, "All the patient's symptoms are a result of the patient's arthritis!" I propose we put a stop to this and place in law, that IME's MUST BE LICENSED AND PRACTICE AT LEAST 50% OR MORE OF THEIR TIME IN WISCONSIN, for them to provide an IME exam and report and opinion and reap the rewards of the IME benefits here in WI..

C) **ABSOLUTELY NO "FILE-REVIEW IMR's!"** – Most insurance companies are now turning the page to more and more "FILE REVIEWS!" These file reviews are done quicker, easier and cheaper than an IME. The problem is this, benefits are being taken away from the patient for the insurance company to stop the bleeding. In other words, they get to the threshold of their exposure on the claim, whatever that may be, and they send out for the review and the IMR doctor always says the same thing which 99% of the time, goes against the patient, without even seeing the patient. They judge the patient and their condition by the file and not an exam as it stimulates is their right, under DWD – 102.13. Nothing under worker's compensation law states that they can or cannot do this. We need to have this written up under the law that states that they are not allowed to utilize these at all. If that is not possible, then perhaps LIMIT the exposure to the patient. In other words, the IMR can be performed, but they cannot utilize ANY of the information to make sound judgment calls on benefits being cut off from the patient, from the providers, or other. This is happening more and more; these file reviews and we ask that the board step up and do something about these as they are getting out of hand. As far as benefits are concerned, the IME is the only thing that should be allowed, in person.

D) **NO IME EXAMINATIONS for the FIRST 90 DAYS FROM INJURY DATE** – I brought this up in my 12/10/2024 council meeting where I testified of a case under my friend's company [redacted] where his employee fractured the tip of his index finger with a hammer he accidently slammed against his finger. He immediately came to me with his employee. For the first 4-6 weeks, the patient was in a finger cast to where we could do nothing but allow him to heal. He then, after 6 weeks, was seen by our hand specialist [redacted] who sees all our hand and wrist patients. He had mentioned that the injury was beyond his index finger and would need surgery to correct the two hooks at the base of the first and second finger or the index and middle finger. As soon as we sent this to the insurance company, they sent his records out to a doctor who *did not examine* the patient. He was in his third or fourth week of therapy at that time with our Doctor of Physical Therapy who was applying occupational therapy. The patient also injured the ligaments and tendons of the tuft at the DIP and had secondary collapse of the finger giving him a partial "Mallot" finger that eventually turned into a slight "Swan-Neck" deformity with the entire finger due to the index tip exposure and damage. The IMR stated that the patient merely "bruised" his finger, and he was healed "7-14 days" after the injury and did not need any further treatment and has no PPD rating! After this report from the IMR doctor, ALL OUR TREATMENT WAS DENIED even though the treatment was still within

the first 90 days of care, and our treatment followed precisely the laws and statutes for worker's compensation according to the Worker's Compensation Act. Further, they denied benefits for the patient, and asked for the benefits that they did pay back. The patient came to us very upset, but we reassured him on what to do. But not only was this another example of an abusive IMR, as we discussed previously that needs to stop, they did the review within the first 60 days. IME's should not be allowed within the first 90 days to give the doctor a chance to correct the problem or injury and need most often, every bit of that time, to assist the patient.

This is just one of many examples where the insurance company gets the IMR's and makes BIG decisions that reflect on not only the providers and clinical outcomes, but the patient and their benefits. The two main benefits that are cut off immediately are, TTD benefits, if they are still off work due to a more serious injury...or, their medical benefits. Most clinics will stop all care, we do not and are able to continue helping the patient and providing the care that they need because we understand the worker's compensation system and how to get around that with the appropriate filings and assisting the patient either at the level where they represent themselves or referring them to an attorney. But so often, they are with other medical centers who will stop their treatment, leaving the patient out in the cold, with an injury and no one to assist them and sometimes, quite often, not even able to work because of the severity of the injury.

E) NO MORE POST-RELEASE IME's – What does this mean? It means that the insurance company can certainly have the right to have the patient examined by a licensed and board-certified Wisconsin Doctor who practices 50% or more of their time, IN WISCONSIN, and who performs the exam *during their treatment time* with their designated primary care doctor for their claim. This means that after the patient is released from care, there is no more claim on the patient for IME's. All too often, we will get a call from a patient we released 6 months ago, a year, sometimes even two years or more ago, and they will tell us that they are being asked by the insurance company to go and get examined. I would propose that this not be allowed after the patient has been released however, I understand that the insurance company may believe that this is not practical, therefore, we place a 90-day cap. 90 days from the date of release, the patient is allowed to have further examinations performed at which point, after 90 days from the concluding events of his treating doctor, no more IME's can be performed. Normally, PPD ratings are submitted within this time frame and the insurance is aware of the patients PPD rating proposed by the treating doctor. Anything beyond 90 days from release date is not practical and should not be allowed. If the case is litigated, then we make it 6 months. But the patient should not have to expose themselves to ongoing exams from the insurance company beyond a reasonable time period of their release! I propose we make it 90 days for non-litigated cases, 6 months for litigated cases.

F) A FRIEND OR FAMILY MEMBER PRESENT at IME – Under the law, section 102.13(1)(b) it states that the patient can have several different providers which truly seems impractical at best but does not state they may have a friend or family member or even their attorney present. Later in the statute, it does recognize a translator, but I am proposing that this statute adds "Friend, Family member or Attorney" present at the exam so that it is in the same location of the statute as the others. Often, I hear about a patient who goes to the exam and wants to bring their friend in to watch the exam and the doctor disallows it. This is not right, but again, is not black and white when it comes to the statute and needs to be clarified.

G) A CAPPED FEE SHOULD BE PLACED ON ALL IME's – This is also necessary so that the motivation from the IME doctor is not driven by money.

There should be a $1500 cap placed on the review of the records and examination. It could be less than this but no more than $1,500. I was a QME for the State of California for almost 20 years and we got paid well from the State, but never did it go over $1,000 and that would be a flat rate of $350-$500 for the exam and the tiered time for records reviewed by 15-minute increments. Otherwise, you have IME's traveling from different States, coming in and performing these IME's for $2500-$5000 some as high as $10,000 to get the claim wiped clean for the insurance company or to favor the opinion medically speaking, for the insurance company. The IME is motivated by the money and will give the insurance company what they need to stop the claim. Fortunately, there are some good insurance companies out there that are still utilizing the doctors who practice here in Wisconsin and perform a very thorough IME and do an impeccable record review, they are practicing doctors here and are well within their right to perform the IME and base an opinion. But some insurance adjusters are dishonest and deceitful utilizing the worst IME's who do not practice here and are doing exams or file reviews only to hear the same thing over and over..." The patient's complaints are not work related and are PRE-EXISTING!" [redacted] who practices in Waukegan, Illinois, is often used who almost has the exact same report...over and over. There are some bad doctors here too, trying to get more business, so they will "ignore" the truth of the claim and state that the injury was pre-existing, which places an immediate hardship on the patient. This has got to stop and the only way to do this is to make the suggested changes that are mentioned above. If these insurance companies are placed on a capped fee to the IME's by law, then the bad doctors will perhaps drop out and not do these anymore. If they are getting paid $2500-$5000 or more per patient to do a 5-minute exam, they will continue to do them. We must stop them by placing a capped fee!!

H) NO RETROCATIVE DIRECTIVES ALLOWED WITH IME's – Almost every IME will answer many questions posed by the insurance adjuster. Some of these will be questions as to WHEN was the patient MMI or completely healed in his or her opinion. And almost every time, the IME or IMR will state some date in the past sometimes several weeks or months prior to the IME, they may say, *"I believe within a reasonable degree of medical certainty that this patient was maximally medically improved XXX"* And if the date of the IME was say 12/15/2024 and they state that the patient healed up November 01, 2024, he is rendering his own professional opinion. But nothing first off in the statutes, states that we are supposed to take the IME's medical report, over the patient's primary treating physician's opinion, yet, it happens all the time, More on this later, and then the benefits stop, that date mentioned, in this example, November 01, 2024, often the injury date just a few weeks to months prior to that time. So, the patient's benefits are cut off for medical care and TTD or restriction benefits as of the date of the IME suggests, in this case, November 01, 2024. Often, if benefits were paid out past November 01, 2024, as in this instance, the insurance company is asking for that money back.

I) BENEFITS STOPPED PRIOR TO IME - Further, often benefits are STOPPED PRIOR TO THE IME to both the provider and the employee. The date could be in this instance, 01/04/2025 and the IME is scheduled for 02/15/2025, yet the insurance company has the audacity to stop all benefits pending the IME! This needs to stop and further and more importantly, the IME RETROACTIVE TIMELINES SHOULD NOT BE PERMITTED FOR CUTTING BENEFITS. ALL BENEFITS, IF IME STATES SHOULD STOP DUE TO A MEDICAL OPINION, SHOULD ONLY BE ALOTTED FROM THE DATE OF THE IME FORWARD!!! It is NOT right nor fair that the insurance company has the right to stop all medical and TTD benefits pending an IME. They do this because they know that the IME is going to come back and say what they need them to say, "That the patient was healed up way before this timeline or that the injury is not work related and is pre-existing!

THEREFORE, NO RETROCATIVE IME DECISIONS OR IN OTHER WORDS, BENEFITS CANNOT BE ALTERED PRIOR TO IME EXAMINATION. THIS NEEDS TO BE IN THE STATUTES.

J) PREPONDERANCE OF MEDICAL BACK EVIDENCE BY TWO OR MORE PHYSICIANS – If the patient is seen by an IME and the IME states like they usually do, opinions that are false, fraudulent, thwarted in an obvious manner by bias, or simply dismiss objective evidence that clearly states that the patient is truly injured, then said IME can be contested at the state level in some fashion and the state can appoint a doctor as it states under 102.13(3). This needs to happen more often and is needed to make the grounds more compatible for the employee to survive as well as the providers for the patient.

K) FURTHER PREPONDERANCE OF EVIDENCE – If the patient receives an IME that is unfavorable and cuts off benefits and the patient has two or more doctors treating him on the primary directive chain of referrals that say otherwise, then the preponderance of the primary chain of two or more doctors would take precedent over the IME and the IME can only be used as a guide for said insurance. In other words, if the patient has a primary treating doctor or Chiropractor, who is working with a physical therapist much like myself, and we refer the patient out to an Orthopedist who also acknowledges that the patient was injured and it is a work related injury, then where two or more physicians testify that it is work related, then that would trump the IME. NO WHERE IN THE STATUTES DOES IT STIPULATE THAT THE IME TRUMPS THE PRIMARY TREATING DOCTORS. This FAVORITISM towards the IME needs to stop because the patient is getting the short end of the stick. In other words, the employee gets the IME, benefits are cut off and the IME states that there is nothing else wrong with the patient and he can go back to work with NO RESTRICTIONS, and the patient has a disc herniation of 5mm's compressing the thecal sac with radicular pain down the leg, waiting on surgery, his TTD benefits are stopped, medical benefits are stopped and now his job is in jeopardy because the employer is listening to the insurance company that there is nothing wrong with the patient, he can go back with no restrictions. This has happened many times with our patients, we try to keep the patient on the restrictions that we believe will allow him or her to tolerate working...but the employer denies them and tells the patient, "Unless you come back full duty, you are fired!" "Our doctor said you are fine!" THIS NEEDS TO STOP! The only way is to have, "WHERE TWO OR MORE DOCTORS SUGGEST THE SAME, THEN THE PROPONDERANCE OF EVIDENCVE TRUMPS ALL OTHER DOCTORS!"

CONCLUSION FOR IME's:

I HAVE BEEN PRACTICING FOR OVER 35 YEARS.

Never have I ever seen so much WORKER'S COMPENSATION abuse as in this state. Don't get me wrong, I love this State and everything that it offers. But the insurance companies have so much power that they are getting away with much and this is part of what needs to change, to give a little back to the patient and providers. The insurance companies are not what run the state, it is the people. Without the workers, we have no industry. It is about time that we take back what is important, and give back to the worker's, their rights to proper benefits, that are not cut off because the employer is in cahoots with the insurance company, or the insurance companies that take advantage of the grey areas of the law to suit their needs and so that they can turn a profit over and over again to make their investors happy. I understand that this is of course very important, but they need to be giving back some. Year after year, especially this past 10 years, LESS and LESS BENEFITS are being paid out to the workers. The only people who can change this...are you guys!

DELAYS IN ACTION:

I sit on the HealthCare Advisory Committee, and it is a travesty what I am seeing. We spent over two and a half years working on updating the PPD ratings for the worker's compensation system of Wisconsin, researching case studies, evaluating claims, discussing with one another, collectively with over 100 years of wisdom and knowledge and applying all our education, experience, research and time, towards some very nominal, slight changes, for the PPD rating for the injured worker. We went through every PPD rating and combed through every one of them and added some that were not even present in there. We prior to submitting this to your committee, went over it, and over, and over again, discussing in some detail as to why we felt in certain areas that some of the PPD ratings were too low. After careful consideration of all these things, we put together a detailed summation and explanation as to why and we submitted this to you. To date, and from my knowledge, we still have not got this approved and submitted for the changes. It has been almost a year and to date, we have heard nothing! This simply should not take this long to decide and move forward. There were many reductions as well. But where there were increases, I suspect that there has to be a review of what increased costs would be, but it should not be about that so much as what is right for the individual who was actually injured and left with a PPD rating and what is right for payout on that individual. There has to be some abiding trust in our committee, that the WCAC must place, otherwise, why is there a HealthCare Committee

RESPECTFULLY, NOT TIME SPENT USEFULLY:

Being at the meeting, I felt was a waste of time, in all honesty, for the public to come and submit proposed changes. We cannot even get proposed changes approved as a board with the State. If we, the very committee that was placed to make proposed changes to the Worker's Compensation Advisory Committee, cannot even get our recommendations reviewed and approved "In a Timely Manner" then how is anyone in the public, going to make a difference or be heard! I think a perfect example of this is the poor EMS people for the past I believe 9 years, that have been at every one of these meetings trying to get approved into the worker's compensation law, benefits, for the very people who are on the streets saving the lives of the good people of this State that see horrific things and acquire PTSD and then are denied benefits for worker's compensation medical assistance through mental healthcare providers. They have been politely asking for years and years and nothing is getting done. Yet 500,000 of these men and women State wide, who are exposed to the elements of the weather and the horrific scenes on the roads from dear going through windshields killing people on the highways to people sprawled out on the highways drenched in their own blood, arriving to the scene trying to save their lives and the dying breath of a man or woman asking for them to tell their wives or husbands that they love them and then they die right there in their arms. That is an awful thing to carry around with you and have no one professionally to talk to. I don't understand this other than you all should be ashamed of yourselves! You are there to serve the people of the great State of Wisconsin and yet, you aren't! You hold these meetings, and nothing seems to get done and everybody agrees to disagree, and we move on for another 6 months, year, 5 years!!! This has got to stop! Make some decisions and determinations that actually FAVOR THE PEOPLE OF WISCONSIN and not just the employers and insurance companies. I know this to be the problem because the pushback I received by the two nice young ladies at the end of the table, [redacted] who said that "She wanted on the record that None of her employers would ever direct care!" And she is ever so wrong! And [redacted] who also disagreed with all that I brought to the table because it favored the people of Wisconsin and not their employers or insurance companies. I don't understand their role under the Worker's Compensation Advisory Council as "Management" but I would suspect they play a role that is geared towards the employers and the insurance companies and certainly not the people.

Please see below, a synopsis of what was already discussed above but in more detail. The list allows you to briefly go through each and every heading and what needs to change on a more permanent basis or changed to be more fairly.

PROPOSED CHANGES UNDER SECTION 102.13 – THE IME PROCESS

A) THE BENEFITS FOR THE EMPLOYEE ARE NOT CUT OFF BY IMR's OR (Independent Medical Reviews). IMR's ARE EITHER CUT OUT COMPLETELY AND DISALLOWED, OR IF USED AT ALL, THEY CANNOT MAKE DETERMINATIONS ON BENEFITS FOR THE INJURED WORKER, *AT ALL*!!!

B) BENEFITS ARE NOT CUT OFF BY SHORT TERM IME's. THIS MEANS IME's DONE WITHIN THE FIRST 90 DAYS, WILL NOT BE ALLOWED FOR USE TO CUT ANY BENEFITS AND CAN ONLY BE USED FOR PURPOSES OF IN-HOUSE INSURANCE INFORMATION TO SEE WHERE THE CASE IS AT. ONLY AFTER 90 DAYS, MAY THEY USE THEM AS NORMAL; HENCE, WHY I AM PROPOSING NO IME's FOR THE FIRST 90 DAYS!

C) Which brings me to C. NO RETROCATIVE IME's. THIS MEANS THAT AN IME THAT IS DONE TODAY CANNOT TELL THE INSURANCE COMPANY NOW THAT THE PATIENT WAS HEALED THREE MONTHS AGO AND THEN THE INSURANCE COMPANY GOES BACK TO THE PATIENT ASKING FOR THE TTD BENEFITS TO BE PAID BACK! OR EVEN THE PROVIDERS. THE IME CAN CERTAINLY "RENDER HIS OR HER MEDICAL OPINION" BUT THE BENEFITS, IF CEASED, CAN ONLY BE STOPPED "AFTER: THE IME DATE OF SERVICE. NO RETROACTIVE BENEFITS ARE CUT TO PROVIDER'S OR EMPLOYEES.

D) *Which now brings me to D. PENDING IME's. BENEFITS SHOULD NOT BE STALLED, STOPPED OR THWARTED IN ANY WAY PRIOR TO AN IME OR PENDING AN IME. ALL BENEFITS MUST CONTINUE FOR MEDICAL PROVIDERS, CHIROPRACTORS OR OTHER LICENSED PROFESSIONAL ACTING AS PRIMARY TREATING DOCTOR, UNDER THE MEDICAL BENEFITS FOR EMPLOYEES, AND...THE EMPLOYEE BENEFITS ALSO, MUST CONTINUE UP UNTIL THE IME.*

E) IF AN IME STATES THAT HEALING WAS PRIOR TO THE IME AND CUTS OFF BENEFITS OR RECOMMENDS AS SUCH, THE INSURANCE COMPANY CANNOT UNDER THE LAWS AND STATUTES FOR WISCONSIN WORKER'S COMPENSATION, DEMAND OR GO BACK ASKING FOR BENEFITS TO BE PAID BACK, FROM THE PROVIDERS OR THE EMPLOYEE. THIS SHOULD NOT BE ALLOWED UNDER THE WORKER'S COMPENSATION ACT OF WISCONSIN.

F) A PATIENT SHOULD BE ALLOWED UNDER 102.13(1)(b) TO HAVE A FRIEND, FAMILY MEMBER, CO-WORKER OR ATTORNEY PRESENT FOR IME.

G) A CAPPED RATE OR FEE MUST BE PLACED ON ALL IME's UNDER SECTION 102.13 OR IN OTHER WORDS, THEY CAN ONLY CHARGE A CERTAIN AMOUNT.

H) ALL IME's MUST BE LICENSED IN THIS STATE TO PERFORM IME's.

I) ALL IME's MUST BE PRACTICING IN WISCONSIN AT LEAST 50% OR MORE OF THEIR TIME, TO PERFORM IME's IN THIS STATE.

J) NO IME's CAN BE PERFORMED PAST 90 DAYS IF RELEASED BY PRIMARY CARE GIVER ON ALL CASES THAT ARE NON-LITIGATED. LITIGATED CLAIMS ARE 6 MONTHS. AFTER THESE TIMES, THE PATIENT CANNOT BE EXAMINED BY THE SAID EMPLOYER OR THE INSURANCE COMPANY ANYLONGER.

K) *PREPONDERANCE OF EVIDENCE TRUMPS IME OR IN OTHER WORDS, WHERE TWO OR MORE DOCTORS STATE THAT THE CASE IS WORK RELATED, NEEDS CONTINUED CARE or NEEDS FURTHER TTD or even WORK RESTRICTIONS, ALL TRUMPS THE IME DOCTOR NO MATTER WHAT. TWO OR MORE WITNESSES IS ALWAYS A FACTOR THAT SHOULD TRUMP A CROOKED IME. OUR STATE IS BETTER THAN THAT AND WE SHOULD MAKE THIS RIGHT BECAUSE THE IME IS NOT THE LAST WORD AND NO WHERE IN THE STATUTE DOES IT STIPULATE THIS YET THE INSURANCE COMPANIES PLAY ON THIS CARD ALL DAY LONG TO STOP ALL BENEFITS.*

FURTHER CONCERNS REGARDING EMPLOYEE RIGHTS UNDER THE WORKER'S COMPENSATION LAWS GOVERNED BY WISCONSIN LAW.

A) PATIENT CANNOT GET FIRED FOR PRESERVING THEIR RIGHTS TO SEE THEIR OWN DOCTOR. IF THIS HAPPENS, THE DWD OR STATE APPOINTS COUNSEL FOR THE EMPLOYEE AND AN IMMEDIATE INVESTIGATION IS FILED, NOTICE GOES OUT TO THE EMPLOYER AND FINES ARE PLACED $10,000. $10,000 BECAUSE IT NEEDS TO HURT. THEY WILL THINK TWICE ABOUT FIRING AN EMPLOYEE ON "FALSE TERMS" THAT IF INVESTIGATED, WOULD BE FOUND TO BE FRAUDULENT. THIS MAY MEAN TO DEPOSE CO-WORKERS, ETC. THE STATE COUNSELS FEES TO REPRESENT THE PATIENT WILL BE AUTOMATICALLY PAID BY THE EMPLOYER.

B) PATIENT CANNOT GET FIRED FOR PRESERVING THEIR RIGHTS TO FILING A WORKER'C COMPENSATION CLAIM AT ALL. IF THIS HAPPENS, SAME THING ABOVE, COUNSEL IS PROVIDED FOR THE PATIENT BY THE STATE, A BAD FAITH CLAIM IS FILED UNDER SECTION 80.70 AND A $10,000 FINE IS BILLED TO THE EMPLOYER WITH ATTORNEY FEES AND RATES TO BE PAID BY THE EMPLOYER, AS THEY ARE PLACED ON NOTICE IMMEDIATELY. *(These two, both A and B, happen more than your committee want to realize, and I have at least 30-40 cases per year where the employer fires the employee. Just this past two to three weeks, I had three, two of which gave me their testimonies in writing. The third was scared too and even stopped coming in for treatment because of the threats of deportation if she continues to treat with her own doctor, etc. My third testimony, however, is from this year but from back in April, he is still a patient waiting for surgery and still, a fourth as well that I attached, who not only was fired, but the employer did not have worker's compensation insurance and…they held back $2,100 pay towards the patient. They fired him and did not pay him. When he came in to us, he shared this with me, I immediately sent a letter to Madison, two-page complaint, along with all the evidence and the complaint from the patient himself, filled out. I sent it in Priority Mail. TO THIS DATE, the patient has not got a call from anyone from the State, a letter, text, email, phone call…NOTHING!!! This is disgraceful! Why do we have laws, if they are not going to be followed or protected??

Please see all attached testimonials and signed affidavits.)

E) NCM, (NURSE CASE MANAGERS) ARE NOT ALLOWED TO SELF DIRECT TREATMENT OF SAID INJURED WORKER. IF SO, SANCTIONS CAN BE FILED IMMEDIATELY FOR THE FINES PROPOSED BY THE COUNCIL, SAY $500.

F) NCM, (NURSE CASE MANAGERS) ARE NOT ALLOWED TO SHOW UP AT PATIENT'S HOME AND ESPECIALLY UNANNOUNCED.

G) CLAIMS ADJUSTERS CANNOT DIRECT TREATMENT AND NEED TO STOP. IF THEY ARE CAUGHT, THROUGH VM MESSAGE, OR TEXT, OR WRITTEN TESTIMONY SIGNED BY THE PATIENT, THEN AFTER INVESTIGATION, SANCTIONS MAY BE FILED IMMEDIATELY UNDER BAD FAITH. A $5000 PENALTY IS SANCTIONED AND IMPOSED IMMEDIATELY UPON SAID INSURANCE COMPANY.

ADDITIONAL CONCERNS REGARDING EXCLUSION OF LOWER EXTREMITY TREATMENT PARAMETERS or GUIDELINES.

Under DWD 81.00, there are copious treatment guidelines for work injuries. The sections are as follows:

81.01 - PURPOSE AND APPLICATION
81.02 – INCORPORATION BY REFERENCE
81.03 - DEFINITIONS
81.04 – GENERAL TREATMENT GUIDELINES; EXCESSIVE TREATMENT
81.05 – GUIDELINES FOR MEDICAL IMAGING
81.06 – LOW BACK PAIN
81.07 – NECK PAIN
81.08 – THORACIC BACK PAIN
81.09 – UPPER EXTREMITY DISORDERS
81.10 – COMPLEX REGIONAL PAIN SYNDROME of UE and LE's
81.11 – INPATIENT HOSPITALIZATION GUIDELINES
81.12 – GUIDELINES FOR SURGICAL PROCEDURES
81.13 – CHRONIC MANAGEMENT
81/14 – HEALTH CARE PROVIDER ADVISORY COMMITTEE

Please take note that there are NO LOWER EXTREMITY TREATMENT GUIDELINES for this section. Being that I sit on the HealthCare Advisory Committee, I took the liberty of submitting this. (ATTACHED). I took the upper extremities and re-wrote everything for the lower extremities. We are in the process of reviewing this, but it has been almost a year, and we are not even halfway through it. We currently have not had enough members to have meetings for the past 6 months and not enough time to get much time when we do meet. Therefore, I felt prompted to just submit this to you firsthand to see if we could get this submitted for approval bar a few minor changes if needed, so that we can have LOWER EXTREMITIES as part of the treatment guidelines. This is very much needed.

I run into at least once or twice a quarter, an insurance company or even an IME, who will use this against us and state that there are no treatment guidelines and then will make up their own to discredit treatment provided.

We need to have lower extremity guidelines like upper extremity guidelines so that there is a base parameter for judgement, not only for our treating doctors, but also, for even the IME's or insurance companies to base sound treatment judgement on. *(I HAVE ATTACHED THE LOWER EXTREMITIES GUIDELINES that duplicate the Upper extremities except with lower extremity maladies/ injuries. *(SEE ATACHED DOCUMENT FOR REVIEW)

CONCERNS REGARDING SECTION DWD 102.42(2) – CHOICE OF PRACTITIONER

The statue is clear on this for the first or second choice when the case is proposed to be accepted. However, when the case gets denied, there is no clarity regarding first, second, etc. I propose that there be no first or second choice rule once the case becomes denied. Rather, something needs to be placed in the statutes perhaps at the very end of this statute, where it states that *"If the case gets denied, the first and second choice rule becomes null and void."* In other words, at that point, it doesn't matter who the patient sees or how many doctors they go see. This means that the patient may see a third, fourth, fifth choice doctor, if they even take it that far. Further, the reports and bills may be submitted for review under the worker's compensation law if the patient is represented by legal counsel and considered as part of the settlement and review.

EXAMPLE CASE: The patient was sent to the company doctor, which is what happens with 85% of the cases that come to us. The patient after a month with [redacted] realizes that they are not getting the care they need and tries to find a different doctor. They call the insurance company, and they send them somewhere, or..., the patient decides to go to a Chiropractor to get adjustments. The DC does not manage the case but bills the worker's compensation insurance and gets paid as the secondary. The patient after 2 months is no better and needs a third choice. By this time, the insurance company gets the IME and the case is now denied and the patient is not seeing anyone. They come to us, and we are now stuck dealing with a patient crying in pain, losing their apartment or home because they have no money and are behind and need help. We go through all kinds of hurtles trying to get the second doctor to send over a referral source, which most of the time we are able, but if the case is denied...THIS, is where we need something written in the statute that just allows us to take over the patients care and assist where we can without trying to get a written referral which quite often, does not come through. This change would be a big help for the injured worker.

CONCERNS REGARDING SECTION DWD 80.70 – BAD FAITH

There is a lot of Bad Faith on both sides, both *the employer* and *the insurance company*, where either one of them denies the claim, decides not to file the claim, or a whole plethora of different reasons, that fall directly under this statue, however, there is no system in place that allows this statute to take precedence to where it has some sort of bite. The patient, it would seem, must literally die because of blatant disregard of proper care, before anyone will step in under bad faith. The employee files complaints, but it seems that it always falls on deaf ears. We have helped the patient file claims against an employer who doesn't pay their wages and then fires them for getting injured, BUT NOTHING HAPPENS! Or an insurance company who denied their claim based on false information by the employer, or other reasons, but nothing EVER happens. There needs to be a form online for THE PROVIDERS to submit a complaint for bad faith, as well, THE PATIENT. The DWD has perhaps an additional department that takes in these complaints, perhaps A COMPLAINT DEPARTMENT for BAD FAITH. Those individuals review the complaint, and an investigation starts, and the statute allows this to be handled immediately with a resolution within 30 days. The employee has no money and is in pain, so the turnaround time needs to be fast.

CONCLUSION:

I am very grateful that you have given me this opportunity to try and make a difference with our system, in a good way. But we need to truly look at what I am sharing with you and address these things because these are big problems. I have attached several affidavits that are real people who have been abused by the employer but also the insurance companies. I have literally 100's of stories that will bring tears to your eyes as well as disappointment and maybe even anger because of the distorted abuse from the insurance companies and the employers, you have only a few. You have no idea how many people are getting fired from their jobs for getting injured, or benefits prematurely getting cut off, or patients' care being directed by not only the employer, but mainly by the NCM's and/or insurance adjusters, and many more ugly things I choose not to focus on but focus on better change or improvement.

Our system here in Wisconsin is working and is probably the best worker's compensation system in all of America, but we can make it better. Sometimes, a little change is needed, to make things fairer across the board because the only one that is getting the short end of the stick is the patient. And it would seem the only people benefiting are the insurance companies and their investors.

Respectfully,

Dr. Kelly G. Von-Schilling Worth

Dr. Kelly G. Von-Schilling Worth, DC, FAFICC, FIACN, DACAN, DABCI, CTN, DABDA, QICE
Fellow of the American Forensic Industrial Chiropractic Consultants
Fellow of the International Academy of Clinical Neurology
Diplomate American Chiropractic Academy of Neurology
Board Certified Chiropractic Neurologist
Board Qualified Chiropractic Electro-Diagnostician
Diplomate American Board of Chiropractic Internists
Board Certified Chiropractic Internists
Board Certified Traditional Naturopathic Physician
Diplomate American Board of Disability Analysts
Wisconsin State HealthCare Advisory Committee for Worker's Compensation
Qualified Independent Chiropractic Examiner
Clinic Director

Cc: Legal Dept – SJIM
Cc: DWD Worker's Compensation Div., HealthCare Advisory Committee

DWD 81.09B – LOWER EXTREMITY DISORDERS

Definition – By definition, a lower extremity disorder could mean any one or more of the following below, at any given time. The lower extremity would consist of the hip, thigh, knee, leg, ankle, foot and any one or more toes, in their entirety.*

Proposed possible disorders could encompass any one or more of the following. This list does not comprise every possible injury or condition that could be related to a work injury. *(Any and All SPRAINS and STRAINS of the lower limb, including but not limited to hip/ thigh/ knee/ lower leg/ ankle and foot whereby SPRAINS of any one or more joints of the lower limb such as Anterior and Posterior Cruciate Ligaments/ Medial and Lateral Collateral Ligaments/ Supra and Infra-Patellar Ligament injuries of the knee, Deltoid or Medial Ligament or Lateral Ligament injuries of the ankle/ Anterior and Posterior TaloFibular/ Calcaneofibular and Superior and Inferior Peroneal Retinaculum Ligaments/ and STRAINS of the thigh muscles such as quadriceps or hamstring muscle groups or lower leg muscle group, calf, etc. whereby there is objective injury to any one or more muscle groups secondary to trauma. All TRAUMA and/or FRACTURES of any portion of the lower limb including but not limited to, hip/ thigh/ knee/ lower leg/ ankle and foot. All DISLOCATIONS of the lower limb including hip/ knee/ ankle and/or foot. TRAUMATIC AVASCULAR NECROSIS of any one or more tarsal bones. CRUSH INJURIES of the lower limb, including the foot and toes. Any one or more TENDON INJURIES or TENDONITIS such as Achilles Tendon, Any one or more NERVE ENTRAPMENTS or COMPRESSION type disorders or injuries. TOE NAILBED INJURIES or DISORDERS/ deformities. PLANTAR FASCITIS of the foot, MENISCUS INJURY or TRAUMA/ disorders, BAKER's CYST secondary to TRAUMA. All forms of lower extremity CONTUSIONS and finally, All LACERATIONS of the lower extremity.) ETC.

(1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF LOWER EXTREMITY DISORDERS.

(a) A health care provider shall determine the nature of a lower extremity disorder before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination, a health care provider shall at each visit, assign the patient to the appropriate clinical category according to subds. 1. to 6. A health care provider shall document the diagnosis in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This section does not apply to lower extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, or systemic rheumatoid arthritis diseases. Instead, applies to any/ all traumatic injuries, cumulative traumatic disorders or disruptions, fractures, dislocations, etc that are work related or determined to be work related or that occurred while on the job and/ or during work hours.

(1) FRACTURES AND DISLOCATIONS – This clinical category includes any/ all fractures or dislocations which occur while on the job, or that are work related. This would include any fracture from the hip down to the ankle and foot that is causing secondary pain, swelling, inflammation, disuse atrophy of surrounding lower extremity muscles, numbness and or pain and tendonitis, or gait disturbances from the fracture or dislocation.

(2) TENDONITIS OF THE LOWER LEG/ANKLE/FOOT – This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the lower extremity at or distal to the knee due to mechanical injury, trauma, or irritation, including the diagnosis of tendonitis, tenosynovitis, or peri-tendonitis.

(3) NERVE ENTRAPMENT SYNDROMES – This clinical category encompasses any compression or entrapment of the femoral, sciatic, posterior tibial or common peroneal nerve/s and any of their branches, including tarsal tunnel syndrome, Lateral Femoral Cutaneous Nerve, Obturator Nerve, Genitofemoral Nerve, Ilioinguinal Nerve, Iliohypogastric Nerve and so on. Entrapment syndrome for the lower extremity will be known by their painful numbing effect on the patient and can be confirmed by an NCV/EMG study which follows the same protocols for 81.06 (f) and 81.07 (f) for neck and lower back radiculopathies and extremity numbness that is persistent.

(4) MUSCLE PAIN SYNDROMES – This clinical category encompasses any painful condition of any of the muscles of the lower extremity, including the muscles responsible for movement of the hip/ knee and ankle/foot characterized by pain and stiffness, including the diagnosis of acute/ chronic traumatic muscle strain, repetitive strain injury, overuse syndrome for any one or multiple muscle or muscle groups, myofascial pain syndrome, myofascitis, nonspecific myalgia, fibrosititis, traumatic fibromyalgia and fibromyositis.

(5) IMPINGEMENT SYNDROMES INCLUDING TENDONITIS and BURSITIS and RELATED CONDITIONS – This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the lower extremity due to mechanical injury or irritation, including the diagnosis of impingement syndrome, Iliotibial Band Syndrome, Peroneal Tendonitis, Achilles Tendonitis, Hip Tendonitis, Patellar Tendonitis, Quadriceps Tendonitis, Pes Anserine Bursitis/ Tendinopathy, Hamstring Tendonitis, etc., or any other tendon or bursa that becomes swollen and/or inflamed secondary to a work related injury.

(6) TRAUMATIC SPRAINS and STRAINS OF THE LOWER EXTREMITY – This clinical category encompasses an instantaneous or acute injury that occurred because of a single precipitating event to any one or several of the lower extremity ligaments or muscles of the lower extremity. Injuries to muscles because of repetitive use or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes under subd. 4. Injuries with complete tissue disruption are also part of this section and would encompass all necessary avenues for relief from the secondary effects of these type of injuries such as pain, swelling and inflammation, deformation, and dysfunction in total.

(c) A health care provider may order certain laboratory tests in the evaluation of a patient with lower extremity disorders to rule out infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications. Laboratory tests may be ordered at any time a health care provider suspects any of these conditions, but a health care provider shall justify the need for the tests ordered with clear documentation of the indications.

(d) Medical imaging evaluation of lower extremity disorders shall be based on the findings of the history and physical examination and may not be ordered before a health care provider's clinical evaluation of the patient. Medical Imaging may not be performed as a routine procedure and shall

comply with the guidelines in s. DWD 81.05. A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(e) Electromyography and nerve conduction studies are only necessary for conditions of the lower extremity that involve ongoing weakness, tingling, numbness or with any nerve entrapment disorders pre or post-surgical.

(f) A health care provider may not order the use of any of the following diagnostic procedures or tests for diagnosis of lower extremity disorders:

1. Surface Electromyography
2. Thermography.
3. Somatosensory evoked potentials and motor evoked potentials.

(g) All of the following diagnostic procedures or tests are considered adjuncts to the physical examination and are not necessary separately from the office visit:

1. Vibrometry
2. Neurometry.
3. Semmes-Weinstein monofilament testing.
4. Algometry.

(h) A health care provider may not order computerized range of motion or strength measuring tests during the period of initial nonsurgical management but may order these tests during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider's evaluation or treatment.

(i) A health care provider may order personality or psychosocial evaluations for evaluating patients who continue to have problems despite appropriate initial nonsurgical care. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in each case, a health care provider performing the evaluation shall consider all the following:

1. Is symptom magnification occurring?
2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, anxiety, or anger that is interfering with recovery?
3. Are there other personality factors or disorders that are interfering with recovery?
4. Is the patient chemically dependent?
5. Are there any interpersonal conflicts interfering with recovery?
6. Does the patient have a chronic pain syndrome or any psychogenic pain?
7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) Diagnostic analgesic blocks and injection studies are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management. All the following guidelines apply to diagnostic analgesic blocks and injection studies:

1. Selection of patients, choice of procedure, and localization of the site of injection shall be determined by documented clinical findings indicating possible pathological conditions and the source of pain symptoms.
2. These blocks and injections may also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5).

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process, and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

1. Functional capacity assessment or evaluation is not necessary during the first 12 weeks of initial nonsurgical treatment.
2. Functional capacity assessment or evaluation *is necessary* after the first 12 weeks of care or any time beyond the 12-week mark of acute care when treatment is needed because of extenuating circumstances as stated in DWD 81.04 where care is indeed needed because of surgery or other unforeseen circumstances that bring care beyond the 12-week mark or, in any of the following circumstances:
   a. To identify the patient's activity restrictions and capabilities.
   b. To assess the patient's ability to return to do a specific job.
3. A functional capacity evaluation is not necessary to establish baseline performance before treatment or for subsequent assessments to evaluate change during or after treatment.
4. Only one completed functional capacity evaluation is necessary per injury.

(l) Consultation with other health care providers may be initiated at any time by the appointed primary or secondary primary treating health care provider as it stipulates in 102.42 (2)(a).

(2) GENERAL TREATMENT GUIDELINES FOR LOWER EXTREMITY DISORDERS

(a) All medical care for lower extremity disorders, appropriately assigned to a category of sub. (1) (b) 1. to 6., is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (16) as follows:

1. Subsection (11) governs fractures and dislocations.
2. Subsection (12) governs tendonitis of the lower extremity in its entirety.
3. Subsection (13) governs lower extremity nerve entrapment syndromes.
4. Subsection (14) governs lower extremity muscle pain syndromes.
5. Subsection (15) governs lower extremity impingement syndromes.
6. Subsection (16) governs traumatic sprains and strains of the lower extremity.

(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted be new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan shall be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury unless the treatment or therapy is subsequently delivered to a different part of the body.

(c) When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality shall be applied simultaneously, if possible, to all necessary areas.

(d) In general, a course of treatment shall be divided into the following 3 phases:

1. First, all patients with a lower extremity disorder shall be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subs. (3), (4), (5), (8), and (10), appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in subs. (9).
2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (16), and s. DWD 81.12 (3). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

b. Surgery shall follow the guidelines in subs. (6), (11) to (16), and s. DWD 81.12 (3).

c. A decision against surgery at any time does not preclude a decision for surgery made later.

3. Third, for those patients who are not candidates for surgery or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be necessary. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment as described in subs. (8).

(e) A treating health care provider may refer the patient for a consultation at any time during treatment consistent with the accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES

(a) *General* - Except as set forth in par. (b) or s. DWD 81.04 (5), a health care provider may not direct the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) beyond the 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the patient at home.

(b) *Additional Passive Treatment Modalities* - A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months if all the following apply:

1. The patient is released to work or is permanently totally disabled, and the additional passive treatment may result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.
2. The treatment is not given on a regularly scheduled basis.
3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.
4. Management of the patient's condition includes active treatment during this period.
5. The additional 12 visits for passive treatment do not delay the required surgical or chronic pain evaluation required by this chapter.
6. Passive care is not necessary while the patient has chronic pain syndrome.

(c) *Adjustment or Manipulation of Joints* – For purposes of this paragraph, "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations. All the following guidelines apply to adjustment or manipulation of joint:

1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to two weeks decreasing in frequency until the end of the maximum treatment period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(d) *Thermal Treatment* – For purposes of this paragraph, "thermal treatment" includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave. All the following guidelines apply to thermal treatment:

1. Treatment given in a clinical setting:
a. Time for treatment response is 2 to 4 treatments.
b. Maximum treatment frequency is up to 5 times per week for the first one to three weeks decreasing in frequency until the end of the maximum treatment duration period in subs. 1(c).
c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.
2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) *Electric Muscle Stimulation* – For purposes of this paragraph, "electrical muscle stimulation" includes but not limited to, galvanic stimulation, transcutaneous electric nerve stimulation, interferential and microcurrent techniques. All the following guidelines apply to electrical muscle stimulation:
1. Treatment given in a clinical setting:
a. Time for treatment response is 2 to 4 treatments.
b. Maximum treatment frequency is up to 5 times per week for the first one to three weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1(c).
c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only given in conjunction with other therapies.

2. Home use of an electrical muscle stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting to ensure proper electrode placement and patient education. All the following guidelines apply to home use of an electrical stimulation device:

a. Time for patient education and training is one to three sessions.

b. Patient may use the electrical stimulation device unsupervised for one month, at which time, effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(f) *Acupuncture Treatments* – For purposes of this paragraph, "Acupuncture Treatments" include endorphin-mediated analgesic therapy that includes classic acupuncture and acupressure. All the following guidelines apply to acupuncture treatments:

1. Time for treatment response is 3 to 5 sessions.

2. Maximum treatment frequency is up to 3 times per week for the first one to three weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(g) *Phoresis* – For purposes of this paragraph, "Phoresis" includes phonophoresis and iontophoresis. All of the following guidelines apply to Phoresis:

1. Time for treatment response is 3 to 5 sessions.

2. Maximum treatment frequency is up to 3 times per week for the first one to three weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 9 sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

(h) *Manual Therapy* – For purposes of this paragraph, "Manual Therapy" includes soft tissue and joint mobilization and therapeutic massage. All the following guidelines apply to manual therapy:

1. Time for treatment response is 3 to 5 treatments.

2. Maximum treatment frequency is up to 5 times per week for the first one to two weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(i) *Splints, Braces, and other Movement Restricting Appliances* – Bracing required for longer than two weeks shall be accompanied by active motion exercises to avoid stiffness and prolonged disability. All the following guidelines apply to splints, braces, and other movement-restricting appliances:

1. Time for treatment response is 10 days.

2. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.

3. Maximum continuous duration is 8 weeks. Prophylactic use is allowed indefinitely.

(j) *Rest* – Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Total restriction of use of an affected body part may not be prescribed for more than 2 weeks unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints shall begin no later than 2 weeks after application of the immobilization.

(4) ACTIVE TREATMENT MODALITIES

(a) A health care provider shall use active treatment modalities as set forth in pars. (b) to (f). A health care provider's use of active treatment modalities may extend past the 12-week limitation on

passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded and/or if the patients condition meets or is consistent with s. DWD 81.04 (5) "Departure from Guidelines."

(b) Education shall teach the patient about pertinent anatomy and physiology as it relates to lower extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments are 3 visits which include an initial education and training session, and 2 follow-up visits.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, low back, and legs, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is 3 visits.

(d) Worksite analysis and modification shall examine the patient's workstation, tools, and job duties. A health care provider may make recommendations for the alteration of the workstation, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is 3 visits.

(e) Exercise, which is important to the success of a nonsurgical treatment program and a return to normal activity, shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall, at least in part, be specifically aimed at the musculature of the lower extremity. While aerobic exercise may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

(f) Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subdivisions 1. and 2. govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. 'Guidelines for supervised exercise.' – One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is up to 3 times per week for 3 weeks and shall decrease with time until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks

2. 'Guideline for unsupervised exercise' – Unsupervised exercise shall be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

(5) THERAPEUTIC INJECTIONS

(a) For purposes of this subsection, "Therapeutic Injections" include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. A health care provider may only give therapeutic injections in conjunction with active treatment modalities directed to the same anatomical site. A health care provider's use of injections may extend past the 12-week limitation on passive modalities, so long as the maximum treatment for injections in pars. (b) to (d) is not exceeded.

(b) All of the following guidelines apply to trigger point injections:

1. Time for treatment response is within 30 minutes.
2. Maximum treatment frequency is once per week to any one site if there is a positive week to any one site if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, trigger point injections shall be redirected to other areas or discontinued. Only 3 injections to different sites per patient visit.
3. Maximum treatment is 4 injections to any one site over the course of treatment.

(c) For purposes of this paragraph, "Soft Tissue Injections" include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion. All of the following guidelines apply to soft tissue injections:
1. Time for treatment response is within one week.
2. Maximum treatment frequency is once per month to any one site if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.
3. Maximum treatment is 3 injections to any one site over the course of treatment.

(d) All of the following guidelines apply to injections for any lower extremity nerve entrapment:
1. Time for treatment response is within one week.
2. Maximum treatment frequency may permit repeat injection in one month if there is a positive response to the first injection. Only 3 injections to different sites per patient visit.
3. Maximum treatment is 2 injections to any one site over the course of treatment.

(6) SURGERY

(a) A health care provider may perform surgery if it meets applicable guidelines in subs. (11) to (16) and s. DWD 81.12 (3).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities shall be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period, the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing is as follows:
1. 12 weeks for knee surgery or repair, ligament and/or tendon surgery or repair or any surgery for a clinical category in this section that requires joint reconstruction.
2. 8 weeks minimum for all other surgery for clinical categories in this section.

(c) Repeat surgery shall also meet the guidelines of subs. (11) to (16) and s. DWD 81.12 (3).

(7) CHRONIC MANAGEMENT

Chronic management of lower extremity disorders shall be provided according to the guidelines in s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT

(a) A health care provider may direct the use of durable medical equipment only in the situations specified in pars. (b) to (e).

(b) Splints, braces, straps, or supports, may be necessary as specified in subs. (3) (i).

(c) For patients using an electrical muscle stimulation device at home, the device and any required supplies are necessary within the guidelines of sub. (3) (e).

(d) Exercise equipment for home use, including bicycles, treadmills, and stair climbers, are necessary only as part of an approved chronic management program. This equipment is not necessary during initial non-surgical care during re-evaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility on its premises with the prescribed equipment instead of authorizing purchase of the equipment for home use.

1. 'Indication' – The patient is deconditioned and requires reconditioning that can be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.
2. 'Requirements' – The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment listed in (e)(1-2) below, are not necessary for home use for the lower extremity disorders specified in subs. (11) to (16):

1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.
2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER

(a) A health care provider shall evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical treatment is effective according to pars. (b) to (e). No later than the time for treatment response established for the specific modality in subs. (3) to (5), a health care provider shall evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in pars. (b) to (e).

(b) The patient's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

(c) The objective clinical findings are progressively improving as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

(d) The patient's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record or documentation of work ability involving less restrictive limitations on activity.

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified, or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to an allied health professional directly providing the treatment but remains the ultimate responsibility of the treating health care provider.

(10) MEDICATION MANAGEMENT

(a) Prescription of controlled substance medication scheduled under ch. 450, Stat., including opioids and narcotics, are necessary primarily for the treatment of severe acute pain. Therefore, these

medications are not generally recommended in the treatment of patients with lower extremity disorders.

(b) A health care provider, appointed primary treating physician or a health care provider in the chain of referral, shall document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine the ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR FRACTURES AND DISLOCATIONS

(a) A health care provider shall use initial nonsurgical management for all patients with any type of fracture or dislocation, provided it is not a surgical case of which, all surgical lower extremity practices shall be followed as stated in DWD 81.12 (3). Nonsurgical management shall be the first phase of care or treatment.

1. The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first 6-8 weeks of healing from the fracture and removal of cast or 4 weeks of healing with a dislocation and removal of bracing, initial nonsurgical care shall always include active treatment modalities under sub. (4).
2. Initial nonsurgical management shall be provided in the least intensive setting consistent with quality health care practices.
3. Except as provided in sub. (3), the use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period more than 12 weeks may be necessary depending on the severity of the fracture, disuse atrophy of surrounding muscle tissue effected by the injury and/or the severity of the dislocation. Therefore, the 12-week rule will be subject to the day of removal of casting or splinting/ bracing, that is provided by the health care provider or the appointed primary treating physician responsible for the treatment being provided. The 12-week rule as described in DWD 81.09 (B) for lower extremities will still be in effect once casting or splinting or bracing is removed, allowing ample time for rehabilitation and use of active and passive modalities as stated in DWD 81.09B (3) and (4). Further, DWD 81.04 (5) (a-e), DEPARTURE FROM GUIDELINES, can or may also apply since the complications of casting a fracture or bracing a dislocation may take longer than 6-8 weeks to heal authorizing active and passive treatment to be applied by the appointed health care provider, beyond the 12-week rule.
4. Use of home-based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period, the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. The purpose and goal of surgical evaluation is to determine whether surgery is necessary for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

1. Surgical evaluation, if necessary, shall begin no later than 12 months after beginning initial nonsurgical management.
2. Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the guidelines of subs. (1), if not already obtained during the initial evaluation. Repeat testing is

not necessary unless there has been an objective change in the patient's condition that would warrant further testing. Failure to improve with therapy does not, by itself, warrant further therapy.

3. Plain films would be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general guidelines in s. DWD 81.05 (1). With lower extremity fracture or dislocation, further medical imaging studies may be deemed necessary.

4. Surgical evaluation may also include personality or psychological evaluation consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers is an important part of surgical evaluation of a patient who fails to recover with appropriate nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition.

6. If surgery is necessary, it may be performed after initial nonsurgical management fails.

7. If surgery is not necessary or if the patient does not wish to proceed with surgery after the 12-week time period of nonsurgical active and passive care, then the patient is a candidate for chronic management as stated under s. DWD 81.13. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(c) If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily living including regular vocational activities, then the patient may be a candidate for chronic management under s. DWD 81.13.

(12) SPECIFIC GUIDELINES FOR TENDONITIS OF ANY LOWER EXTREMITY TENDON

(a) A health care provider shall use initial nonsurgical management for all patients with tendonitis and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a).

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all the guidelines of sub. (11) (b), with the following modifications:

1. For patients with a specific diagnosis of tendonitis in the lower extremity and it has been diagnosed accurately by the health care provider, surgical evaluation, and potential surgical therapy, if necessary, may begin after only 2 months of initial nonsurgical management or in other words, a trial of 8 weeks of traditional active and passive modality care as specified in s. DWD 81.09B (3) and (4).

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with any lower extremity tendonitis shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR NERVE ENTRAPMENT SYNDROMES

(a) A health care provider shall use initial nonsurgical management for all patient with nerve entrapment syndromes, except as specified in par. (b) 2., and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a),

with the following modifications: Nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression in the lower extremities, such as abnormal two-point discrimination, motor weakness, or muscle atrophy, or for patients with symptoms of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be necessary.

(b) If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all the guidelines of sub. (11) (b), with the following modifications:

1. Surgical evaluation may begin, and surgical therapy may be provided, if necessary, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is necessary under par. (a).
2. Surgery is necessary if an electrodiagnostic study, (NCV/EMG), confirms the diagnosis or if there has been temporary resolution of symptoms lasting at least 7 days with local injection.
3. If there is neither a confirming electrodiagnostic study, (NCV/EMG), nor appropriate response to local injection or if surgery has been previously performed at the same site, surgery is not necessary.

(c) If the patient continues with symptoms and objective physical findings after all surgery, or the patient refused surgery therapy, or the patient was not a candidate for surgery therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with nerve entrapment syndromes shall be provided under the guidelines of s. DWD 81.13.

(14) SPECIFIC TREATMENT GUIDELINES FOR MUSCLE PAIN SYNDROME

(a) A health care provider shall use initial nonsurgical management for all patients with muscle pain syndromes and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a).

(b) Surgery is not necessary for the treatment of muscle pain syndromes.

(c) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life or living, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management with patients with muscle pain syndromes shall be provided under the guidelines of s. DWD 81.13.

(15) SPECIFIC TREATMENT GUIDELINES FOR LOWER EXTREMITY IMPINGEMENT SYNDROME

(a) A health care provider shall use initial nonsurgical management for all patients with lower extremity impingement syndrome without clinical evidence of surrounding tissue damage or tears, and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a) except for the following:

1. Continued nonsurgical management may be inappropriate, and early surgical evaluation may be necessary, for patients with any of the following:
   a. Clinical findings of any surrounding tissue tears.
   b. Acute rupture of any tendon or tendons.

2. Use of home-based treatment modalities with monitoring by a health care provider may continue up to 6 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as necessary treatment.

(b) If the patient continues with symptoms and objective physical findings after 6 months of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life or living, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all the guidelines of sub. (11) (b), with any of the following modifications:

1. Surgical evaluation shall begin no later than 6 months after beginning initial nonsurgical management.
2. Diagnostic injection, arthrography, computed tomography-arthrography, or magnetic resonance imaging scanning may be necessary as part of the surgical evaluation.
3. Any/ all surgical procedures that are appropriate and accepted as part of the medical community relating to impingement surgery or repair including but not limited to, impingement of a tendon, nerve or other, excision of bony protuberance, removal of adhesions or excision of a damaged bursa, all of which meet the guidelines of s. DWD 81.12 (3).

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or was not a candidate for surgery, and if the patient's condition prevents the resumption of regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with any lower extremity impingement syndrome shall be provided under the guidelines of s. DWD 81.13.

(16) SPECIFIC TREATMENT GUIDELINES FOR TRAUMATIC SPRAINS AND STRAINS OF THE LOWER EXTREMITY

(a) A health care provider shall use initial nonsurgical management for the first phase of treatment for all patients with traumatic sprains and strains of the lower extremity without evidence of complete tissue disruption. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11).

(b) Surgery is not necessary for the treatment of traumatic sprains and strains unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery and would be warranted if indicated and recommended by the appointed primary treating health care provider or the health care provider assisting within the chain of referral.

(c) If the patient continues with symptoms and objective physical findings after 12-weeks of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life or living, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with traumatic sprains and strains shall be provided under the guidelines of s. DWD 81.13.

From: Alan DeYoung
Sent: Wednesday, December 11, 2024 12:45 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Council Support for PTSD Coverage for EMS and Fire

Dear Chair Dipko,

As a Wisconsin citizen, I urge the Workers Compensation Advisory Council to extend worker's compensation coverage for post-traumatic stress disorder (PTSD) to all emergency medical services (EMS) practitioners and firefighters, including volunteers. They face the same risks and mental health challenges as their full-time counterparts (police and career firefighters) but are excluded from current protections. Studies show EMS professionals are significantly more likely to experience PTSD compared to other first responders. Extending this coverage is a matter of acknowledgment and fairness of their critical role in protecting our communities. If we lose additional providers to mental health challenges, this further increases the staffing crisis that affects the ability for EMS to respond to 911 medical emergencies. Please ensure that all EMS personnel receive the support they need.

I am a member of the Wisconsin EMS Association (WEMSA) and support their advocacy efforts on this issue. This is a unified issue across Wisconsin that needs the Council's support.

Sincerely,

Alan DeYoung

Wisconsin EMS Association
Serving Those Who Serve Others

To: John Dipko, Chair
Members, Wisconsin Worker's Compensation Advisory Council
From: Alan DeYoung, Executive Director
Date: Friday, January 10, 2025
Re: Request PTSD Coverage for all EMS Personnel

As the Executive Director and on behalf of the Wisconsin EMS Association (WEMSA) and the over 7,000 members and 350 EMS departments we serve - I am asking that the Wisconsin Worker's Compensation Advisory Council (WCAC) please support extending in the agreed upon Council bill or similarly introduced legislation that expands to all emergency medical service professionals, regardless of their paid or volunteer status, to the same standard of Worker's Compensation coverage policy for law enforcement officers and full-time fire fighters and EMTs affiliated with a fire department that are diagnosed with post-traumatic stress disorder (PTSD), similar to what was provided in 2023 Wisconsin Senate Bill 992 and Assembly Bill 1074.

Our association and its members are very appreciative of the Council's endorsement last session of these policies in the agreed upon bills: 2023 Wisconsin Senate Bill 992 and Assembly Bill 1074.

However, our association asks that the Council not deviate from past precedent by introducing a second bill. Please include this provision in the agreed upon one bill traditionally introduced each session. This deviation from WCAC precedent led to the State Legislature ignoring the second set of bills (SB-992 and AB-1074) and passing only Assembly Bill 1073 (Senate Bill 991).

It should be noted that in past sessions, the State Legislature has shown support PTSD coverage for EMS. During the 2021-22 session PTSD worker's compensation coverage legislation was introduced: 2021 SB-680\AB-683 that provided changes to include paid emergency medical services practitioners; and 2021 SB-681\AB-778 that proposed changes to include various professions including all EMS practitioners and firefighters, including volunteers. And, while they passed a senate committee (5-0) and the state senate (32-0) unanimously - they passed too late in the session to receive final action. It should be noted that a similar proposal was included in the Governor's proposed 2023-2025 biennial state budget.

78.6% of EMS departments rely on volunteers to serve their community. These men and women donate their time, with some may receive a minimal stipend, to provide the same emergency care as their EMS-firefighter affiliated contemporaries. Further, the volunteerism and sacrifice of time, effort and wages generate significant savings to Wisconsin's municipalities, residents and those businesses located in these communities.

Why does it appear that volunteer EMTs and EMTs working in standalone EMS departments being punished and looked down upon as second-class emergency responders by our state policymakers and elected officials? These men and women serve to save lives – and they do so

by generating significant property tax savings to the municipalities served and the businesses and residents located in those communities. Yet volunteer EMTs and EMTs serving in stand alone EMS departments are treated differently under state law.

Please note that volunteer EMS services also pay worker's compensation insurance. And like our full-time law enforcement, firefighter, and firefighter-EMS colleagues – stand-alone services experience the same work-related challenges and risks serving in their emergency responder capacity. In fact, studies of emergency medical providers / ambulance personnel have shown higher estimated rates of PTSD prevalence.

Simply put – it's about fairness. It's about recognizing that all EMS providers are essential first responders that face similar experiences and work-related hardships, regardless if they are associated with a municipal, private-sector based EMS service or administrated with the fire department.

Again, on behalf of the Wisconsin EMS Association membership I want convey our true gratitude and appreciation for the Council's approval of all EMT PTSD coverage under the Workers Compensation agreed upon bills last session. But, we ask that this approval be included in the one agreed upon bill as is the Council's tradition.

Wisconsin law has already extended such provisions for full-time emergency medical providers that serve on EMS services affiliated with a fire department – along with law enforcement and fire.

Thank you,

Alan DeYoung, M.S.
Executive Director
Wisconsin EMS Association
26422 Oakridge Dr
Wind Lake, WI 53185

Statistics of Interest…

- A study conducted using in-hospital and prehospital providers found that "prehospital providers were significantly more likely to screen positive for PTSD compared to the in-hospital providers (42% vs. 21%, P<0.001)."[1]

- From a study published in the Journal of Emergency Medical Services researchers found that first responders (EMS) in the United States were approximately 10 times more likely to have suicidal ideations and/or attempt suicide compared to the CDC national average.

[1] Reference: **Journal of EMS: First Responders and PTSD: A Literature Review**

- Studies show that first responders are at an increased risk of post-traumatic stress disorder and additional mental health issues including substance abuse. These studies compared police, firefighters, and first responders in each study.[2]

- Depression and PTSD affect an estimated 30% of our nation's first responders – compared to 20% of the general population. [3]

- Approximately 3.7% of Americans have contemplated suicide, that rate jumps to 37% for fire and EMS professionals - same thing as above but different wording.[4]

[2] Reference: **Journal of EMS: First Responders and PTSD: A Literature Review**
[3] Reference: **America's first responders' struggle with PTSD and depression**
[4] Reference: **America's first responders' struggle with PTSD and depression**

From: Willard T. Walker Jr. <Willard.Walker@walkerforge.com>
Sent: Wednesday, December 18, 2024 4:04 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Comments in Support of medical fee schedule adoption

The biggest cost driver in the workers compensation system is health care. Health care consumes 61 percent of total cost in the system – the highest in the country. This is compared to 24.8 percent in North Carolina – one of the lowest in the country – and is significantly higher than all of Wisconsin's Midwest neighbors.

Other states - 45 in total - have all implemented a medical fee schedule, as they have proven to lower workers compensation costs.

The biggest cost driver in the workers compensation system is health care. Health care consumes 61 percent of total cost in the system – the highest in the country. This is compared to 24.8 percent in North Carolina – one of the lowest in the country – and is significantly higher than all of Wisconsin's Midwest neighbors

It's time for Wisconsin to adopt a medical fee schedule and control health care costs within the workers compensation system.

Willard T. Walker
CEO
Walker Forge, Inc.
(414) 223-2001 Phone
Willard.Walker@walkerforge.com

From: Doug Fearing <NoFear@fearings.com>
Sent: Wednesday, December 18, 2024 4:12 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Medical Costs

Dear John Dipko, Chair, Workers' Compensation Advisory Council

As a small business employer, I am writing to express my concerns about healthcare costs and the lack of cost controls on healthcare within the Workers' Compensation system. Our company's healthcare costs increase 15% to 27% depending on the plan and while you can't do anything to help my business directly as it relates to that, you can help reign in Worker's comp costs, another major expense, by better oversight of healthcare cost to worker's comp claimants. Medical fee schedules could limit what providers can charge to treat injured workers, helping keeping costs comparable to what private health insurers would pay for the same service. Whatever it takes, please look into lowering WC costs by lowering healthcare expenditures.

Thank you.

DOUGLAS FEARING | CEO
Fearing's Audio Video Security
Corporate Office: 722 Walsh Rd. Madison, WI 53714
Milwaukee Office: 1711 Paramount Court, Suite 2, Waukesha, WI 53186
Phone: 800. 252.2253 | www.fearings.com

From: Rob Peaslee <Rvpeas@mgifinc.com>
Sent: Thursday, December 19, 2024 7:40 AM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Health insurance costs

WCA,
My company faces daily competition from surrounding states who produce similar products to what MGIF does. The industry I work within operates on very slim margins and having health care and Workman's Compensation costs as high as they are in Wisconsin make it very difficult to compete with other foundries in those States. Anything that can be done to mitigate that disparity would not only help my company but the foundry industry as a whole in Wisconsin. Please do what you can to level the playing field for my company and all Wisconsin foundries.
Rob Peaslee
CEO
Manitowoc Grey Iron Foundry
Celebrating our 170th year serving Wisconsin

ANDRÉ JACQUE
STATE SENATOR • 1ST SENATE DISTRICT

Phone: (608) 266-3512
Fax: (608) 282-3541
Sen.Jacque@legis.wi.gov

State Capitol · P.O. Box 7882
Madison, WI 53707-7882

To: John Dipko, Chair
Wisconsin Worker's Compensation Advisory Council

From: Sen. André Jacque

Date: January 3, 2025

Re: Request PTSD Coverage for All EMS and Fire Personnel

Chair Dipko and Members of the Wisconsin Worker's Compensation Advisory Council,

As the lead author of 2021 Senate Bill 11/Act 29, I would like to thank you again for your past support for providing line-of-duty coverage for Post-Traumatic Stress Disorder (PTSD) for public safety personnel and enshrining these important protections in law for those responding to catastrophic emergencies in their service to our state.

I write to ask for your formal endorsement of the common sense extension of this protection to emergency medical service practitioners and fire fighters, regardless of their level of employment or volunteer status. I appreciate that correction of this oversight was included in one of the WCAC's agreed-upon bills from last session (2024 Senate Bill 992/Assembly Bill 1074), and would ask that it be allowed to move forward as both a standalone bill in addition to being considered for inclusion in an omnibus package.

There are countless reminders in our society of our need for protectors - the ones who willingly put themselves in harm's way and answer the call when lives are on the line. Whether on our daily commute or elsewhere about the community, or even just through a news broadcast, we are bombarded almost daily with situations none of us would EVER want to face with our friends and families, times where we take a moment and say a silent prayer for those affected, including our first responders. This sadly includes several recent incidents throughout our state and country, and I hear often of the trauma experienced by those responding to such calls and thank God that there are those still willing to bring incredible skill and care whenever called upon in the worst of circumstances.

As you recall, the Wisconsin Legislature enacted 2021 Act 29 with overwhelming bi-partisan support to remove the "greater dimensions" test from being utilized to effectively block Post-Traumatic Stress Disorder (PTSD) recovery support for law enforcement and full-time firefighters. Essentially, these brave men and women were being punished based on the traumatic and harrowing nature of what they see and hear every day on the job protecting our communities.

This legislation was a critical step toward eliminating the basic injustice of the greater dimensions test and continuing the work I began years ago in authoring legislation to ensure this essential treatment is available to all first responders. It made no sense for state worker's compensation law to essentially castigate someone for choosing an occupation where they must routinely rush toward, rather than away from, danger. Those who put their lives on the line to

protect us are true heroes, and they deserve all the support we can give them. But now that this avenue for treatment is open to some of our first responders, more work needs to be done to fairly address the needs of all first responders and workers within the law enforcement community. Extending PTSD coverage in Wisconsin has already seen utilization without significant financial impact, and is expected to aid significantly in improved workforce retention and mental resiliency.

Later that session, my colleagues and I introduced legislation to expand 2021 Act 29 to make PTSD coverage also available to our emergency medical service practitioners, dispatchers, corrections officers, medical examiners, coroners, and volunteer firefighters, as many other states have already done, and as 2021 Senate Bill 681 it passed both the Senate Labor and Regulatory Reform Committee (5-0) and the full State Senate (32-0) unanimously. I am pleased to be joined by many first responders that have continued their engagement with the WCAC in urging this issue to be addressed.

We know PTSD can be treated effectively, and allow these heroic men and women to return to protecting and serving the public. It is critical that those we have depended on as first responders who are affected by PTSD have access to treatment and the support they need to recover, both for their own health and the benefit of the communities they serve. Again, I ask for your blessing that this critical coverage be provided to our emergency medical service practitioners and volunteer firefighters as the next step toward expanding this coverage to all first responders. Over 75 percent of EMS and fire departments rely on volunteers to serve their community and that percentage is higher when there is a combination of full-time, paid-on-call, or volunteer members. Regardless, all the men and women who serve provide the same emergency care and response as their EMS-firefighter affiliated contemporaries.

Thank you for your consideration of my request, and I would be happy to address the council on this topic again at a future WCAC meeting or at any time on my cellphone at 920-819-8066.

Sincerely,

State Senator André Jacque
1st Senate District

Northwestern Municipal EMS, Inc.
150 Snow Street
Amery, WI 54001
(715) 268-8698 office (715)268-2121 Fax
NorthwesternEMS@proton.me
www.ameryareaems.com

Nicole Gullickson, NRP, CCEMT-P
EMS Director

January 6, 2025

RE: Council Support for PTSD Coverage for EMS and Fire

Dear Council,

I have worked in EMS for the past 26 years. Our department has consistently advocated for us by setting up Critical Incident Stress Management (CISM) following stressful calls. These sessions are provided by volunteer EMS, Fire, Police, and chaplains from our communities. They remind us that the critical incidents we see and experience are not everyday events. We are also reminded to care for ourselves and give ourselves grace as we process and heal.

This support has carried me personally through for the past 24 years. However, starting about 18 months, over about 1 year, I experienced some very tragic events. I provided care to a 1-month-old girl in cardiac arrest; I responded to two head-on collisions, a few miles apart from each other, which resulted in two fatalities each. My year continued with a very traumatic death from a partially ejected 19-year-old boy from a high-speed crash, and the last straw for me was providing CPR on a newborn, born at home without a pulse.

I consider myself very resilient; however, about three months ago, I had to ask for help. The CISMs were not enough. I was not able to sleep at night, and when I did sleep, I would experience nightmares. The nightmares would resemble some of the calls I responded to. I would start to experience anxiety anytime I had to go to work or think about going to work. I could only relax for the first day or two of family vacations. As soon as I realized the week was quickly approaching and I would have to go to work, the anxiety would kick in, and the rest of the trip would be a blur. It is challenging for first responders to ask for help because we are seen as the caretakers of everyone else. As a leader, I am afraid of losing respect by showing weakness.

I am fortunate enough to have decent health insurance. However, many of my coworkers do not have health insurance, mainly because it is not affordable. As an EMS Director, I understand this is a double-edged sword. Small, rural departments like ours already struggle for staff, so losing people for mental health is detrimental to our service. We also pay a lot of money for Worker's Compensation every year, and part of our vast staffing issue is not having money to compete with more significant nearby services. So, the likelihood of our workers' compensation rates increasing more if this bill passes is likely, causing the service to struggle monetarily. I would like our staff to know they are taken care of and can seek help if they need it and not lose great providers to mental health crises or, worse, to suicide.

Northwestern Municipal EMS, Inc.
150 Snow Street
Amery, WI 54001
(715) 268-8698 office (715)268-2121 Fax
NorthwesternEMS@proton.me
www.ameryareaems.com

Nicole Gullickson, NRP, CCEMT-P
EMS Director

As an EMS/ Fire Professional in Wisconsin, I urge the Workers Compensation Advisory Council to extend worker's compensation coverage for post-traumatic stress disorder (PTSD) to all emergency medical services (EMS) practitioners and firefighters, including volunteers. We face the same risks and mental health challenges as our full-time counterparts (police and career firefighters) but are excluded from current protections. Studies show EMS professionals are significantly more likely to experience PTSD compared to other first responders. Extending this coverage is a matter of acknowledgment and fairness of their critical role in protecting our communities. If we lose additional providers to mental health challenges, this further increases the staffing crisis that affects the ability of EMS to respond to 911 medical emergencies. Please ensure that all EMS personnel receive the support they need.

I am a member of the Wisconsin EMS Association (WEMSA) and support their advocacy efforts on this issue. It is a unified issue across Wisconsin that needs the Council's support.

Thank you for considering this important issue.

Sincerely,

Nicole L. Gullickson

Nicole L. Gullickson

-----Original Message-----
From: Bur <bur@nationalrivet.com>
Sent: Tuesday, January 7, 2025 3:01 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Work Comp Advisory Concil

John Dipko,

I am writing to share my concerns with the costs of Workmans Compensation insurance in Wisconsin. My Company is a 96 year, old 5 generation family owned, manufacturer of precision fasteners, in Waupun, WI. In recent years, inflation has impacted many areas of our business, but nowhere has it been as significant as in workers compensation costs. Medical providers seem to view WC claims as highly desirable, because there are no deductibles to worry about and there's no concern about unpaid bills. It would seem that this should give the WC system a very beneficial negotiating platform for rates, but alas, that opportunity seems to be left behind, with drastically rising costs falling to business owners.

I strongly encourage any and all efforts to gain control of runaway WC costs in Wisconsin.

Sincerely,

Bur Zeratsky
President
National Rivet
Waupun, WI

From: George Forish <GeorgeF@precisionpattern.net>
Sent: Tuesday, January 7, 2025 3:11 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Wisconsin Medical Fee Schedules for Worker's Compensation

TO: Mr. John Dipko, Chair, WCAC

RE: Worker's Compensation Fee Schedule

Dear Mr. Dipko,

I am writing to you to advocate for the inclusion of a Medical Fee Schedule in the Wisconsin Worker's Compensation system.

Anyone who utilizes the health care system here in Wisconsin will likely tell you that the "list" prices paid for health care procedures are almost beyond belief, especially when compared to the negotiated prices paid by the insurance companies and by Medicare. Yet, we are paying these "list" prices for care if it happens that the injury was caused at ones workplace.

I urge you to finally include provisions in the law to allow our worker's compensation insurance companies to negotiate prices for health care services provided to injured workers.

Thank you.

Regards,

George Forish, VP
Precision Pattern Co., Inc.
1601 Airport Road, Suite 100
Waukesha, WI 53188-2460
414-541-5911 X102

Healthesystems
Transforming healthcare.

January 9, 2025

John Dipko, Chair
Workers' Compensation Advisory Council
201 E Washington Avenue
Madison, WI 53703
WCAdvisoryCouncil@dwd.wisconsin.gov

RE: Recommended Statute Changes | Workers' Compensation Act

Dear Mr. Dipko,

Healthesystems appreciates the opportunity to submit comments for the upcoming agreed bill. To support the Workers' Compensation Advisory Council (WCAC), we are submitting feedback on key cost drivers in the workers' compensation system. Our comments focus on cost-containment strategies for opioids, physician dispensing, reimbursement for repackaged drugs, compounded medications, co-packaged drug kits, and durable medical supplies.

Opioids

Opioid prescribing has declined over the past decade due to effective policies, prevention, and education. However, opioid dependency and addiction remain a public health threat, often leading to overdose and death. [1]Research shows long-term opioid treatment for chronic pain is generally ineffective and poses significant risks, such as addiction, overdose, and other serious side effects, with limited evidence supporting its long-term benefits. We recommend reserving opioids for short-term use during the acute phase after severe injury or surgery, at the lowest effective dose, while prioritizing alternative treatments for chronic pain. For these reasons, we support the opioid prescribing guidelines proposed by WCAC Labor:

- **Limits physician-dispensed opioids to a 7-day supply per claim.** Opioids dispensed beyond this limit should be deemed unnecessary treatment under 102.16(2m).
- **Encourage adherence to the Wisconsin Medical Board Guidelines** for opioid prescribing.
- **Educate injured workers on alternative therapies** for chronic pain to supplement or replace opioids.
- **Provides guidance on discontinuing opioid medications** following an IME recommendation that opioids are no longer necessary.

Physician Dispensing

To improve medication safety, we urge adopting policies to limit physician dispensing, especially for opioids. Unlike pharmacies, physician dispensing lacks safeguards like pharmacist oversight and system-integrated checks for drug interactions, duplications, and refill monitoring, which are critical for preventing misuse.

To address these concerns, we propose the following policies for physician-dispensed medications:

- **Limit the physician-dispensed medications** to a 7-day supply during the initial visit and within the first 10 days following a work-related injury.
- **Require prior authorization for physician-dispensed medications** in outpatient settings.

[1] CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR

Repackaged Drugs
Repackaged drugs continue to present challenges due to inflated pricing practices. These drugs, altered from their original packaging and assigned new National Drug Codes (NDCs) with marked-up Average Wholesale Prices (AWPs), drive up costs without added value. To address this, we recommend adopting the following language, similar to that proposed in the 2014 WC Agreed Bill (AB-711):

- Reimbursement should be tied to the AWP of the original manufacturer's NDC.
- If the original NDC cannot be determined, reimbursement should be based on the lowest-priced therapeutic equivalent drug.

Compounds and Co-Packaged Drug Kits
Compounded medications and co-packaged drug kits often add significant costs without proven medical benefit. Compounded drugs lack FDA approval, while co-packaged kits such as a $120 diclofenac paired with a $20 capsaicin cream, can cost as high as $3,600. To address this, we recommend:

- Requiring preauthorization for compounded drugs and co-packaged kits.
- Limiting reimbursement to rates established under §102.425(3)(a), based on the original National Drug Code (NDC).
- Exclude reimbursement for incidental items such as gloves or gauze.

Prescription Drug Pricing Source
We recommend updating §102.425 to include Medi-Span, alongside Red Book, as an authorized Average Wholesale Price (AWP) source. Medi-Span, widely utilized in pharmacy and PBM systems, offers advanced tools for drug classifications, utilization management, and a proprietary generic product indicator that supports standardization and substitutions required under §102.425(2)(a). Recognizing both sources ensures consistent pricing and enhances support for pharmacists and payers.

Durable Medical Equipment Supplies
Durable Medical Equipment (DME) plays a critical role in the recovery of injured workers by enhancing mobility and managing injuries. However, the automatic shipping and billing of unused DME supplies has become a growing concern in many states. This practice results in unnecessary costs to the system and leaves injured workers with excessive supplies they don't need, leading to confusion and frustration on what to do with them. To address this issue and reduce waste, we strongly urge the council to consider prohibiting auto-shipping of DME related supplies and include the following language as new section of the Act:

- The auto-shipping of monthly DME supplies is prohibited. An affirmative request from the injured worker or prescribing provider is required.

We sincerely appreciate the opportunity to submit our recommendations for changes to the Workers' Compensation Act. We fully support the agreed bill process and commend the council's ongoing commitment to maintaining a fair and balanced system that serves the best interests of injured workers, employers, and the stakeholders who play a vital role in delivering benefits to those workers.

Sincerely,

Tiffany Grzybowski

Tiffany Grzybowski
Analyst, Advocacy and Compliance

From: chrisk <chrisk@wistateff.org>
Sent: Thursday, January 9, 2025 10:13 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Comments from WI State FF Association

To Whom It May Concern;

The WI State Fire Fighters Association (WSFA) would like to register comments on allowing Post Traumatic Stress Disorder coverage for volunteer firefighters, emergency medical personnel, and first responders. Attached are the WSFA comments on the issue. Thanks for your consideration on this important matter.

Respectfully,

Chris Klahn

President, WSFA

(609) 297-7599

Position Paper

Wisconsin State Firefighters Association

Issue

Changing the conditions of liability for worker's compensation benefits for volunteer fire fighters, emergency medical responders and emergency medical services practitioners who are diagnosed with post-traumatic stress disorder (PTSD).

Position

The Wisconsin State Firefighters Association (WSFA) **supports** this change in the worker's compensation benefits. The WSFA is comprised of 10,000 primarily volunteer firefighters from across Wisconsin, bound by public service to providing emergency fire, rescue and emergency medical services to our communities.

The adoption of this change was enacted last year for career, fulltime firefighters but NOT for volunteer firefighters or emergency medical responders.

Ninety five percent of fire service providers are all volunteer or mostly volunteer. These first responders are the spines of smaller communities in Wisconsin. They live, work and are integral part of their communities. The tentacles of living in a small community extends relationships through employment, school, sports and church to name a few.

First responders in smaller communities routinely answer calls where the victims are known to them directly or indirectly. These traumatic situations can cause intensive mental stress and lead to PTSD for some responders. PTSD causes adverse mental health consequences for these responders. This change eases liability standards in the Worker's Compensation System and expands the opportunities for these first responders to gain professional mental health assistance. This assistance is vital for the members of the WSFA and for all first responders and emergency workers in the state.

Some other facts to consider:

- Reported mental health issues for firefighters are at an all-time high.
- Firefighters are more likely to die of suicide than in the line of duty.
- Volunteer firefighters face additional stressors:
  - Full time jobs away from fire department
  - Fire department meetings/trainings schedule
  - Work/Fire balance
  - Family schedule
  - 24/7 call responses
  - Time commitments/conflicts
- Some volunteer firefighters may not have mental health coverage from any other source than worker's compensation.

In summary; the proposed change to the conditions of liability for worker's compensation benefits for volunteer fire fighters, emergency medical responders and emergency medical services practitioners who are diagnosed with post-traumatic stress disorder (PTSD) is needed in Wisconsin. It is a benefit to the individual first responders, a benefit to the communities they serve and a benefit to the citizens of Wisconsin.

WIA
Wisconsin Insurance Alliance
44 East Mifflin Street • Suite 901
Madison, Wisconsin 53703
(608) 255-1749
www.wisinsalliance.com

January 10, 2025

John Dipko, Administrator
Worker's Compensation Division
201 E. Washington Avenue
Madison, WI 53702

Dear Mr. Dipko:

The Wisconsin Insurance Alliance (WIA) is a state trade association of property and casualty insurance companies. Our membership ranges from some of the largest property and casualty insurers in the country to some of the smaller Wisconsin insurance companies.

In preparation for the 2025-26 legislative session, we present the following items to be considered by the Worker's Compensation Advisory Council:

- As has been the case for the past two decades, total medical costs continue to be a challenge in what is arguably one of the nation's best worker's compensation systems and markets. The council has in the past approved medical cost containment measures, only to have the state legislature reject those important and meaningful reforms. The council must continue its advocacy to balance the system between injured workers and employers by addressing this very important issue.

- Propose a change to the language in 102.44(4M) highlighted:

  (a) The department shall promulgate rules establishing minimum permanent disability ratings for amputation levels, losses of motion, sensory losses, and surgical procedures resulting from injuries for which permanent partial disability is claimed under sub. (3) or (4). ~~At least once every 8 years t~~ The department shall review and revise those minimum permanent disability ratings at the direction of the Workers Compensation Advisory Council as necessary to reflect advances in the science of medicine. Before the department may revise those ratings, the department shall appoint a medical advisory committee under s. 227.13, composed of physicians practicing in one or more areas of specialization or treating disciplines within the medical profession, to review and recommend revision of those ratings, based on typical loss of function, to the department and the council on worker's compensation.

- Amend Permanent and Total Disability payments by setting a limitation to the number of weeks or set a presumptive age of retirement, such as ending eligibility at "old age" social security.

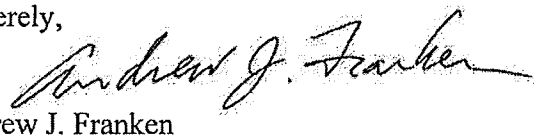
- Use the AMA guidelines for permanency, which are periodically updated and are managed on a much broader scale and currently used by 40 states.

- Disputing parties that agree to a full and final settlement should not be restricted from achieving such resolution by the Department. There seems to be an unwritten authority threshold, of a dispute needing to exceed 100 weeks in order to achieve approval for a full and final settlement. Again, there does not seem to be any statutory threshold or conference for such authority. Should the Council feel that a threshold is needed in this respect, the Council should act to ensure that such language is codified into the statute and conferred to the Department.

- Adopt appropriate utilization review standards to address consistent outliers in the medical provider community. As an example, Illinois 820 ILCS 305/8.7 provides a workable solution (included).

The Wisconsin Insurance Alliance appreciates the opportunity to submit matters for consideration by the council and we remain committed to WCAC "agreed bill" process to ensure a balanced worker's compensation system.

Sincerely,



Andrew J. Franken
President

§ 8.7. Utilization review programs.

(a) As used in this Section:

"Utilization review" means the evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. The evaluation must be accomplished by means of a system that identifies the utilization of health care services based on standards of care of nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence-based medicine based upon standards as provided in this Act. Utilization techniques may include prospective review, second opinions, concurrent review, discharge planning, peer review, independent medical examinations, and retrospective review (for purposes of this sentence, retrospective review shall be applicable to services rendered on or after July 20, 2005). Nothing in this Section applies to prospective review of necessary first aid or emergency treatment.

(b) No person may conduct a utilization review program for workers' compensation services in this State unless once every 2 years the person registers the utilization review program with the Department of Insurance and certifies compliance with the Workers' Compensation Utilization Management standards or Health Utilization Management Standards of URAC sufficient to achieve URAC accreditation or submits evidence of accreditation by URAC for its Workers' Compensation Utilization Management Standards or Health Utilization Management Standards. Nothing in this Act shall be construed to require an employer or insurer or its subcontractors to become URAC accredited.

(c) In addition, the Director of Insurance may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (b).

(d) This registration shall include submission of all of the following information regarding utilization review program activities:

(1) The name, address, and telephone number of the utilization review programs.

(2) The organization and governing structure of the utilization review programs.

(3) The number of lives for which utilization review is conducted by each utilization review program.

(4) Hours of operation of each utilization review program.

(5) Description of the grievance process for each utilization review program.

(6) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.

(7) Written policies and procedures for protecting confidential information according to applicable State and federal laws for each utilization review program.

(e) A utilization review program shall have written procedures to ensure that patient-specific information obtained during the process of utilization review will be:

(1) kept confidential in accordance with applicable State and federal laws; and

(2) shared only with the employee, the employee's designee, and the employee's health care provider, and those who are authorized by law to receive the information. Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.

Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When making retrospective reviews, utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided.

(f) If the Department of Insurance finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with the requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.

(g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.

(h) The Department of Insurance may by rule establish a registration fee for each person conducting a utilization review program.

(i) Upon receipt of written notice that the employer or the employer's agent or insurer wishes to invoke the utilization review process, the provider of medical, surgical, or hospital services shall submit to the utilization review, following accredited procedural guidelines.

(1) The provider shall make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If the provider fails to make such reasonable efforts, the charges for the treatment or service may not be compensable nor collectible by the provider or claimant from the employer, the employer's agent, or the employee. The reporting obligations of providers shall not be unreasonable or unduly burdensome.

(2) Written notice of utilization review decisions, including the clinical rationale for certification or non-certification and references to applicable standards of care or evidence-based medical guidelines, shall be furnished to the provider and employee.

(3) An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section.

(4) When a payment for medical services has been denied or not authorized by an employer or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review pursuant to subsection (a) is reasonably required to cure or relieve the effects of his or her injury.

(5) The medical professional responsible for review in the final stage of utilization review or appeal must be available in this State for interview or deposition; or must be available for deposition by telephone, video conference, or other remote electronic means. A medical professional who works or resides in this State or outside of this State may comply with this requirement by making himself or herself available for an interview or deposition in person or by making himself or herself available by telephone, video conference, or other remote electronic means. The remote interview or deposition shall be conducted in a fair, open, and cost-effective manner. The expense of interview and the deposition method shall be paid by the employer. The deponent shall be in the presence of the officer administering the oath and recording the deposition, unless otherwise agreed by the parties. Any exhibits or other demonstrative evidence to be presented to the deponent by any party at the deposition shall be provided to the officer administering the oath and all other parties within a reasonable period of time prior to the deposition. Nothing shall prohibit any party from being with the deponent during the deposition, at that party's expense; provided, however, that a party attending a deposition shall give written notice of that party's intention to appear at the deposition to all other parties within a reasonable time prior to the deposition.

An admissible utilization review shall be considered by the Commission, along with all other evidence and in the same manner as all other evidence, and must be addressed along with all other evidence in the determination of the reasonableness and necessity of the medical bills or treatment. Nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment or employee choice of health care provider under Section 8(a) or the rights of employers to medical examinations under Section 12.

(j) When an employer denies payment of or refuses to authorize payment of first aid, medical, surgical, or hospital services under Section 8(a) of this Act, if that denial or refusal to authorize complies with a utilization review program registered under this Section and complies with all other requirements of this Section, then there shall be a rebuttable presumption that the employer shall not be responsible for payment of additional compensation pursuant to Section 19(k) of this Act and if that denial or refusal to authorize does not comply with a utilization review program registered under this Section and does not comply with all other requirements of this Section, then that will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of whether the employer may be responsible for the payment of additional compensation pursuant to Section 19(k) of this Act.

The changes to this Section made by this amendatory Act of the 97th General Assembly apply only to health care services provided or proposed to be provided on or after September 1, 2011.

From: Julie Schatz <julie.schatz@robertsandcrow.com>
Sent: Thursday, January 9, 2025 4:45 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Medical Fee Schedule

I am supporting the initiative to adopt a medical fee schedule for Wisconsin Worker's Compensation Medical Benefits. Any control you can put in place with your medical providers will be a huge win for employers.

As a nationwide consulting Risk Manager, I see first hand the difference in this approach in other geographical areas and Wisconsin is so behind in management of their workers' compensation system it is criminal.

The fact that Wisconsin doesn't allow their employers to negotiate any costs on their workers' compensation coverage beyond their experience modifier is making employers strongly considering moving their labor forces to other states. The rate structure is prohibitive because the medical expenses are out of control.

I hope that you are successful in putting Wisconsin back on the map as a good state in which to have operations!

Julie K. Schatz
Roberts & Crow, Inc.
Risk Management Consultant
214.228.8161
Julie.Schatz@RobertsAndCrow.com

From: Renae Langel <renael@drivemidwest.com>
Sent: Friday, January 10, 2025 9:32 AM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Wisconsin Workers Compensation Health Care Affordability

Dear Members of the Workers Compensation Advisory Council,

I am writing to you on behalf of Midwest Carriers, an employer committed to the health and safety of our employees. We are a growing transportation company that currently employs an average of 165 truck drivers and 35 support staff. As a company that strives to provide the best working environment for our employees, we are also deeply invested in maintaining a sustainable work comp system. While we recognize and appreciate the vital role workers compensation plays in protecting injured workers, I am compelled to express concern over the current state of the system, particularly when it comes to the high cost of unregulated health care.

As you may know the State of Wisconsin has the fifth highest hospital costs in the country and the second highest for medical payments for worker's compensation cases, which is unbelievable. There are already 45 states in our country that have adopted a medical fee schedule for worker's compensation cases, and our company strongly feels that Wisconsin should the next state to set these fee schedules and limit what providers can charge to treat injured workers. If the goal of those at the state level is to build Wisconsin's manufacturing and employment base, work comp health care availability reform would be another positive attribute for our great state.

While we fully support the principle of ensuring injured workers receive the necessary care and treatment they deserve, we believe reforming the current workers' compensation system is essential to Wisconsin employers.

Thank you for your time and consideration.

Renae Langel | Vice President HR & Risk Management | Midwest Carriers
T 920 462 5019

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www.drivemidwest.com

From: Lockwood, Rachel C. <Rachel.Lockwood@waupacafoundry.com>
Sent: Friday, January 10, 2025 1:32 PM
To: DWD MB WC Advisory Council <WCAdvisoryCouncil@dwd.wisconsin.gov>
Subject: Work Comp Medical Fee Schedules

Good Morning!

I was one of the employers that completed the survey and expressed our concerns with work comp fees and the high cost this brings to us as an employer. We have several thoughts related to work comp fees in the State of Wisconsin.

1. We continue to put measures and programs in place to contain our personal health care insurance costs, in the face of rising healthcare costs throughout the State. Our programs are effective, however as we look to raise insurance deductibles to further cost sharing with our employees, drives our employees to file a claim as work comp, rather than through personal insurance (filing false work comp claims) – we particularly see this with chronic musculoskeletal issues. The claim is paid at no cost to them when it goes through work comp then AND we are hit with a double whammy – the cost is even more money to us as a company, than had they left it with their personal insurance because of the lack of a fee schedule.

2. I have worked in healthcare for over 30 years as a Registered Nurse through local healthcare organizations. I have seen first hand how Work Comp is treated in the healthcare setting. Work Comp in the State of WI is seen as the "bread and butter" of their industry. Physician offices will move mountains to see a work-related injury/illness, as these claims pay exceedingly more than personal health injuries/illnesses. Within a healthcare organization there are occupational health offices (specialists that understand work-related injuries and the necessity of returning to work with restrictions), however primary care offices will NOT send patients to the occ health providers (within their very own organization) because the pay is higher for them to see this patient. This model is completely broken! Can you imagine a primary care provider not sending a patient to a cardiologist or oncologist because they wanted the money themselves, when they are clearly not the experts in the care – this would not be acceptable. Lacking a fee schedule and the clear motivation over money, is placing the care at the wrong place and not with the expert.

Putting a fee schedule in place is necessary and way past time to be implemented. A fee schedule is vital to the future of WI businesses, the current model is not sustainable and it is not in the best interest of the injured worker.

Rachel Lockwood, BSN, RN | Health Services & Benefits Manager
Waupaca Foundry, Inc.
1955 Brunner Drive | P.O. Box 249 | Waupaca, WI 54981
715.258.1799 (desk)
715.467.7256 (cell)
Email: rachel.lockwood@waupacafoundry.com / www.waupacafoundry.com

William R. Sachse, Jr.
[redacted]

Feb. 6, 2025

Worker's Compensation Advisory Council
Division of Worker's Compensation
Department of Workforce Development
201 E Washington Ave
P O Box 7901
Madison WI 53707-7901

Dear Members of the Worker's Compensation Advisory Council,

Please accept this as my comments on the proposed amendments to Wis. Adm. Code Sec. DWD 80.32. Specifically, I write to ask that you consider eliminating the provision in subsection (2) that allows for permanent partial disability of an amputated limb at the midpoint of available weeks between one joint and another most distal to it when there is a functional prosthesis. That provision of the rule directly contradicts statutory provisions and is, therefore, prohibited. It is settled law in Wisconsin that an administrative rule may not be inconsistent with statutes.

The issue came to my attention during two mediations I conducted at the end of 2020. Each case involved an amputation distal to the knee joint and proximal to the ankle joint caused by traumatic injuries. In each case, there were claims for unscheduled compensation due to emotional or spinal consequences of the trauma and its residuals. As part of the mediation, I had to put a value on the applicant's best case and the respondent's minimum obligation to determine how much money was at issue. I learned something about the Dept. of Workforce Dept.'s interpretation of Wis. Adm. Code Sec. DWD 80.32(2) that is inconsistent with statute.

In each case, the amputation was amenable to prosthesis and the respondent had provided prostheses. When I calculated the value of the leg amputation I did so at the knee joint. Thus, I ascribed 425 weeks to the amputation. But one of the insurers provided a worksheet from the DWD that calculated the amputation at 337.5 weeks, the precise midpoint between 250 weeks for an ankle amputation and 425 weeks for a knee amputation.

The DWD interprets the rule to say that when there is a functional prosthesis, the rating is at the midpoint between the two nearest joints. If there is no prosthesis, then the rating is at the joint most proximal to the amputation. The language is by no means clear, but that is my understanding of its interpretation and how it was applied in my two cases.

Wis. Stat. Sec. 102.55(1) mandates that an amputation between two joints in the Wis. Stat. Sec. 102.52 schedule be rated at the nearest joint closet to the body. "Loss" and "amputation" in that section mean the total severing of the member. Sec. 102.55(2) makes expands the meaning of "loss" to include complete loss of function, regardless of amputation status, but that is a

supplement to, not replacement for, an amputation or total loss of the member. Wis. Stat. Sec. 102.55(3) allows for "relative disabilities" -- something less than a 100% loss -- but it applies only where the "member is not actually severed." There is no provision for a "functional prosthesis."

Rule 80.32(2), as interpreted by the DWD creates relative disabilities for amputations, which in my view is not permitted under a proper reading of sec. 102.55. In the cases I mediated the member was severed between the ankle and the knee, but the DWD's calculations ignored the command of sec. 102.55(1). Secs. 102.55(2) and 102.55(3) did not apply to those cases because sec. 102.55(1) applied.

I do not see how Wis. Adm. Code Sec. 80.32(2) is consistent with Wis. Stat. Sec. 102.55. The DWD apparently believes this is a "relative disability" -- that is, something less than total loss -- as it awarded the applicants less than 425 weeks for a below knee and above ankle amputation.

The DWD seems to acknowledge that the joint is lost at the knee, but then reduces the weeks from 425 to 337.5 because the amputation was allegedly halfway between the ankle (250 weeks) and the knee (425 weeks). Wis. Stat. Sec. 102.55(1) says that when an amputation occurs between two joints provided in Wis. Stat. Sec. 102.52, the PPD is rated at the joint closest to the body. The DWD has created, through its interpretation of the rule, a "joint" midway between the ankle and the knee. There is no such "joint" in sec. 102.52. Moreover, sec. 102.55(3), which allows compensation for "relative disabilities," specifically says it applies only when "the member is not actually severed." In my opinion, the DWD's application of the law is contrary to statute. A rule must yield to a statute when the terms of the two conflict.

The notion that being amenable to a prosthesis means that an injured person is dealing with less than a total loss of function, while irrelevant under the law, is unrealistic. In both cases I mediated, as well as most that I handled during my four-decade career, the prosthesis was less than desirable. The workers struggled with poor fit, stump ulcers, infections, falls and altered body mechanics causing other orthopedic and psychiatric problems. The workers rarely wore the prosthesis during the entire day, often having to turn to wheelchairs or elaborate crutches. The current schedule is already woefully inadequate compensation for a person who has lost a limb. The DWD's rule does further harm to that person. The Legislature, in its wisdom, has prescribed by statute the compensation for an amputation. That prescription cannot be eroded by administrative fiat.

I urge the WCAC to remove language from Wis. Adm. Code Sec. DWD 80.32(2) that allows for compensation "[e]quivalent to amputation at the midpoint" for amputated or lost "upper or lower extremities . . . [a]t functional level."

Thank you for considering my position.

Very truly yours,

William R. Sachse, Jr.