WORKERS' COMPENSATION

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INTRODUCTION

Following the lead of many other states, West Virginia adopted its first workers' compensation statutes in 1913. Prior to this enactment, the only means for injured workers to get compensation for lost wages and medical bills was by suing the employer in negligence. Few injured workers had financial resources available to bring a lawsuit. Employers could avoid liability with such defenses as assumption of risk, contributory negligence, and the fellow servant rule.

Workers' compensation provided a system in which employers agreed to pay lost wages and medical bills for injured employees regardless of fault, and the injured employees, in turn, gave up their right to sue. "The Act [wa]s designed to compensate injured workers as speedily and expeditiously as possible in order that injured workers and those who depend upon them for support sh[ould] not be left destitute during a period of disability. The benefits of this system accrue[d] both to the employer, who [wa]s relieved from common-law tort liability for negligently inflicted injuries, and to the employee, who [wa]s assured prompt payment of benefits." *Meadows v. Lewis*, 172 W. Va. 457, 469, 307 S.E.2d 625, 638 (1983).

From its earliest inception, workers' compensation in West Virginia was a state-run system. In 2003, the legislature eliminated the Workers' Compensation Division of the Bureau of Employment Programs, and reconstituted it as the Workers' Compensation Commission ("WCC"), tasked with evaluating the viability of privatizing workers' compensation in the state. In turn, the WCC was eliminated in 2005, with regulation of the workers' compensation system transferred to the Office of the Insurance Commissioner. The legislature transitioned the system from a wholly public system, to a combination public/private system, with a single private insurance carrier, to a system made up of over 270 private workers' compensation insurance carriers.

The following materials are roughly divided into three sections: The first section deals with procedures, coverage, and other general matters. The second section presents the statutory and case law authority controlling claim decisions. The third section provides sample forms used in

the processing of workers' compensation claims and litigation. It is not intended that this cover all nuances of WV Workers' Compensation law; it merely provides an overview of basic principles. Claims with a date of injury prior to July 1, 2005 are now considered "Old Fund" claims, administered by the Office of the Insurance Commissioner, through a third-party administrator. While many of these claims linger, this volume is written presuming that a new attorney would be handling claims with dates of injury after July 1, 2005.

The statutes governing workers' compensation, which provides medical and financial benefits to workers injured "in the course of" and "resulting from" their work, are found in W.Va. Code § 23-1-1, *et. seq*. For traumatic injuries, there also must have been an "isolated fortuitous event" which gave rise to the injury. An "injury" includes traumatic or repetitive motion injuries, as well as diseases caused by certain employment conditions (i.e. hearing loss, or dust-related lung diseases). It should be noted that dust-related lung disease claims (Occupational Pneumoconiosis) are covered by slightly different procedural and disability determination rules.

Coverage by employers is generally mandatory. Only employers who employ domestic servants, five or fewer full time agricultural workers, out-of-state workers, or three or fewer employees for less than ten days per quarter are exempt from coverage. In addition, churches, professional sports teams, employers of certain volunteer municipal emergency workers, and federal Longshore and Harbor Workers' Compensation Act eligible are statutorily exempt employers. These employers may opt to provide workers' compensation coverage for their employees, but are not required to do so.

Employers may purchase workers' compensation insurance from among a variety of private carriers. If the employer can demonstrate sufficient fiscal responsibility, it may self-insure. Should the employer not be able to secure insurance through the private market, there is an "Assigned Risk Plan" available. Premium amounts are based upon a percentage of gross wages payroll, and is modified by the risks associated with the type of employment and the safety history of the particular employer. Ratings data are set by the National Council on Compensation Insurance ("NCCI").

Failure to pay premiums subjects the employer to suits for negligently caused injury and deprives the employer of certain common law defenses. Failure to pay may also subject the employer to criminal charges. In addition, the employee of the delinquent employer can still draw workers' compensation benefits.

The immunity from law suit granted to the employer in good standing does not extend to acts of deliberate intention by the employer, as set forth in § 23-4-2(d)(2). The employer must act with such utter disregard for employee safety that severe injury was almost a foregone conclusion. However, insurance against deliberate intent suits is available as separate coverage.

Benefits available to injured workers (claimants) include payment of medical bills, payment of wages for the time when the employee is unable to work due to the injury, compensation for any permanent impairment of the affected body part or total disability, vocational retraining, physical rehabilitation, and/or monthly compensation to surviving dependents of workers killed as a result of employment.

INITIAL APPLICATION/REPORT OF INJURY/CLAIM

Only claimants who apply for benefits may receive benefits. Application is made by completing and submitting to the carrier an "Employees' and Physicians' Report of Injury" (or similarly titled) form. The claimant completes the top part of the form describing how and when he was injured. The attending physician completes the bottom part of the form and describes the nature of the condition, the initially anticipated length of disability, and her opinion as to whether or not the condition was caused by an occupational injury/disease. Within five (5) days after the employer has been notified of the injury (by the employee or the carrier), the employer must complete and submit to the carrier an "Employers' Report of Injury" (or similarly titled) form. In addition to information about the employee and his injury, this form includes wage and lost time information and allows the employer to give reasons to question the claim. Failure by the employer to submit the form in a timely fashion does not deny the claimant benefits.

The law requires workers to report any injury to the employer immediately or as soon thereafter as is practicable. Failure to immediately give notice to the employer of the injury weighs against a finding of compensability in the weighing of the evidence and dilutes the credibility and reliability of the claim. However, failure to make a separate immediate report to the employer is not generally grounds to defeat a claim. Submitting the Report of Injury form to the employer generally suffices as notice to the employer. It is important to remember that notice of an incident

is not the same as notice of an injury, though notice of an injury may be contained in a notice of incident. Not all incidents result in injuries.

There are different statutes of limitations for filing, depending upon the nature of the claim. For traumatic injuries, claims must be filed within six months of the date of injury. Claims for occupational disease other than occupational pneumoconiosis ("OP") must be filed within three years of the date of last harmful occupational exposure, or three years from the date the claimant was told by his physician that he had an occupational disease or should have reasonably known his condition was occupationally related, whichever occurs last. For OP claims, application must be made "within three years from and after the last day of the last continuous period of sixty days or more during which the employee was exposed to the hazards of occupational pneumoconiosis or within three years from and after a diagnosed impairment due to occupational pneumoconiosis was made known to the employee by a physician." Dependents of deceased employees whose deaths were as a result of an occupational injury or disease must file within six months of the date of death for traumatic injuries, one year of the date of death for occupational diseases other than OP, or within two years of the date of death for OP claims.

INITIAL APPROVAL/DENIAL OF CLAIM

Once the application is received by the Claim Administrator (CA) for the carrier or self-insured employee, the CA must decide whether to approve or deny the claim within fifteen (15) working days. See W.Va.C.S.R.85-1-110.1 (2009). This period may be tolled if the carrier needs more information to decide the matter, to allow the CA to investigate. The CA may "conditionally approve" the claim during the investigation, allowing benefits to be paid. Should the CA ultimately deny the claim, the claimant would be responsible for reimbursing the carrier for any benefits paid pursuant to the "conditional approval." The basis for the decision whether to approve or deny the claim is whether or not the injury occurred "in the course of" and "resulting from" the employment.

The initial decision ("order") is sent in writing to the claimant, employer, and any counsel of record. If the order approves the claim, it should list the approved condition(s), including ICD-10 diagnosis codes, as well as any that are not approved. The order should also explain whether or

not temporary disability benefits will be paid. If the order denies the claim, it should give the reason for the rejection, and should list the documents on which the decision was based. Finally, the order must notify the claimant of his/her protest rights. (W.Va. Code § 23-5-1 (2009).

BENEFIT TYPES

Medical Benefits: Medical benefits – sums for health care services, durable medical and other goods and other supplies and medically related items as may be reasonably required – are paid to the injured employee or to medical providers registered with the Offices of the Insurance Commissioner ("OIC"). The maximum amount of benefits is fixed according to a schedule developed by the OIC, or established according to a Managed Care Plan. Charges in excess of the scheduled amounts may not be passed on to the claimant by the provider.

In addition to limiting the fees providers can charge for health care services and supplies, OIC has established treatment guidelines for nearly every type of injury/condition. These are found in "Rule 20," OIC's Exempt Legislative Rule on "Medical Management of Claims, Guidelines for Impairment Evaluations, Evidence, and Ratings and Ranges of Permanent Partial Disability Awards." Treatment outside these guidelines should not be authorized unless the case is special and requires additional treatment beyond the norm. W.Va. C.S.R. 85-20-et.seq (2006)

Many forms of treatment require prior-authorization. Treatment such as inpatient hospital stays subsequent to the date of injury, transfers between hospitals, surgeries, some TENS units and supplies, psychiatric treatment (excluding an initial consultation), outpatient pain management, hearing aids, vision services, physical and vocational rehabilitation, and dental procedures require prior review and authorization before services are rendered and reimbursement made. Although prior authorization may not be required for all treatment, medical services will be reviewed retrospectively to determine medical necessity and relationship to the compensable injury.

Claims may be re-opened for medical treatment. However, if the claimant has gone more than five years without receiving any compensation-covered treatment, no further medical benefits will be paid. It should be noted that OP claims are never closed for medical benefits. See W.Va. Code § 23-4-16 (2005) W.Va. Code § 23-4-8d (2009)

Temporary Total Disability (TTD): TTD benefits are paid to the claimant for the time the injury prevented the claimant from working, from the date of the injury until he returns to work, is released to return to work by the treating physician, or there has been a finding of maximum medical improvement ("MMI"), whichever occurs earliest. No TTD benefits are paid if the period off work is less than four days. The first three days are not paid unless the injury results in at least seven days of lost time. TTD benefits will not be approved for more than 90 days at a time; however, if the claimant continues to be disabled from work, additional periods not to exceed 90 days each may be authorized. In no event is an aggregate TTD award for a single injury to be for a period exceeding 104 weeks. No TTD benefits are available for noise-induced hearing loss or OP claims.

Should TTD benefits continue more than 120 days, the claimant may be sent for an independent medical examination ("IME") to ascertain whether he has reached MMI, or whether continued, additional or different treatment is recommended.

The benefit rate for TTD is 66 2/3% of the worker's average weekly wages ("AWW"), not to exceed 100%, nor be less than 33 1/3%, of the AWW in West Virginia, as established by Workforce West Virginia. The worker's AWW is computed based on the daily rate of pay at the time of the injury or the weekly average derived from the best of the prior four quarters of earnings, whichever is more favorable to the worker.

A carrier can terminate TTD benefits if it receives evidence suggesting that the claimant has reached MMI, has been released to return to work, has returned to work, has taken other work, or is otherwise no longer temporarily and totally disabled. Before TTD benefits can be terminated, the claimant must be given 30 days to rebut the evidence submitted. TTD benefits are suspended during the 30 day rebuttal period.

Permanent Partial Disability (PPD): If, after the claimant has reached MMI, been released to return to work, or returned to work, some permanent impairment of the injured body part remains, the injured worker is entitled to compensation for the percentage of impairment to his physical functioning as compared to his whole-person. Compensation is based on an amount equal to 4 weeks of TTD benefits per each percent of impairment. However, if the claimant has been released to return to work, but the employer will not accept the claimant back, and the

employer has not replaced the claimant with another worker, then the PPD benefits are based on 6 weeks of TTD benefits per each 1% of impairment.

Impairment ratings generally are to be determined by the Range of Motion models in the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fourth Edition," as modified by Rule 20. However, certain impairment percentages are set by statute – such as when impairment is based on the amputation of a body part. "The Guides" also is not used for assessing OP impairment, noise-induced hearing loss, and mental or emotional loss. Although any examination or report not conforming to "The Guides" is not invalid on its face, deviations from "The Guides" affect the weight of the rating as evidence of permanent impairment.

The percentage of permanent impairment may be rated by either the treating physician or an independent medical examiner. An impairment rating by the treating physician for up to 15% PPD is automatically awarded. However, a treating physician's impairment rating for more than 15% is entitled to a second opinion by an independent medical examiner.

If the claim was closed without an impairment rating or PPD award, the claimant must request an impairment rating within five years of the closure. Only two such requests may be filed during that period. If a PPD award was made, any request for a new impairment rating must be made within five years of the date of the initial award, also limited to two such requests.

If, over time, multiple PPD awards are made for the same body part, as a result of subsequent reinjury or other worsening of impairment, any prior award will be deducted from a subsequent PPD award. Cumulative awards for a single body part may not exceed the statutory limits for amputation of that body part. For example, compensation for a loss of a finger, wrist injury, elbow injury, plus shoulder injury may not exceed 60%, the statutory limit for the loss of the entire arm. It should also be noted that impairment that is attributable to a non-work-related condition, such as degenerative conditions or injuries occurring outside of the employment, will not be compensated. Compensation will only be awarded for that portion of impairment fairly attributable to the work-related injury.

Non Awarded Partial (NAP): These are stop-gap benefits paid to the claimant after his TTD benefits have been suspended until the insurer can calculate and award PPD benefits. They are at the same rate as PPD benefits and are an advance payment of the PPD benefits. As such, any NAP benefits paid are deducted from the initial PPD award.

Permanent Total Disability (PTD): If an injury, or combination of injuries, causes a claimant to be permanent1y unable to work, he may be entitled to monthly benefits – at the TTD benefit rate – until age 70. PTD results when the claimant is rendered unable to engage in substantial gainful activity requiring skills or abilities that can be acquired or are comparable to those of gainful activities previously engaged in regularly over a substantial period of time. Although the comparability of pre-disability to post-disability income is not a factor to be considered, the availability of employment within 75 miles of the claimant's home or the distance to his pre-injury employer, whichever is greater, is to be considered.

"The Guides" discusses the distinction between impairment and disability. Impairment, as defined by the World Health Organization, is any loss or abnormality of psychological, physiological, or anatomical structure or function. In "The Guides," impairments are defined as conditions that interfere with an individual's activities of daily living, which include self-care and personal hygiene, eating and preparing food, communication, maintaining one's posture, walking and traveling, caring for the home and personal finances, recreational and social activities, and work activities.

Disability, on the other hand, may be defined as an alteration of an individual's capacity to meet personal, social or occupational demands, or statutory or regulatory requirements, because of an impairment. Disability refers to an activity or task that the individual cannot accomplish, and arises out of the interaction between impairment and external requirements. Disability may be thought of as the gap between what a person can do and what a person needs or wants to do.

An impaired individual is not necessarily disabled. Consider this example: Loss of the distal phalanx of the little finger of the right hand will impair the functioning of the digits and hand of both a concert pianist and a bank president; however, the bank president is less likely to be disabled than the pianist.

The loss of both eyes, both hands, both feet, or one hand and one foot is presumed to be totally disabling for workers' compensation purposes. A rebuttable presumption also exists when aggregate PPD awards total 85% whole-person impairment. However, impairment based on carpel tunnel syndrome ("CTS") is not included in calculating aggregate impairment. A claimant may not even apply for PTD benefits unless he has at least 50% permanent partial disability medical impairment or 35% statutory impairment. Before PTD benefits may be awarded, a

reviewing panel must confirm the 50% whole body or 35% statutory disability threshold impairment level.

The CA must continue to monitor PTD award recipients, and may periodically, after due notice to the claimant, reopen a claim for reevaluation of the continued need for PTD benefits. The CA may require the claimant to provide documentation of financial status, income level, physical activities, and medical condition; to appear under oath and answer questions; and may suspend or terminate PTD benefits if the claimant willfully fails to provide the information or appear as required. The CA also may reopen a claim for reevaluation when, in its sole discretion, it concludes that there exists good cause to believe that the claimant no longer meets the PTD eligibility requirements.

The CA may require the claimant to undergo an IME every year for the first 5 years of a PTD award, or until age 50 to confirm her ongoing permanent total disability. Thereafter, he/she may be required to submit to an IME every 3 years until age 70 when benefits cease.

Vocational and/or Physical Rehabilitation: If it is determined that a disabled employee can be physically and vocationally rehabilitated and returned to remunerative employment by the provision of rehabilitation services, the carrier is to develop and pay for a rehabilitation plan for the employee. It is the goal of rehabilitation to return injured employees to employment which is comparable in work and pay to that which the individual performed prior to the injury. If a return to comparable work is not possible, the goal of rehabilitation is to return the individual to alternative suitable employment, using all possible alternatives of job modification, restructuring, reassignment, and training, so that the individual will return to productivity with his or her employer or, if necessary, with another employer.

The first priority of rehabilitation is to return the claimant to the same employer in his pre-injury job. If that is not possible, the claimant is to be returned to the same employer in his pre-injury job with modifications. If that is not possible, the claimant is to be returned to the same employer in a different position. If that is not possible, the claimant is to be returned to the same employer in a different position with retraining. However, if there is no position with the same employer for which the claimant is qualified or can be made qualified, he is to be returned to a position for which no retraining is required with a new employer. Finally, if none of these options are possible, he is to be placed in a position with a new employer which requires retraining.

During the time that a claimant is not working but participating in an approved rehabilitation plan, he is paid TTD benefits. If the claimant is able to return to work while receiving rehabilitation, but his AWW are less than he was receiving pre-injury, he may receive temporary partial rehabilitation ("TPR") benefits, calculated as 70% of the difference between the AWW of his old and new positions. The claimant may not receive both TTD and TPR benefits at the same time. TPR benefits for any single injury may not exceed 52 weeks unless they are associated with a vocational retraining program, in which case they may be extended for up to 104 weeks. TPR benefits are reviewed every 90 days and adjusted as necessary to reflect changes in the claimant's AWW.

TPR benefits are also available to claimants who have at least 50% medical impairment or 35% statutory impairment, but who have been denied PTD benefits and continue to work in a lesser paying position. In such a case, TPR benefits will be paid for 4 years, in an amount necessary to ensure receipt of 80% of the pre-injury AWW in year 1, 70% of the pre-injury AWW in year 2, 60% of the pre-injury AWW in year 3, and 50% of the pre-injury AWW in year 4.

Dependents' Benefits: When a compensable injury causes death, workers' compensation will pay reasonable funeral expenses as established by OIC to the funeral home or person who advanced payment for funeral expenses.

When a compensable injury causes death, and the period of disability continued from the date of injury until the date of death, dependents may receive the amount of TTD benefits to which the injured worker was entitled, until the dependency ends: for a widow(er) until death or remarriage, for a child until age 18 (or 25 if a full time student), and for an invalid child as long as he remains an invalid. Dependents are jointly entitled to the benefit. If no such dependents exist, wholly dependent parents may receive the benefit until death. Otherwise, other wholly dependent persons (grandparents or invalid siblings) may receive benefits for 6 years.

When a claimant who was receiving PTD benefits dies other than due to the compensable injury, dependents may receive 104 times the weekly PTD rate in a lump sum or in periodic payments. When a claimant is entitled to a PPD award but dies before payment is made in full, dependents are entitled to any unpaid balance owing.

OCCUPATIONAL PNEUMOCONIOSIS CLAIMS

OP claims cover all lung diseases which are caused by inhalation of minute particles of dust. Most common of these are black lung and asbestosis. The procedural and disability determination processes are slightly different than those in traumatic injury claims. When applying for Workers' Compensation benefits in OP claims, the employee, physician, and employer each have a special form. The forms ask for detailed information about exposures, lung/chest illnesses, work history, and other benefits received.

As stated earlier, the statute of limitations for filing a claim for OP is complicated. The application must be filed "within three years from and after the last day of the last continuous period of sixty days or more during which the employee was exposed to the hazards of occupational pneumoconiosis or within three years from and after a diagnosed impairment due to occupational pneumoconiosis was made known to the employee by a physician." There is also a minimum time of exposure threshold for filing. The claimant must have been exposed to the OP dust hazards in the workplace for either two continuous years during the ten years preceding the date of last exposure, or a cumulative total of five years during the last fifteen years preceding date of last exposure. If the claimant was exposed for ten of the previous fifteen years, and he has a chronic respiratory disability, he is presumed to be suffering from work-related OP. This is a rebuttable presumption.

If a claimant has been exposed to OP hazards at multiple employers, only the last may be held accountable. Hence, the last employer for whom the claimant was exposed for as much as 60 days during the period of 3 years immediately preceding the date of last exposure at that employer may be charged entirely regardless of the degree of exposure elsewhere.

After an OP claim is filed, the carrier determines "non-medical" issues, including whether the claim was timely filed, whether exposure thresholds have been met, whether the claimant is entitled to a presumption of OP, and whether and to what extent multiple employers are chargeable. The carrier's order on non-medical issues is protestable to the OOJ for a hearing on the matter. While an ALJ decision dismissing the claim is immediately appealable, an ALJ decision referring the claim to the OP Board is interlocutory and can only be appealed in conjunction with an appeal from a final order with respect to the findings of the OP Board.

Once the application is determined to be appropriately filed, the claim is referred to the OP Board for determination of impairment, if any. The OP Board consists of 5 licensed physicians with special knowledge of pulmonary diseases. At least one member must be a roentgenologist (radiologist). The OP Board may require the claimant to appear for physical examination and testing. The OP Board will conduct a hearing at which all medical evidence will be considered. Upon completion of the hearing, the OP Board prepares a report of its findings and decision for the carrier.

Either party may object to the OP Board's initial findings and conclusions. If so, the members of the OP Board joining in the findings and conclusions appear before the OOJ for a hearing. At the hearing, evidence to support or controvert the findings and conclusions of the OP Board is limited to examination and cross-examination of the members of the board and to the taking of testimony of other qualified physicians and roentgenologists.

If no objections are filed to the OP Board's report, the findings and conclusions of a majority of the OP Board are taken as plenary and conclusive evidence. The carrier may then issue a protestable order setting forth the OP Board's findings as to whether the claimant has OP and if so, the degree of medical impairment, if any. Impairment ratings are set forth in Rule 20. A diagnosis of OP alone is insufficient to entitle a claimant to PPD or PTD benefits.

HEARING LOSS CLAIMS

Occupational hearing loss claims may be caused by either single incidents of trauma or by long-term exposure to "hazardous noise." As noted above, TTD benefits are not available for noise-induced hearing loss. PPD benefits are not available for tinnitus, psychogenic hearing loss, recruitment, or hearing loss above 3,000 hertz. The formulas for computing PPD percentages for monaural and binaural hearing loss are established by statute. Additional PPD may be granted for impairment of speech discrimination, if any.

As with OP, noise-induced hearing loss may be the result of exposure to hazardous noise from multiple employers. However, claim charges are allocated among employers where the claimant was exposed to hazardous noise for as much as 60 days during the three years immediately preceding the date of last exposure. The allocation is based upon the time of exposure

with each employer, considering all the time of employment by each employer during which the claimant was exposed and not just the time within the three year period. This allocation is similar to that in OP claims.

RE-OPENINGS and MODIFICATIONS

Claims may be re-opened for benefits under certain circumstances if the request discloses cause for a further adjustment. Generally speaking, a claim in which the claimant receives ongoing care, will never close for medical treatment, and will therefore never need to be re-opened. However, re-openings for treatment and rehabilitation shall be denied in any claim in which medical treatment or rehabilitation services have not been rendered or durable medical goods or other supplies have not been received for a period of five years. To obtain further treatment or rehabilitation in a claim in which there has been no activity for a while, the claimant or physician need only file a request for authorization of such treatment or rehabilitation. There must be sufficient medical evidence that the current symptoms are a progression or aggravation of the claimant's compensable condition or the request must disclose some other fact or facts not previously considered which would entitle the claimant to greater benefits than already received, or the request will be denied.

Claims may also be re-opened for TTD benefits. This frequently occurs when it is later determined that the compensable condition requires surgery, for which the claimant will need to be off work to recover. Again, there must be sufficient medical evidence that the reason the claimant cannot work is due to a progression or aggravation of the claimant's compensable condition or some other fact or facts not previously considered which would entitle the claimant to greater benefits than already received. Any such re-opening must be requested within five years of claim closing if there was no PPD award or within five years of an initial PPD award. Any decision on the application must be made within thirty days.

When a claimant's condition has progressed or been aggravated to a point that leads to additional permanent impairment, the claim also may be re-opened for purposes of reassessing PPD. The same five year limitations apply. If the re-opening request meets the progression/aggravation or other facts not previously considered standard, the claimant has the

right to a new impairment evaluation. Any further award is not guaranteed, but is dependent on the findings of the IME.

If a claim re-opening results in a further PPD award which places the claimant above the PTD threshold, the claimant may request a PTD assessment. However, if a claimant has already been granted a PTD award, the claim may be re-opened to determine the claimant's continued right to PTD payments. If there is good cause to believe that the claimant no longer meets the eligibility requirements (as stated at the time of the re-opening), the carrier may re-open the claim for reevaluation of the continuing nature of the disability and possible modification of the award. However, the law which was in effect on the claimant's date of injury or date of last exposure, is the law applicable to his eligibility for permanent total disability benefits. The carrier may request such documentation as tax returns, financial records and affidavits demonstrating level of income, recreational activities, work activities, medications used and physicians or other medical or rehabilitation providers treating or prescribing medication or other services for the claimant. The carrier may take evidence, have the claimant evaluated, make findings of fact and conclusions of law and vacate, modify or affirm the original PTD award as the record requires.

While a claimant has the option to request a claim re-opening to obtain additional benefits, the employer has a similar option to seek a modification to suspend, modify, or end benefits. Like claimant's request for re-opening, an employer's request for modification must disclose cause for a further adjustment, and some fact or facts which were not previously considered which would entitle the employer to a modification of the prior award.

THE LITIGATION/APPEAL PROCESS

Generally speaking, the only party who may protest a carrier's decision is the claimant. An employer may protest (1) decisions incorporating findings made by the OP Board, (2) decisions made in Old Fund claims, or (3) decisions entered pursuant to a treating physician's PPD award recommendation.

Appeals of CA decisions go first to the Office of the Insurance Commissioner's Office of Judges ("OOJ"), which is composed of Administrative Law Judges ("ALJs"). Claimants have sixty (60) days within which to file an appeal ("protest") with the OOJ. In addition to the OOJ,

copies of any protest must be sent to the employer and carrier or self-insured employer's claim administrator. An additional 60 days to protest can be obtained when good cause for the delay is shown. Failure to timely file is a jurisdictional bar to litigation. After filing the protest, all evidence, correspondence, and communications about the issue in litigation are with the Office of Judges. Copies of all communications must be sent to the employer and the carrier.

The Office of Judges will acknowledge the filing of a protest and will set a time limit – Acknowledgement and Automatic Time Frame Order ("TFO") – for the filing of all evidence. The deadlines set forth in the TFO vary depending on the matter in issue – from as little as 45 days for a claimant's protest to a treatment decision, to as much as 180 days for the claimant and 360 days for the employer in PTD entitlement cases. Motions for extending the TFO must be filed within ten (10) days before the TFO expires, stating why the extension is needed and how much additional time is requested. Within ten (10) days after the TFO expires, the parties may submit closing arguments. Once all evidence and arguments have been filed, the issue is submitted to an ALJ for decision. The OOJ issues a notice of all the evidence received; if there are mistakes, notify the assigned ALJ immediately. The ALJ will then issue a written decision.

An aggrieved party may appeal the ALJ's decision by filing a Notice of Appeal to the Board of Review ("BOR") within 30 days of the date of receipt of the decision. The BOR will acknowledge the appeal and inform the parties of the briefing schedule – the appellant's brief is due 30 days from receipt of the acknowledgement; the appellee's brief is due 30 days from receipt of the appellant's brief. No new evidence will be accepted. Oral arguments are not required, but are available upon request. *See* W.Va.C.S.R. 102-1-et, seq.

The ALJ's decision may only be reversed, vacated or modified if the substantial rights of the petitioner has been prejudiced based on certain grounds set forth by statute: the ALJ's findings are (1) in violation of statutory provisions; (2) in excess of the statutory authority or jurisdiction of the ALJ; (3) made upon unlawful procedures; (4) affected by other error of law; (5) clearly wrong in view of the reliable, probative and substantial evidence on the whole record; or (6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. The BOR will issue a written decision based on the record from the OOJ, the parties' written briefs, and any oral arguments made.

Any party aggrieved by the BOR's decision may appeal to the Supreme Court of Appeals within 30 days. To perfect the appeal, the appellant/petitioner must file with the Court a docketing

statement, petitioner's brief, and record appendix pursuant to Rule 12 of the Revised Rules of Appellate Procedure. The BOR will not transfer the record to the Court; this is the responsibility of the parties. No new evidence will be considered. Within 30 days of receipt of the appellant/petitioner's brief, the appellee/respondent may file either a respondent's brief or a summary response. The appellee/respondent may also file additional relevant documents from the record not already included in the appellant/petitioner's appendix. However, no cross-assignments of error are permitted. The appellant/petitioner may file a reply brief within 20 days of receipt of the appellee/respondent's brief or summary response.

After all briefs have been filed, the Supreme Court will (1) decide the case on the merits without oral argument; (2) set the case for oral argument and decide the case on the merits; or (3) issue an appropriate order after considering any written and oral arguments made by the parties (e.g. the appeal is premature because it is an appeal from an interlocutory decision, or the appeal is dismissed because the case has been settled.) Cases determined to require oral argument will be placed on either the Rule 19 or Rule 20 docket. Cases set for Rule 19 arguments (limited to ten (10) minutes per side) include, but are not limited to: (1) cases involving assignments of error in the application of settled law; (2) cases claiming an unsustainable exercise of discretion where the law governing that discretion is settled; (3) cases claiming insufficient evidence or a result against the weight of the evidence; (4) cases involving a narrow issue of law; and (5) cases in which a hearing is required by law. Cases suitable for Rule 20 argument (limited to 20 minutes per side) include, but are not limited to: (1) cases involving issues of first impression; (2) cases involving issues of fundamental public importance; (3) cases involving constitutional questions regarding the validity of a statute, municipal ordinance, or court ruling; and (4) cases involving inconsistencies or conflicts among the decisions of lower tribunals. The Supreme Court is the final level of appeal.

While one issue is pending anywhere in the litigation process, the carrier may continue to administer the claim. Each order of the carrier is protestable and multiple issues may, at any time, be at different points in the litigation process. When multiple issues are in litigation, it is important to carefully document for which issue evidence/argument is being submitted. The law permits mediation as an alternative to the litigation process described above.

ALTERNATIVES TO LITIGATION: MEDIATION & SETTLEMENT

Mediation: The parties may agree to mediate a disputed issue rather than proceed through the litigation process described above, or a case may be referred to mediation by the ALJ on his or her own motion, or on the motion of a party. If an issue is ordered to mediation, the OOJ will assign a mediator from a list of qualified mediators maintained by the West Virginia State Bar. The parties may agree that the result of the mediation is binding. Upon entering into mediation, the OOJ will stay further proceedings on that issue.

Mediation is conducted in an informal manner and without regard to the formal rules of evidence and procedure. Decision-making authority remains with the parties; the mediator has no authority to render a judgment on any issue of the dispute. The role of the mediator is to encourage and assist the parties to reach their own mutually acceptable settlement by facilitating communication, helping to clarify issues and interests, identifying what additional information should be collected or exchanged, fostering joint problem-solving, exploring settlement alternatives, and other similar means. The procedures for mediation are extremely flexible, and may be tailored to fit the needs of the parties to a particular dispute. Within ten (10) days after mediation is completed or terminated, the mediator will report the outcome of the mediation. With the consent of the parties, the mediator may identify any pending motions, discovery, or issues which, if resolved, would facilitate the possibility of settlement. In the event of unsuccessful mediation, the OOJ would lift the stay and litigation would proceed.

Settlement: Any and all issues in a claim, at any stage in the administrative or appellate process, and whether or not contested. However, in order for a claimant to settle medical benefits for non-orthopedic occupational disease claim, the claimant shall be represented by an attorney and may be resolved by negotiated settlement between the parties. Except in cases of fraud, no issue that is the subject of an approved settlement agreement may be reopened by any party, including the carrier. The injured worker has five (5) business days to revoke an executed settlement agreement. The Insurance Commissioner may void settlement agreements entered into by an unrepresented injured worker which are determined to be unconscionable pursuant to criteria established by rule of the commissioner.

Any settlement agreement may provide for a lump-sum payment or a structured payment plan, or any combination thereof, or any other basis as the parties may agree. Pursuant to statute, the following will be deducted from any settlement award: amounts owed for child or spousal support, overpayments (unless otherwise agreed by the parties), any award of monetary benefits entered by the OOJ, the BOR or the Supreme Court of Appeals after the date the settlement agreement was signed by the necessary parties to the extent such awards involve the same issues as the settlement, or if the settlement was a full and final settlement of all issues involved in the claim. If the amount of any such award is greater than the agreed upon settlement amount, the claimant's recovery shall be limited to the amount specified in the settlement agreement. If a self-insured employer fails to make an agreed-upon payment, the commission assumes the obligation to make the payments and recovers the amounts paid or to be paid from the self-insured employer and its sureties or guarantors or both as provided by statute.

The terms of a settlement agreement do not constitute an admission against interest by any party. All communications and correspondence between the parties during settlement negotiations are confidential and may not be used against a party if a settlement is not reached.

ATTORNEY FEES

Attorney fees for the representatives of employers/carriers are regulated only by the marketplace. However, attorney fees for claimants' representatives are limited by statute. A claimant's attorney's fee is limited to 20% of any "award" granted. The fee is further limited to no more than 20% of the benefits to be paid during a period of 208 weeks. Any interest on disability or dependent benefits is not considered part of an award in determining any such attorney's fee. In 2009, the West Virginia Supreme Court interpreted this limitation on fees to prohibit an attorney from charging a fee based upon the settlement of medical benefits. The Legislature quickly enacted an additional subsection providing that on a final settlement, an attorney may charge a fee limited to 20% of the total value of the medical and indemnity benefits. When combined with any fees previously charged or received by the attorney for PPD or PTD benefits, the total fees are not to exceed 20% of an award of benefits to be paid during a period of 208 weeks.

Because of the nature of compensation claims and litigation concerning claims, multiple awards may be made to a claimant during the history of a single claim. The 208 weeks limitation

is not cumulative for each claim, but for each award in a claim; thus, if any single award covers more than 208 weeks, both retroactively and prospectively, the 208 weeks limit is enforced. Syl. pt. 6, *Hinerman v. Levin*, 172 W. Va. 777, 310 S.E.2d 843 (1983) ("West Virginia Code 23-5-5 [1973] [now W. Va. Code § 23-5-16] requires that an attorney's fee for representing a client in a single workers' compensation claim shall not exceed twenty percent (20%) of the claimant's recovery during a period of two hundred eight weeks even if the attorney's fee comes from two separate sources and results from two separate contractual agreements. This limitation applies to the litigation of one claim up to the rendition of a final order, but does not apply to new claims, such as reopenings, that may be related to the first claim but involve the full litigation of a new case. If a separate award is given to the claimant, the attorney may receive the agreed additional payment for his services on this new claim up to the statutory limit.").

In assessing attorney fees incurred in reversing an unreasonable denial of an authorization of medical benefits, the fees are calculated at a rate of $110 per hour worked through a final decision by the Office of Judges, up to a maximum of $1,500. The attorney may also be paid $110 per hour worked for any appellate work at the Board of Review and West Virginia Supreme Court of Appeals, up to a maximum additional $1,500. Attorney's fees are payable only upon the conclusion of all litigation and appeals if the denial decision has been reversed and if the Office of Judges has determined that the denial decision is unreasonable. The hours worked begin to accrue upon the injured workers' receipt of the denial of medical authorization.

In 2003, the Legislature amended W.Va. Code § 23-5-16 which provides for attorney fees to be paid, to claimant counsel when claimant successfully prevails in a proceeding related to a denial of medical benefits by a private carrier or self-insurer. *See also* W.Va. C.S.R. 85-12-et. seq. (2003).

II. WV WORKERS' COMPENSATION CASE LAW

WHICH STATUTE APPLIES?

"When an employee, who has been injured in the course of and as a result of his/her employment, applies for workers' compensation benefits in the form of a permanent total disability (PTD) award, the employee's application for such compensation is governed by the statutory, regulatory, and common law as it existed on the date of the employee's injury or last exposure when there is no definite expression of legislative intent defining the law by which the employee's application should be governed." Syl. Pt. 8, *State ex rel. ACF Indus. v. Vieweg*, 204 W.Va. 525, 514 S.E.2d 176 (1999).

"Once an award has been made, the claimant or the claimant's dependents are entitled to the benefit of all statutory amendments which become effective while the claim is pending." Syl. Pt. 1, *Cole v. State Workmen's Comp. Com'r*, 166 W. Va. 294, 273 S.E.2d 586 (1980).

"A procedural modification of the Workmen's Compensation Law is beneficially applicable to all claims pending in litigation on the date the statute becomes effective." Syl. Pt. 2, *Cole v. State Workmen's Comp. Com'r*, 166 W. Va. 294, 273 S.E.2d 586 (1980).

"The workmen's compensation statutes in effect on the date of death of an injured employee control the death claims of the employee's dependents." Syl. Pt. 3, *Hubbard v. SWCC & Pageton Coal Co.*, 170 W. Va. 572, 295 S.E.2d 659 (1981).

"It is an accepted rule of statutory construction that where a particular section of a statute relates specifically to a particular matter, that section prevails over another section referring to such matter only incidentally." *Cropp v. State Workmen's Comp. Com'r*, 160 W. Va. 621, 626, 236 S.E.2d 480, 484 (1977) (citing *Kelley & Moyers v. Bowman*, 68 W.Va. 49, 69 S.E. 456 (1910)).

COVERAGE

"An employee injured in another state in the course of and resulting from his employment is entitled to seek workers' compensation benefits in West Virginia, where the employee's employment in the other state is temporary or transitory in nature." Syl. *Fausnet v. State Workers' Compensation Comm'r*, 327 S.E.2d 470 (W.Va. 1985).

If the worker is injured in West Virginia and the employer is a foreign corporation or business, five factors must be considered in assessing whether the worker is covered: (1) whether the employer obtained authorization to do business in West Virginia; (2) whether the employer operated a business or plant or maintained an office in West Virginia; (3) whether the injured employee was hired in West Virginia; (4) whether the employer regularly hired other West Virginia residents to do work at a West Virginia facility or office; and (5) whether the employee in question worked on a regular basis at a West Virginia facility for the employer prior to the injury. *Van Camp v. Olen Burrage Trucking, Inc.*, 184 401 S.E.2d 913 (W.Va. 1991).

"[T]he workers' compensation scheme of another state is the exclusive remedy against the employer for a non-resident employee who is temporarily employed in this State, if such employee is injured in this State and is covered by the workers' compensation act of the other state." Syl. Pt 3, *Pasquale v. Ohio Power Co.*, 418 S.E.2d 738 (W.Va. 1992).

Employees and employers may agree to be bound by the workers' compensation laws of another state. If the employer complies with the laws of that other state, the employee's exclusive remedy is as provided for in that state's workers' compensation scheme without regard to the state in which the employee was injured or exposed to occupational pneumoconiosis or other occupational disease. W.Va. Code § 23-2-1c (b).

An independent contractor injured while performing his contract is not entitled to payment of Workers' Compensation benefits. *Null v. State Compensation Comm'r*, 35 S.E.2d 359 (W.Va. 1945). However, in West Virginia., there is a presumption that a worker is a covered employee. *Myers v. Workers' Compensation Commissioner*, 148 S.E.2d 664 (W. Va. 1966). "If the right to control or supervise the work in question is retained by the person for whom the work is being done, the person doing the work is an employee and not an independent contractor, and the determining factor in connection with this matter is not the use of such right of control or supervision but the existence thereof in the person for whom the work is being done." Syl. Pt 2, *Spencer v. Travelers Insurance Company*, 133 S.E.2d 735 (W.Va. 1963). The burden is on the employer to show that an injured worker is an independent contractor rather than an employee. *Null*, *supra*.

Political subdivisions of the state may elect NOT to cover elected officials. Certain business entities also may elect NOT to cover the members of a partnership, the owner of a sole proprietorship, corporate officers, or members of the board of directors of a corporation or

association. W.Va. Code § 23-2-1(g)(1), (2). "[U]niformed members of the West Virginia Division of Public Safety, who are covered under the Death, Disability and Retirement Fund, are not eligible for coverage under the Workers' Compensation System." *Beckley v. Kirk*, 455 S.E.2d 817, 818 (W.Va. 1995).

Workers' compensation benefits cannot be waived. W. Va. Code § 23-2-7. The benefits are imposed by the police power of the State and are not contractual. *Lester v. State Workers' Comp Comm'r*, 242 S.E.2d 450 (W.Va. 1978).

"The right to workmen's compensation benefits is created wholly by statute. Under the workmen's compensation statutes of this state, a claimant has a right to receive benefits and the workmen's compensation commissioner may pay benefits to a claimant only as authorized by statute." Syl. Pt. 1, *Bounds v. State Workmen's Comp. Comm'r*, 153 W.Va. 670, 172 S.E.2d 379 (1970).

"An employer who is otherwise entitled to the immunity provided [statute] may lose that immunity in only one of three ways: (1) by defaulting in payments required by the . . . Act or otherwise failing to be in compliance with the Act; (2) by acting with 'deliberate intention' to cause an employee's injury as set forth in [statute]; or (3) in such other circumstances where the Legislature has by statute expressly provided an employee a private remedy outside the workers' compensation system. Syl. Pt. 2, *Bias v. E. Associated Coal Corp.*, 220 W. Va. 190, 640 S.E.2d 540 (2006).

COMPENSABILITY

Workers' Compensation benefits are paid for injuries received "in the course of" and "resulting from" employment. W.Va. Code § 23-4-1(a). The two phrases, "in the course of" and "resulting from" are not synonymous and both elements must concur in order to make a claim compensable. The statute is in the conjunctive and not the disjunctive. *Damron v. State Compensation Commissioner*, 155 S.E. 119 (W.Va.).

"'[I]t may be stated as a very general proposition that an injury occurs "in the course of" the employment when it takes place within the period of the employment, at a place where the employee reasonably may be in the performance of his duties, and while he is fulfilling those duties or engaged in doing something incidental thereto, or, as sometimes stated, where he is engaged in

the furtherance of the employer's business.'" *Emmel v. State Compensation Director*, 145 S.E.2d 29, 32 (W.Va. 1965) (quoting 58 Am.Jur., Workmen's Compensation, § 212). "In determining whether an injury resulted from claimant's employment, a causal connection between the injury and employment must be shown to have existed." *Id*. at Syl. Pt. 3.

Where an employee voluntarily remains on the premises of his employer after his shift of employment has terminated, an injury received during that time will not warrant a finding that it occurred in the course of or resulting from his employment. *Damron*. "Under normal circumstances, an employee's use of a public highway going to or coming from work is not considered to be in the course of employment. The reasoning underlying this rule is that the employee is being exposed to a risk identical to that of the general public; the risk is not imposed by the employer." Brown v. City of Wheeling, 212 W. Va. 121, 125-26, 569 S.E.2d 197, 201-02 (2002). "An employee is entitled to compensation for an injury sustained in going to or from his work, only where such injury occurs within the zone of his employment, and that zone must be determined by the circumstances of the particular case presented." Syllabus Point 1, *Carper v. Workmen's Compensation Comm'r*, 1 S.E.2d 165 (W.Va. 1939). If an off-the-job activity benefits the employer in some way and an injury results, it is compensable. *Emmel*.

An employee injured during horseplay, "which was engaged in independently of, disconnected with, or disassociated from the performance of any duty of the employment" is not compensable because "such injuries do not result from the employment, within the meaning of such acts, but are in substance and in their nature foreign to the character of the work and are not within any duty of the employee to the employer." *Shapaka v. Compensation Comm'r*, 199 S.E.2d 821 (W.Va. 1961). However, "[a]n innocent victim of horseplay injured during the course of his employment is entitled to Workmen's Compensation benefits for such injury." Syl., *Sizemore v. State Workmen's Comp. Comm'r*, 235 S.E.2d 473 (W.Va. 1977).

Prior to the enactment of W.Va. Code § 23-4-1f, a purely psychiatric claim (a so-called "mental-mental" claim) was compensable if it developed in the course of and resulting from employment. *See Breeden v. Workers' Compensation Commissioner*, 285 S.E.2d 398 (W.Va. 1981). However, with the enactment of § 23-4-1f in 1993, injuries or diseases caused by non-physical means and not resulting in any physical injury or disease are no longer compensable. That statute, providing that mental-mental claims are not compensable, is not retroactively applicable to workers' compensation mental-mental claims filed prior to the statute's effective date,

where the statute affected claimant's substantive right to be considered for benefits. *Conley v. Workers' Compensation Div.*, 483 S.E.2d 542 (W.Va. 1997). Further, an employee who is precluded from receiving workers' compensation benefits for a mental injury without physical manifestation cannot, because of the immunity afforded employers by the Workers' Compensation Act, maintain a common law negligence action against his employer for such injury. *State ex rel. Darling v. McGraw*, 647 S.E.2d 758 (W.Va. 2007).

Suicide may be compensable if "(1) the employee sustained an injury which itself arose in the course of and resulted from covered employment, and (2) without that injury the employee would not have developed a mental disorder of such degree as to impair the employee's normal and rational judgment, and (3) without that mental disorder the employee would not have committed suicide." Syl. Pt. 1, *Hall v. State Workmen's Comp. Comm'r*, 172 W. Va. 87, 88, 303 S.E.2d 726, 726 (1983).

The Workers' Compensation Act specifically excludes benefits for deliberately self-inflicted injuries or injuries caused by intoxication. W.Va. Code § 23-4-2(a).

Workers' Compensation pays for "injuries" incurred in the course of and resulting from the employment. A compensable injury is one incurred by an employee "attributable to a definite, isolated, fortuitous occurrence." *Adams v. G. C. Murphy Co.*, 174 S.E. 794 (W.Va. 1934). But "an isolated, fortuitous occurrence" can also be a course of action (i.e. shoveling coal) over a period of time. *Pennington v. State Workers' Compensation Comm'r*, 222 S.E.2d 579 (W.Va. 1976). The term injury also includes occupational diseases. W.Va. Code § 23-4-1(b).

An occupational disease other than OP is considered to have been incurred in the course of and resulting from the employment "only if it is apparent to the rational mind, upon consideration of all the circumstances: (1) That there is a direct causal connection between the conditions under which work is performed and the occupational disease; (2) that it can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment; (3) that it can be fairly traced to the employment as the proximate cause; (4) that it does not come from a hazard to which workmen would have been equally exposed outside of the employment; (5) that it is incidental to the character of the business and not independent of the relation of employer and employee; and (6) that it appears to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction[.]" W.Va. Code § 23-4-1(f).

"Workmen's Compensation covers only occupational diseases; a disability resulting from the normal diseases of life was not intended to be compensated under our statute." *Mullins v. State Workmen's Comp. Comm'r*, 165 W. Va. 194, 196, 271 S.E.2d 771, 772 (1980).

If studies and research clearly link a disease to a particular hazard of a workplace, a prima facie case of causation arises in a workers' compensation proceeding upon a showing that the claimant was exposed to a hazard and is suffering from the disease to which it is connected. *Casdorph v. W. Va. Office Ins. Comm'r*, 225 W. Va. 358, 690 S.E.2d 102 (2009).

A preexisting infirmity of an employee does not disqualify him from prosecuting a successful claim for compensation based upon a new injury arising from his employment. *Caldwell v. Workmen's Compensation Commissioner*, 144 S.E. 568 (W.Va. 1928). But where there is evidence of a preexisting like injury, his new claim will not be treated as compensable unless it is directly attributable to a definite, isolated and fortuitous occurrence, that is to say, from a definable incident resulting from his employment. Although recognizing that the employer must take the employee as he finds him-with all of his attributes and all of his previous infirmities, it is also axiomatic that the employer, by subscribing to the workmen's compensation fund, does not thereby become the employee's insurer against all ills or injuries which may befall him. *Barnett v. State Workmen's Compensation Comm'r*, 153 W.Va. 796, 172 S.E.2d 698 (1970). When one incurs a disability personal to one's own condition of health, though the disability may occur in the course of employment, it is not compensable. *Martin v. State Compensation Commission*, 149 S.E. 824 (W.Va. 1929).

A diseased workman who in the course of and resulting from employment receives an injury which aggravates or accelerates disease to the extent of causing a disability sooner than would otherwise have occurred is entitled to workers' compensation. *Charlton v. State Workman's Compensation Comm'r*, 160 W. Va. 664, 236 S.E.2d 241 (1977).

It should be noted, that by filing an application for benefits, a claimant agrees that any physicians may release to and orally discuss with the employer, its representatives, or representatives of the insurance carrier, the claimant's medical history and medical reports containing detailed information relevant to the claimant's compensable condition, treatment, prognosis, and anticipated period of disability. W.Va. Code § 23-4-7(b). The statute expressly waives the doctor/patient privilege of confidentiality.

When a claimant files a workers' compensation claim, he consents to the release of written medical reports to adversarial party; however, this consent does not waive the existing fiduciary relationship, thereby permitting *ex parte* oral communication between physician and adversarial party which involves providing confidential information unrelated to written medical reports. *Morris v. Consolidation Coal Co*., 191 W. Va. 426, 466 S.E.2d 846 (1994).

BENEFITS

Workers' Compensation pays for "health care services, rehabilitation services, durable medical and other goods and other supplies and medically related items as may be reasonably required" by the compensable injury or disease. W.Va. Code § 23-4-3. Sections 24 through 53 of Rule 20 (85 C.S.R. 20 *et seq.*) – Medical Management of Claims, Guidelines for Impairment Evaluations, Evidence, and Ratings, and Ranges of Permanent Partial Disability Awards – provides standards of care for many medical conditions that are presumed to be "reasonably required." Treatment outside those guidelines is presumed unreasonable. "A preponderance of evidence, including but not limited to, detailed and documented medical findings, peer reviewed medical studies, and the elimination of causes not directly related to a compensable injury or disease, must be presented to establish that treatments in excess of those provided for in this Rule are medically reasonable." 85 C.S.R. 20-4.1.

A specially fitted automobile can be considered "reasonably required" for a quadriplegic, but the claimant is not entitled to the full cost of the vehicle because he would have owned a vehicle regardless of his injury; the cost of an average, mid-priced automobile of the same year is to be deducted. *Crouch v. Workers' Compensation Commissioner*, 403 S.E.2d 747 (W. Va. 1991).

"One of the basic purposes of workmen's compensation legislation is to impose upon industry the cost of medical expenses incurred in the treatment and rehabilitation of workers who have suffered injuries in the course of and as a result of their employment; and one of those costs, by necessary implication from W. Va. Code, 23-4-3, is payment for transportation expenses necessarily incurred in obtaining medical treatment." Syl. Pt. 2, *Ney v. State Workmen's Comp. Comm'r*, 171 W. Va. 13, 297 S.E.2d 212 (1982).

W. Va. Code § 23-4-3 establishes schedules of maximum disbursements for medical, surgical, dental and hospital treatment. It also provides that carriers may establish Preferred

Provider and Managed Care Plans to provide for fees and other payments which deviate from the schedule set forth in the statute.

W. Va. Code § 23-4-3(a)(3) requires pharmacists to dispense prescriptions of generic drugs rather than brand names unless a generic brand does not exist. A physician may prescribe the use of brand name drugs but must do so using the form in his or her own handwriting to require this. Claimants who elect to receive the brand name drug rather than a generic brand, where the brand name drug has not been indicated, must pay the difference between costs of the generic drug and the brand name drug.

"No person can be forced to undergo a surgical operation [or other medical treatment]. However, a claimant cannot demand compensation . . . for a physical impairment which he permits to continue by reason of his refusal to accept the benefits under the provisions of the law intended to help and rehabilitate him without any expense or unusual risk to him." *Cox v. Workmen's Compensation Commissioner*, 150 W.Va. 412, 414-415, 146 S.E.2d 577, 578 (1966) (citing *Barnes v. State Compensation Commissioner*, 116 W.Va. 9, 178 S.E. 70 (1935)). Such procedures may be required as a condition precedent to further compensation, "only when surgical opinion substantially concurs that the operation is indicated, that it is reasonably safe and not attended by unusual suffering, that it will likely produce material physical improvement and that it is one which a person of ordinary prudence and courage would undergo for his own betterment, regardless of compensation." Syllabus, *Gillam v. Workmen's Compensation Appeal Board*, 118 W.Va. 571, 191 S.E. 204 (1937).

A claimant has a right to select his initial health care provider or provider of rehabilitation services for the treatment of a compensable injury or disease, and if the claimant thereafter wishes to change his provider, and if the employer participates in a program to manage health care costs, then the claimant must choose a provider through the employer's managed care program, and if the claimant thereafter wishes to change his provider, and if the employer does not participate in a managed care program, but the Workers' Compensation Division does participate in a managed care program, then the Division may choose the claimant's new provider through its managed care program. *State ex rel. McKenzie v. Smith*, 212 W.Va. 288, 569 S.E.2d 809 (2002).

RE-OPENINGS/ MODIFICATIONS

"Cause for further adjustment" as required by W.Va. Code §§ 23-5-2 and 5-4, has been defined as nothing more than any evidence which would tend to justify, but not compel, the inference that there has been a progression or aggravation of the former injury. *Harper v. State Workmen's Compensation Commissione*r, 234 S.E.2d 779 (W.Va. 1977). It is a deliberately relaxed standard.

OCCUPATIONAL PNEUMOCONIOSIS

Claimant must have been exposed to "minute particles of dust" in "abnormal" quantities. W.Va. Code § 23-4-1, 23-4-15, *Meadows v. WCC*, 198 S.E.2d 137 (W.Va. 1973).

Exposure must be for two continuous years in West Virginia out of ten immediately preceding the date of last exposure OR five continuous or non-continuous years in West Virginia out of fifteen immediately preceding the date of last exposure. "Continuous" 'is not discounted by weekends, holidays, or brief absences due to illness, injuries or strikes. *Richardson v. SCC*, 74 S.E.2d 258 (W.Va. 1953); *Sluss v. WCC*, 327 S.E.2d 413 (W.Va. 1985).

If the claimant's exposure is questionable, such as a clerical job in an office, the employer or the Commissioner can refer the claimant to the Occupational Pneumoconiosis Board ("OP Board") to determine if the claimant was actually exposed. *Fraga v. SCC*, 23 S.E.2d 641 (W.Va. 1942); W.Va. Code §23-4-8c.

"Once the Commissioner has made the non-medical finding that there is a dust hazard, a pneumoconiosis claimant must be referred to the Occupational Pneumoconiosis Board to determine the question of causation under Code, 23-4-8c(c)(2), as amended." Syl. pt. 2, *Meadows v. State Workmen's Compensation Commissioner*, 157 W.Va. 140, 198 S.E.2d 137 (1973). Thus, even if the claimant's application may be marked "No diagnosis of OP" by the treating physician, the claim must be ruled compensable if he has sufficient exposure and the claim is timely filed. *Godfrey v. SWCC*, 27 S.E.2d 802 (W. Va. 1981).

If a claimant has been exposed at work to the hazards of inhaling minute dust particles for ten of the fifteen years prior to the date of last exposure, it is presumed that any chronic respiratory disability he has is due to his employment. W.Va. Code § 23-4-8c(b).

Mere employment status for the prescribed period does not invoke the presumption; the employment must have caused a risk of exposure. Thus, mere employment at a coal mine does not invoke the presumption if the position did not involve an exposure to coal dust. *Sluss v. WCC*, 174 W.Va. 433, 327 S.E.2d (1985).

There is no requirement that the claimant must have been exposed to the hazards of OP solely within the state of West Virginia to benefit from the statutory presumption. *Zachery v. SWCC*, 162 W.Va. 932, 253 S.E.2d 532 (1979).

This is a rebuttable presumption; an employer may present evidence showing the chronic respiratory disability is not due to the claimant's job. Thus, if the OP Board "cannot make a diagnosis of occupational pneumoconiosis," this finding is sufficient to rebut the non-conclusive presumption . *See Rhodes v. WCD*, 209 W.Va. 8, 543 S.E.2d 289, (W.Va., 2000)

Awards are based on evidence showing the highest degree of impairment unless shown to be unreliable, incorrect or the impairment due to a clearly identifiable other disease or illness. *Javins v. SWCC*, 320 S.E.2d 119 (W.Va. 1984).

If a claimant has sixty (60) additional continuous days of exposure, he has a choice of filing a new claim for OP or filing a re-opening of an earlier claim. *Ford v. State Workmen's Compensation Commissioner*, 236 S.E.2d 234 (W.Va. 1977).

To be awarded dependent benefits when an OP claimant dies, occupational pneumoconiosis must have caused the death or have contributed to the death in a material degree. *Bradford v. WCC*, 408 S.E.2d 213 (W.Va. 1991). The fact that someone had occupational pneumoconiosis at the time of his death is NOT proof that he died because of it.

BURDEN OF PROOF

The claimant has the burden of proving "(1) a personal injury (2) received in the course of employment and (3) resulting from that employment." Syl. Pt. 1, in part, *Barnett v. State Workmen's Compensation Comm'r*, 153 W.Va. 796, 172 S.E.2d 698 (1970).

Any workers' compensation decision is to be made based upon a weighing of all evidence pertaining to the issue and a finding that a preponderance of the evidence supports the chosen manner of resolution.

> The process of weighing evidence shall include, but not be limited to, an assessment of the relevance, credibility, materiality and reliability that the evidence possesses in the context of the issue presented. Under no circumstances will an issue be resolved by allowing certain evidence to be dispositive simply because it is reliable and is most favorable to a party's interests or position. If, after weighing all of the evidence regarding an issue in which a claimant has an interest, there is a finding that an equal amount of evidentiary weight exists favoring conflicting matters for resolution, the resolution that is most consistent with the claimant's position will be adopted.

Wilkinson v. OIC & Putnam County Bd of Educ, [citation] (2008) (quoting 23-4-1g(a)).

"'A claimant in a workmen's compensation case must bear the burden of proving his claim but in doing so it is not necessary to prove to the exclusion of all else the causal connection between the injury and the employment.' Syllabus Point 2, S*owder v. State Workmen's Compensation Commissioner*, 155 W.Va. 889, 189 S.E.2d 674 (1972)." Syllabus Point 1, *Myers v. State Workmen's Compensation Comm'r*, 160 W.Va. 766, 239 S.E.2d 124 (1977).

§ 23-4-1 requires proof of a disease, not merely fear of contracting a disease after exposure to the hazards of that disease. Although this dealt with occupational pneumoconiosis, it is contrary to *Godfrey*, 276 S.E.2d 802 (W.Va. 1981). *Marlin v. Bill Rich Construction*, 482 S.E.2d 620 (W.Va.1996).

A decision of the board is clearly wrong if it is not supported by the evidence of record, is clearly against a preponderance of evidence, or is based upon evidence which is speculative and inadequate to sustain the decision of the Board. *Gibson v. State Compensation Commissioner*, 31 .S.E.2d 555 (W. Va. 1944); *Estep v. State Workers' Compensation Commissioner*, 44 S.E.2d 305 (W. Va. 1947); *Barnett v. State Workers' Compensation Commissioner*, 172 S.E.2d 698 (W.Va. 1970); *Smith v. State Workers' Compensation Commissioner*, 189 S.E.2d 838 (W.Va. 1972).

III. SAMPLE FORMS

Coverage Forms

Workers' Compensation Coverage Application

Application for Exemption from Workers' Compensation Coverage

Application for Exclusion or Reinstatement of Coverage (for officers)

Employee Claim Forms

Employee's & Physician's Report of Occupational Injury or Disease

Employee's & Physician's Report of Occupational Hearing Loss

Hearing Loss Exposure Addendum

Employee's Report of Occupational Pneumoconiosis

Application for PTD Benefits

Claim Re-Opening Application for TTD Benefits

Employer Claim Forms

Employer's Report of Occupational Injury or Disease

Employer's Report of Occupational Pneumoconiosis

Dependent Claim Forms

Application for Fatal Dependents' Benefits

Application for 104 Weeks Dependents' Benefits

Physician Claim Forms

Physician's Report of Occupational Pneumoconiosis

Diagnosis Update

Litigation Forms

Contract of Employment

Request for Order Compelling Carrier to Act upon Claim

Document Submission Form

Request for Award of Claimant's Attorney Fees and Expenses

Petition for Stay of Payment of ALJ Decision

Notice of Appeal to the Board of Review

Workers' Compensation Appeals Docketing Statement

[other helpful info – coverage lookup, brochures, informational letters, etc from IOC website]

west virginia
OFFICE OF THE
INSURANCE
COMMISSIONER

Application for Exemption
from
WV Workers' Compensation Coverage

1124 Smith Street
Charleston, WV 25301

Mail Completed Application To:

WV OFFICES OF THE INSURANCE COMMISSIONER
Employer Coverage Division
PO Box 11682
Charleston, WV 25339-1682

Telephone: 304-558-6279

For Insurance Commission Use Only

Exemption ID #: _____

Effective Date: _____

Reviewed By: _____ Date: _____

ALL QUESTIONS ON THIS APPLICATION MUST BE ANSWERED IN FULL. ADDITIONAL PAGES MAY BE ATTACHED IF A SPACE PROVIDED IS INADEQUATE. THE APPLICATION MUST BE NOTARIZED AND A $25.00 APPLICATION FEE IS REQUIRED OR THE APPLICATION CANNOT BE PROCESSED. IF YOU HAVE ANY QUESTIONS PLEASE CALL 304-558-6279.

With limited exceptions, as set forth more specifically in W. Va. Code § 23-2-1 and W. Va. Code St. R. § 85-8-1, *et. seq.*, workers' compensation coverage is **mandatory** for all employers who employ one or more employees in West Virginia. The Insurance Commissioner will review this application in light of all law in West Virginia relevant to workers' compensation exempt status, and make a decision based upon such law as applies to the information stated herein and any additional information requested. Therefore, it is strongly advised that before submitting an application for exemption, the applicant be familiar with the applicable law as referenced above, and only make application if the applicant or his or her business believes that he or she qualifies for one of the limited exemptions.

SECTION I: BUSINESS INFORMATION

1. **State the Reason(s) for Filing an Exemption Application.** *This must be a reason or reasons supported by one of the specific exemptions as set forth in W. Va. Code § 23-2-1(b)(1) through (8), or stating otherwise that the employer is exempt from West Virginia workers' compensation laws because it does not fall under the purview of W. Va. Code § 23-2-1(a). Within this section, please account for all of the persons or entities that perform work or services in the State of West Virginia on the employer's behalf, but whom the applying employer does not consider to be an "employee" for the purposes of workers' compensation (i.e., the person(s)/entity(s)) is a subcontractor, independent contractor, etc.).*

   Sufficient documentation in support of the claimed exemption should be provided with this application. If the applicant provides coverage in another state, the applicant must attach proof of coverage from that state. Attach an explanation of why you are requesting an exemption. Please provide the number of your employees, or last date on which you or your business had employees.

2. **Legal Name of Business:** _____

   Trading As/Doing Business As: _____

3. **Primary Business Address:** _____
   Not a Post Office Box
   Street

   City *County* *State* *Zip*

   Name of Contact Person *Telephone #* *Fax #*

   Contact Person's Email Address *Cell #*

4. **Mailing Address:** _____
   Street

   City *County* *State* *Zip*

5. **Primary WV Address:** _____
   Not a Post Office Box
   Street

   City *County* *State* *Zip*

STATE OF WEST VIRGINIA
Notice of Election or Rejection of Workers' Compensation Coverage

Pursuant to W. Va. Code §23-2-1(g)-(h) and W. Va. Code St. R. §85-8-6.3., certain owners, corporate officers, corporate members and members of board of directors are permitted to reject coverage under a WV workers' compensation policy.

You are attesting that in your capacity as an owner, officer, or member of a board of directors for the company described below, you are giving your workers' compensation carrier notice to:

☐ Be excluded from workers' compensation coverage on your workers' compensation policy.

☐ Be reinstated for workers' compensation coverage from which you were previously excluded.

Legal Name of Corporation, LLC or Company: _____

Federal Employer Identification Number (FEIN): _____

Business Name (DBA) if different from legal name: _____

Address of Corporation, LLC or Company: _____

Name	Position	Social Security Number	Signature	Date

By signing this document you are at risk of civil and criminal penalties, do hereby attest and swear that you serve in the above described position with _____ and that, to the best of your knowledge, you are entitled to be excluded/included in the West Virginia workers' compensation coverage for your company. If you are electing to be excluded from coverage, you understand that in the event you are injured or contract an occupational disease while working for the above stated company, you will not receive any benefits from the company's workers' compensation policy.

Please attach documentation such as a corporate secretary of state filing, certified board meeting minutes, etc. evidencing that you serve in the above described position with the company. The West Virginia workers' compensation carrier has sole discretion to accept such documentation or require additional documentation to satisfy it that you are in fact in the position represented.

A copy of this form must be filed with your current workers' compensation carrier.

WVWC-RF01-08/10

OIC-E362
Rev. 3/2013

TERMINATION OF COVERAGE

L 50

WV Offices of the Insurance Commissioner
Revenue Recovery
1124 Smith Street Room 103
Charleston, WV 25301
Telephone No. (304) 558-1200
Fax No. (304) 558-0671

The undersigned hereby states that as of the date indicated below, the business as stated below was discontinued or discontinued to have any employees required to be covered with mandatory workers' compensation coverage pursuant to Chapter 23 of the West Virginia Code.

Employer Name and Address (as listed on account)

Account #_____

FEIN #_____

(Name of Business) (Current Phone Number)

(Street or PO Box) (City) (State) (Zip)

(Permanent Mailing Address, if different from above)

ONLY COMPLETE BELOW WHAT APPLIES TO YOUR SITUATION. IF NONE APPLIES, ATTACH LETTER EXPLAINING OR WRITE IN MARGINS.

1. The business was ☐ Discontinued ☐ Closed ☐ Sold on the _____day of _____, 20____.

   SOLD TO: _____.

2. Last date for employees was the _____ day of _____, 20____

3. Rehire on the _____ day of _____, 20____.

AFFIRMATION: I hereby swear or affirm that to the best of my knowledge and belief these statements and representations are true and accurate. I accept the provisions of the WV Workers' Compensation Act and the Rules promulgated there under, as amended. I further realize that all businesses are subject to inspection and audit. **I further understand that in accordance with W.Va. Code §61-3-24e(5), it is a felony to knowingly and willingly make false statements respecting any information required to be provided under the WV Workers' Compensation Code Chapter 23. Upon conviction the individual shall be confined in a penitentiary for up to three years, fined up to $10,000, or both.**

Signature and title:

(Printed Employer Name)

(Signature of Owner) (Printed Name of Owner) (Title If Not Owner) (Date)

Form OIC-WC-1

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employee's Claim Information

Insurer: **Third-Party Administrator:**

1. Name: (Last): (First): (M.I):

2. Address: **3. Telephone:** ( ) -

City: State: Zip: **4. Social Security No.:** - -

5. Date of Birth: ____/____/____ **6. Sex:** ☐ M ☐ F **7. Marital Status:**

8. Date of Injury or Last Exposure: ____/____/____ **Time:** ☐ a.m. ☐ p.m. **9. Time You Began Work on Date of Injury:** ☐ a.m. ☐ p.m.

10. Date You Stopped Working Due to Injury: ____/____/____

11. Have You Retired? ☐ yes ☐ no If "yes," what was the date you retired: ____/____/____

12. Employer's Name: Supervisor's Name:

Address:

City: State: Zip: Telephone: ( ) -

13. Job Title/Description:

14. Body Part(s) Injured:

15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):

16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:

17. Please Identify Any Witnesses to Your Injury:

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chirogractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: _____ **Date:** _____/_____/_____

Section II — All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital: **2. FEIN/Social Security No.:** - -

3. Address:

City: State: Zip: **Telephone:** ( ) -

4. Date of Initial Treatment: ____/____/____ **5. Date Patient May Return to Work:** ____/____/____

6. Have you advised the patient to remain off work 4 or more days?

☐ Yes. Indicate dates: from to

☐ No. If "no," is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?

8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No. If Yes, explain:

9. Description of injury or occupational disease:

10. Body part(s) injured: **11. ICD9-CM Diagnosis Code(s) in order of severity:**

12. Name of physician referred to: **13. If the patient was hospitalized, where?**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: _____ **Date:** _____/_____/_____

Form OIC-WC-1HL

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Hearing Loss

PLEASE PRINT OR TYPE

Section I	Employee Information
Name:	Telephone: ( ) -
Address:	Social Security No.: - -
City, State, Zip:	Date of Birth: / /
Gender: ☐ M ☐ F	Marital Status:

Check One: ☐ Still Working – Date Last Exposed to Loud Noise on Job: / /

☐ Not Working – Date Last Worked: / / Reason No Longer Working:

Have You Ever Filed a Hearing Loss Claim? ☐ Y ☐ N

- If yes, provide Claim Number, Date of Last Exposure, Name of Employer and Name of Insurer, if applicable:

EMPLOYMENT HISTORY: LIST ALL EMPLOYMENT, BEGINNING WITH THE MOST RECENT – USE SEPARATE SHEET IF NECESSARY

Employer Name and Address:	From:	To:	Description of Job Duties:

Explain HOW and WHEN your hearing loss was caused by exposure to noise at work:

Date on which you were made aware you have suffered noise-induced hearing loss: / /

Daily rate of pay on the last day you were exposed to noise at work: $

LIST ALL DOCTORS YOU HAVE SEEN FOR HEARING LOSS OR PROBLEMS RELATED TO YOUR EARS – USE SEPARATE SHEET IF NECESSARY

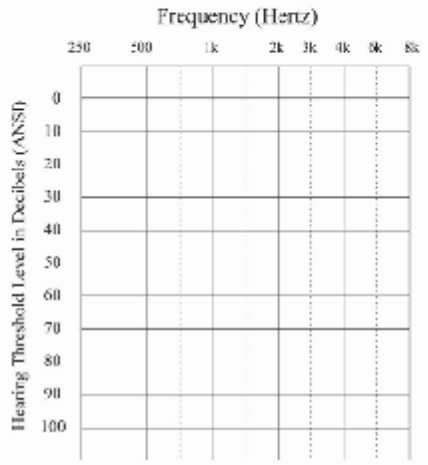
Name:	Address:	Date Seen:

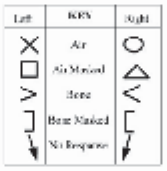
I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

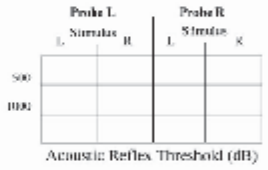
Signature: Date: / /

Section II – Part A	TO BE COMPLETED BY AUDIOLOGIST

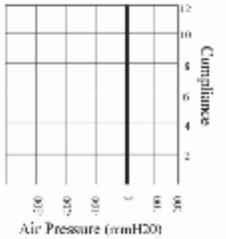
Only audiometric test results obtained by an audiologist having a certificate of clinical competence in audiology (CCCA) or a West Virginia audiology licensure are acceptable for purpose of awarding compensation.







	Left	Right
SRT:		
Best 2Fiverage (.5,1,2 kHz):		
Difference:		



Left	Right
%@ dB	%@ dB
%@ dB	%@ dB

Speech Discrimination (Word Recognition)
Materials used (e.g. W22):
25 or 50 word list, recorded or live voice

1 kHz Ascending threshold: Left _____ Right _____
1 kHz Descending threshold: Left _____ Right _____

	500	1000	2000	3000	TOTAL	%Discrimination SD
R air						
R bone						
L air						
L bone						

Test/Response Reliability: Good ☐ Fair ☐ Poor ☐

Audiologist Name (Print): _____ CCC/A or Licensed? Yes ☐ No ☐

Audiometer: _____
Electroacoustic Calibration ___/___/___ Listening Check ___/___/___ Audiologist Signature: _____ Date: _____

PTA/SRT within 10 dB? ☐ Y ☐ N	Ascending/Descending thresholds with 5 dB? ☐ Y ☐ N	Reliability rated GOOD? ☐ Y ☐ N

Section II – Part B	MUST BE COMPLETED BY E.N.T., OTOLOGIST OR OTOLARYNGOLOGIST

EMPLOYMENT HISTORY: LIST ALL EMPLOYMENT, BEGINNING WITH THE MOST RECENT – USE SEPARATE SHEET IF NECESSARY

Employer:	From:	To:	Description of Duties/Nature of Noise Exposure:	Hearing Protection?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

Chief complaints/symptoms as related to hearing loss:	ICD9-CM Diagnosis Code(s):

List any pre-existing conditions which may have attributed to hearing loss:

Section II – Part B (Continued)	MUST BE COMPLETED BY E.N.T., OTOLOGIST OR OTOLARYNGOLOGIST

Examination Results:

Does the claimant have a bilateral sensorineural hearing loss directly attributable to or perceptibly aggravated by industrial noise exposure in the course of and resulting from his/her employment? ☐ **Y** ☐ **N** **If yes, please answer A and B below.**

A. Recommended percentage of impairment due to work-related noise exposure:	**B. Explain and qualify:**

Do you recommend additional treatment or correctional devices? ☐ **Y** ☐ **N** **If yes, explain:**

Date you first informed the injured worker of the diagnosis of Noise-Induced Hearing Loss: / /

Physician's Name and Address:	**Telephone Number:** ( ) -	**FEIN:**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: **Date:** / /

AMCS
American Mining Claims Service
WEST VIRGINIA UNIT

Hearing Loss Exposure Addendum

Return completed form to:
American Mining Claims Service
P.O. Box 660988
Birmingham, AL 35266-0988

Claimant's Name

Claimant's Social Security Number

				Protection Used?		
	Yes	No	How Often	Yes	No	Type (Plugs, Muffs or Caps)
Hunting	☐	☐		☐	☐	
Trap Shooting	☐	☐		☐	☐	
Firing Range	☐	☐		☐	☐	
Loud Music	☐	☐		☐	☐	
Walkmen	☐	☐		☐	☐	
Weed Eater	☐	☐		☐	☐	
Lawn Mower	☐	☐		☐	☐	
Power Tools	☐	☐		☐	☐	
Chain Saw	☐	☐		☐	☐	
Skill Saw	☐	☐		☐	☐	
Band Saw	☐	☐		☐	☐	
Air Compressor	☐	☐		☐	☐	
Heavy Equipment	☐	☐		☐	☐	
Farm Machinery	☐	☐		☐	☐	
Auto Mechanic	☐	☐		☐	☐	
Racing	☐	☐		☐	☐	
Pilot	☐	☐		☐	☐	
Motorcycle	☐	☐		☐	☐	
Snow Mobile	☐	☐		☐	☐	
Indoor Athletics	☐	☐		☐	☐	
Other	☐	☐		☐	☐	
Other	☐	☐		☐	☐	

MILITARY SERVICE

Do you have prior military experience? ☐ Yes ☐ No If yes, which branch?

Did you have a combat assignment? ☐ Yes ☐ No If yes, how long?

What was your job in the military? | How many weeks of basic training?

Noise exposure other than basic training?

Military Address / Location	Service From – To	Job Description	Type of Machinery / Equipment Used	Exposure to Noise Hours / Days	Hearing Protection Worn?

Comments?

Form OIC-WC-1OP

West Virginia Workers' Compensation
Employees' Report of Occupational Pneumoconiosis

PLEASE PRINT OR TYPE

Section I	Employee Information
Name:	Telephone:
Address:	Social Security No.:
City, State, Zip:	Date of Birth:
Gender: ☐ M ☐ F	Marital Status:
Date you were last exposed to minute particles of dust: / /	Have you ceased work? ☐ Y ☐ N If yes, when? / /
If you have ceased working, please explain why:	

Are you receiving Federal Black Lung or Workers' Compensation benefits for occupational pneumoconiosis from any state? ☐ Y ☐ N
If yes, please provide the following information:

- What type of payments you are receiving:
- Date payments began (month/day/year):
- Monthly amount:

List ALL workers' compensation claims for Occupational Pneumoconiosis (West Virginia and other states); Attach a separate sheet if necessary:

Claim No.:	Impairment %:	Date of Last Exposure:	Employer:	State:

List ALL disability claims you have filed with federal agencies (including Social Security, Veterans Administration, etc.):

Currently receiving?	Type of injury/medical condition:	Date began:	Monthly amount:
☐ Y ☐ N			
☐ Y ☐ N			

Do you have a family physician? ☐ Y ☐ N If yes, please provide the following information:

Physician's name:	Complete mailing address:	Telephone number:

Have you ever suffered any other accidents, injuries or illness(es) of the chest or lungs? ☐ Y ☐ N If yes, provide the following information:

Illness/Condition:	Date of onset:	Treating physician/Facility (Name, Address):	Were you hospitalized?	Did you require surgery?
			☐ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N

Do you have medical reports indicating that you have occupational pneumoconiosis? ☐ Y ☐ N If yes, provide the following information:

Date of diagnosis:	Physician name:	Complete Mailing Address:	Telephone No:	Diagnosed impairment %:

Have you had any of the following procedures performed within the last five (5) years? If yes, provide the following information:

Procedure:		Date of procedure:	Attending physician:	Hospital (name, address):
Chest X-Ray	☐ Y ☐ N			
Blood Gas Analysis	☐ Y ☐ N			
Breathing Studies	☐ Y ☐ N			
Tuberculosis Check	☐ Y ☐ N			

How long have you been exposed to the hazards of occupational pneumoconiosis while working in West Virginia?

List your employment history prior to your date of last exposure. Start with your most recent employer (or current employer if still employed). Union hall employment history printouts should be attached if applicable. Attach additional sheets if necessary:

Employer:	From:	To:	Location (Name of Site, City, State):	Type of Industry:	Job Title:	Alleged Exposure?
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical, employment, wage or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Claimant's Signature: **Date:** / /

If you have an attorney, please provide:

Attorney Name:	Date Hired:	Attorney's Address	Attorney's Telephone No.:

Attorney's Signature: **Date:** / /

AMCS
American Mining Claims Service
WEST VIRGINIA UNIT

Application for Permanent Total Disability Benefits

Return completed form to:
American Mining Claims Service
P.O. Box 660988
Birmingham, AL 35266-0988

PLEASE REVIEW THE INSTRUCTIONS AND COMPLETE ALL FIELDS BELOW

Please be advised that any person desiring consideration must have:

- Been awarded the sum of 50% in prior permanent partial disability awards;
- Suffered a single occupational injury or disease which results in a finding by American Mining Claims Service that a medical impairment of 50% exists; or have
- Sustained a 35% statutory disability.

All of the information contained in this application for benefits is necessary to properly adjudicate the request. Failure to complete all questions on this application may cause substantial delay and possible rejection for consideration, which may affect your rights to benefits in the future. Any incomplete application will not be accepted and will be returned for complete information.

After completion, please forward this application for benefits and any supporting evidence to:
American Mining Claims Service, P.O. Box 660988, Birmingham, AL 35266-0988

PLEASE TYPE OR PRINT WITH A BLACK OR BLUE BALLPOINT PEN

1. Personal Information

Name	Social Security Number
Address	Date of Birth
City, State, Zip	Most Recent Date of Injury
Phone (include area code)	County of Residence

2. Present Employment Status: ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Off Due to Injury ☐ Retired

3. Are you receiving any of the following retirement benefits? ☐ Yes ☐ No Check any that apply.
☐ Social Security ☐ Employer-Funded ☐ Self-Funded Date Benefits Started: / /

4. Are you receiving any of the following disability benefits? ☐ Yes ☐ No Check any that apply.
☐ Social Security ☐ Employer-Funded ☐ Self-Funded Date Benefits Started: / /

5. Are you receiving any income from other sources not listed above? Describe benefit and onset. (Retirement, pension, etc.)

Benefit:	Onset: / /	Did you contribute? ☐ Yes ☐ No
Benefit:	Onset: / /	Did you contribute? ☐ Yes ☐ No

6. Is there a pending civil action in any of your AMCS claims that has been brought by you or on your behalf? ☐ Yes ☐ No If yes, please attach a copy.

7. Dependent Information: Please list all dependent information below.

Dependent	Social Security Number	Date of Birth	Relationship

8. Please list all American Mining Claims Service claims and any impairment rating (%) that may have been awarded. Attach additional pages as necessary.

Claim Number	PPD %	Date of Injury	Body Part(s)

9. List all disability claims you have filed with other state or federal agencies (include Social Security, veteran's and workers' compensation from other states). Attach additional pages as necessary. Please include a copy of the decision granting benefits.

10. List any non work-related conditions for which you have received treatment in the past 10 years. Include the name, address and telephone number of the treating physician, clinics or hospitals that treated you. Attach additional pages as necessary.

11. List all prescription medications you are taking and include the name of the prescribing physician.

Prescription Medication	Prescribing Physician	Prescription Medication	Prescribing Physician

12. Rehabilitation: List all vocational rehabilitation services you have received because of a work-related condition (job placement, retraining, etc.)

Services Received	Service Provider	Dates of Services

13. Employment History: Please complete your employment history beginning with the most recent and continue in reverse order.

Begin Date	End Date	Employer's Name	Employer's Address
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

14. List job titles you have held and any specialized training you received to perform these jobs.

Job Title	Duties / Training Received	Date(s) of Training

15. Educational Background: Please list the names of all schools you have attended. This should include public, private, vocation or colleges and universities. Please include date of attendance and highest degree attained.

School Name	Location	Program	Dates Attended	Degree / Result

16. Did you receive a GED? ☐ Yes ☐ No If yes, date of completion: / /

17. Have you served in the military? ☐ Yes ☐ No If yes, dates of service: From / / to / /

18. If yes, please list the specific military branch, the highest rank attained and any special duties or training received.

Branch	Highest Rank Attained	Training / Duties

I certify the statements and answers set forth in this document are true and correct to the best of my knowledge. I am aware the law, generally, Chapters 23 and 61 of the WV Code, and specifically, § 61-3-24f, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested by American Mining Claims Service. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly and with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.

Signature Date / /

Form OIC-WC-2

West Virginia Workers' Compensation
Employers' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employer Information

Insurer:		**Third-Party Administrator:**	
Employer's Name:	Nature of Business:		FEIN:
Address:			
City:	State:	Zip:	Telephone: ( ) -

Section II — Employee Information

Name: (Last):	(First):	(M.I.):	**Occupation/Job Title:**
Address:			**Telephone:** ( ) -
City:	State:	Zip:	**Social Security No.:** - -
Date of Birth: ____/____/____	**6. Sex:** ☐ M ☐ F		**Marital Status:**
Injured Employee is (check all that apply): ☐ Full-Time ☐ Part-Time ☐ Volunteer ☐ Owner/Partner ☐ Officer ☐ Retired – Date Retired: ____/____/____			**Employee's Occupation/Job Title:**

Section III — Information Regarding Injury or Disease

Date of Injury or Last Exposure: ____/____/____ **Time:** ☐ a.m. ☐ p.m.		**Witnesses to Injury:**
Date Employer Notified of Injury or Disease: ____/____/____	**Supervisor to whom Injury or Disease Reported:**	
If Injury was Fatal, Indicate Date of Death: ____/____/____		
Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address or location where injury occurred:		

What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.):

How did the Injury or Disease Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary):

Nature of Injury or Disease (cut, bruise, strain, etc.):

Body Part(s) Injured:

Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part? ☐ Yes ☐ No

Do You Have Reason to Question this Injury? ☐ Yes ☐ No (If "yes," attach a specific explanation to this form).

Location of Initial Treatment: **Emergency Room?** ☐ Yes ☐ No **Hospitalized?** ☐ Yes ☐ No

Section IV — Wage and Lost Time Information

Date Hired: ____/____/____	**Last Day Worked After Occupational Injury or Disease:** ____/____/____	
Number of Work Days Lost:	**Date of Return to Work:** ____/____/____	**Hours Worked per Week:**
Is Light Duty Available? ☐ Yes ☐ No	**Wage on Date of Injury:** $ per ☐ hour ☐ day ☐ week ☐ month	
Are Wages Being Paid to Injured Employee During Disability? ☐ Yes ☐ No	**If Employee has Returned to Work, is it Alternative or Modified Work?** ☐ Yes ☐ No If "yes," indicate current wage: $ per ☐ hour ☐ day ☐ week ☐ month	
Daily rate of pay on the date of injury: $	**and best quarter wages of preceding four quarters** $	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code §61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____/_____/_____

AMCS
American Mining Claims Service
WEST VIRGINIA UNIT

Employer's Report of Occupational Disease

For AMCS Use Only
Claim Number: _____
Team Assigned: _____
ICD9: _____

ALL INFORMATION MUST BE COMPLETED

PRIOR TO COMPLETING THIS FORM YOU MUST READ THE INSTRUCTIONS ON THE BACK OF THIS FORM.

I have been informed of my responsibilities under WV Workers' Compensation Law and agree to abide by such in the administration of services provided by American Mining Claims Service. I am aware the law provides for severe penalties for providing false statements or information.
Initials of Employer Representative:

1. OIC policy number:		FEIN or SSN:	
2. Industrial code:		Phone number:	
3. Name of employer as listed with American Mining Claims Service :			
Address of employer:			
City:	County:	State:	Zip Code:
4. Employee SSN:		Date of last exposure:	
5. Employee name:		Marital status:	
Job title/description:		Telephone:	
6. Address of employee:			
City:	County:	State:	Zip Code:
7. Employee date of birth: / /		Sex: ☐ Male ☐ Female	

8. Employee is (check all that apply):

☐ Owner/part owner	☐ Full-time	☐ Part-time
☐ Officer	☐ Volunteer	☐ Leased (if leased employee, complete 8a, 8b, and 8c.)

8a. Name and policy number of leasing company:
8b. Name and policy number of client employer:
8c. Date the employee was first assigned to the client employer: / /

9. If owner, part owner, or officer, are wages included on wage reports? ☐ Yes ☐ No
10. Date employee was first employed by you? / /
11. Is this employee still employed by you? ☐ Yes ☐ No If not, indicate last date of employment: / /
12. Was this employee, while employed by you, exposed to the hazards of this disease for 60 continuous days? ☐ Yes ☐ No
13. Indicate in the space below all employment with you. Show begin date, end date, location and job title.

	Begin date	End date	Job title/location		Begin date	End date	Job title/location
a.				d.			
b.				e.			
c.				f.			

14. Daily rate of pay on the date of last exposure: $
15. If part-time employee: Hourly rate: $ Hours per week (25 or less):
16. Did alleged exposure occur on employer's property? ☐ Yes ☐ No Address where alleged exposure occurred:
17. Nature, body part and type of disease:
17a. Nature:
17b. Body part:
17c. Type of disease:
18. Date disease was first diagnosed: / / By whom? Phone
19. Are you aware of or suspect a previous claim filed for this disease? ☐ Yes ☐ No
If yes, please provide the claim number.
20. Has this work site been tested for employee exposure to air contaminants or noise? ☐ Yes ☐ No
If yes, please provide results and dates of testing.

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically § 61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested by AMCS . I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent to aid or abet anyone in securing or attempting to secure benefits to which he or she is not entitled. **Signature:** **Date:** / /

AMCS
American Mining Claims Service
WEST VIRGINIA UNIT

Employers' Report of Occupational Pneumoconiosis

Please return completed form to:
American Mining Claims Service
P.O. Box 660988
Birmingham, AL 35266-0988

PLEASE PRINT OR TYPE.

1. Claimant's Full Name (First, Middle, Last)	2. Social Security Number	3. Sex ☐ Male ☐ Female	4. Claim Number (For office use only)

4. Claimant's Complete Mailing Address (Street or P.O. Box, City, County, State, Zip Code)	5. Claimant's Date of Birth (Month/ Day,/Year)

6. Employer's Complete Name	7. Employer's phone number	8. Employer's FEIN

9. Employer's Complete Address (Street or P.O. Box, City, County, State, Zip Code)	10. Employer's BrickStreet Policy Number

11. Date claimant began working (Month/ Day/Year)	12. Is claimant still working for you? ☐ Yes ☐ No If not, date ceased and reason:

13. While employed by you, was the claimant ever potentially exposed to the hazards of occupational pneumoconiosis for a continuous period of 60 days?
☐ Yes ☐ No

14. Do you question the claimant's alleged disability? ☐ Yes ☐ No If yes, please provide complete details (attach additional sheets if necessary).

15. What work was regularly performed by the claimant?

16. Based on the alleged last date of exposure, list the exact location where the claimant last worked

Worksite	City, Town or Village	State	County

17. Has the claimant filed for any prior Workers' Compensation benefits while employed by you? ☐ Yes ☐ No If yes, please provide the following:

Claim Number	Impairment %	Date of Injury	Type of Claim and injured Body Part (s)

18. Claimant's Employment History - Start with the most recent position (or current position if still employed). List every position the claimant has held with your company as well as previous or other employment of which you are aware. List breaks in employment. Please use a month/day/year format for all dates. (Attach additional sheets if necessary).

From	To	Company	Location or Worksite	City and State	Department	Job Title

Please print or type.

19. Please give the dates of any unemployment or layoff. Please use a month/day/year format for all dates. (Attach additional sheets if necessary.)

From	To	Company	Reason for Unemployment or Layoff

20. What was the claimant's daily rate of pay on the date of last employment (Or the date the application was filed if employee is still working)? $ _____ Daily

21. What were the total earnings of the claimant during the prior four full quarters from the alleged date of exposure:

Time Period	Gross Wages
Most Recent Full Quarter	
Prior Quarter	
Prior Quarter	
Prior Quarter	

Any person or firm, or the officer of any corporation, who knowingly and willfully makes a false report or statement under oath, affidavit or certification respecting any information required to be provided under this chapter, shall be guilty of a felony and, upon conviction thereof, shall be fined not less than $1,000 nor more than $10,000 or confined in the penitentiary for a definite term of imprisonment of not less than one year nor more than three years or both.

Name of Employer or Employer's Representative	Title	Phone Number	Date

Signature of Employer or Employer's Representative

Return completed form to: American Mining Claims Service, P.O. Box 660988, Birmingham, AL 35266-0988. If you have any questions regarding this form, please contact American Mining Claims Service at 1.888.823.4496.

Form OIC-WC-201

West Virginia Workers' Compensation
Application for Fatal Dependents' Benefits

In all claims for compensation, except occupational pneumoconiosis or other occupational diseases, the application and proofs of dependency in fatal cases must be filed within six months from and after the employee's date of death. In occupational pneumoconiosis claims, the application for compensation and proofs of dependency in fatal cases must be filed by the dependents of the employee within two years from and after the employee's death. In occupational disease claims other than occupational pneumoconiosis, the application for compensation and proofs of dependency in fatal cases must be filed by the dependents of the employee within one year from and after the employee's death. NOTE: THESE TIMES FOR FILING ARE A CONDITION THAT MUST BE MET OR THE RIGHT TO COMPENSATION WILL BE FOREVER BARRED.

Section I — Deceased Employee Information

Employee:	**Employer:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Social Security No: - -	**Date of Injury:** / /
Date of Death: / /	**Date of Birth:** / /

Section II — Reason for Filing Claim

I, _____ hereby apply for fatal dependents' benefits. My relation to the deceased is: _____
(Name of Applicant)

Death resulted from: ☐ **Occupational Injury** ☐ **Occupational Disease**

Name, Address of Employer:	**Dates Worked:**
Name, Address of Employer:	**Dates Worked:**

Explain how this injury or disease, suffered in and resulting from employment, was a contributing factor to this death. (If additional space is needed, complete this statement on a separate piece of paper).

Section III — Dependents' Information – Please See Instructions on the Back of This Form

TO BE COMPLETED BY SURVIVING SPOUSE:

Current Address (Include City, State, Zip):	**Social Security No.:** - -
What was your name before marriage to the deceased?	**Date and Place of Marriage:** / /
Date and Place of Birth: / /	**Driver's License Number and State of Issuance:**

Did you live with the deceased from the date of marriage to the date of death? ☐ Yes ☐ No
If no, please explain:

Was the deceased ever previously married? ☐ Yes ☐ No
If yes, how was the marriage dissolved:

Were you actually dependent on the earnings of the deceased at the date of death? ☐ Yes ☐ No

Were you pregnant with the deceased's child at the time of death? ☐ Yes ☐ No **If yes, provide expected birth date:** / /

PLEASE IDENTIFY ALL SURVIVING DEPENDENT CHILDREN – TO BE COMPLETED BY SURVIVING SPOUSE OR GUARDIAN:

Name	Social Security No.	Date of Birth	Full Time Student Driver's License No. and State	18-25 or Disabled?
	- -	/ /		
	- -	/ /		
	- -	/ /		
	- -	/ /		

Please note: Full-time students between the ages of 18 and 25 must complete a student contract application to receive benefits. If you have an invalid child you must provide medical evidence. If any surviving dependent children are not in the immediate care and custody of the surviving spouse, see instructions on reverse side and explain. Also, please list those children in the space provided above.

Rev. 1/11

PLEASE IDENTIFY ALL SURVIVING DEPENDENTS OTHER THAN A SPOUSE OR CHILD (SIBLINGS, PARENTS, GRANDPARENTS, ETC.):

Name	Social Security No.	Date of Birth	Driver's License No. and State	Relationship to Deceased	Medical Evidence of Invalidism Enclosed?
	- -	/ /			
	- -	/ /			
	- -	/ /			

Are you aware of any other surviving dependents? If so, please provide as much information as possible about them:

Were you fully dependent upon the earnings of the deceased at the date of death? ☐ **Yes** ☐ **No**
If yes, provide documentation of dependency (i.e., tax returns, proof of health insurance, trustee accounts, etc.)

Were you partially dependent upon the earnings of the deceased at the date of death? ☐ **Yes** ☐ **No**

Did you reside in the same household as the deceased at the date of death? ☐ **Yes** ☐ **No**
If no, provide current address:

What weekly amount was contributed to your support by the deceased at the date of death? $

Were you incapable of self-support? ☐ **Yes** ☐ **No**
If yes, why?

Other Income: List all amounts and sources and provide documentation:

Signature of Applicant:	**Telephone Number: ( ) -**
Signature of Witness	**Signature of Witness:**

Sworn and subscribed before me, the undersigned authority, on the _____ day of _____, _____

Officer Taking Acknowledgment:	**Date:**	**My Commission Expires:**

INSTRUCTIONS

IMPORTANT: To avoid delay in considering your claim, be sure to answer all questions that apply and attach the appropriate certificates and documents to your application. Please note that the form must be notarized.

Certified copies of the following documents must be submitted where applicable:

Death Certificate Autopsy Report Marriage Certificate Divorce Decree Birth Certificate

A certified copy of the death certificate showing the cause of death must be submitted. If an autopsy was performed, a complete copy of the autopsy report must be submitted.

A certified copy of the marriage certificate must be filed. If either the surviving spouse or the deceased employee was previously married and divorced, a certified copy of the divorce decree must be submitted. If the former marriage dissolved by death, a certified copy of the death certificate must be submitted.

If surviving children are to receive benefits, a birth certificate must be submitted for surviving children under 18 years of age. Children under 25 years of age attending school full-time may qualify for benefits if a statement verifying their attendance is sent to your insurance carrier by the registrar of an accredited school.

If dependent children are living in a different household from that of the deceased, information must be submitted including their name, date of birth, Social Security number, driver's license number (if applicable), address and the dependency circumstances involved. Their legal guardian must file an application on behalf of such children and must include a copy of the guardianship appointment.

Benefits must be paid for an invalid child if appropriate medical information is filed that proves that the child is an invalid.

Other dependents (parents, grandparents, siblings, etc.) must submit proof of dependency, in affidavit form, with their application for compensation. Individuals having knowledge that the applicants were dependent upon the earnings of the deceased for support, and describing the amount of contribution and the dates and methods of contribution should make affidavits. Also, a statement must be filed by the applicant explaining all the amounts and sources of other income.

Services invoice must be completed to apply for funeral expenses. You may request a printed form by calling the number listed below.

If you have any questions or need assistance with this form, please contact the employer that you believe is responsible for the occupational injury or occupational disease that contributed in any material degree to the decedent's death or that employer's carrier. You may also call the OIC at 888-879-9642 for assistance.

Rev. 1/11

Form OIC-WC-202

West Virginia Workers' Compensation
Application for 104 Weeks Dependents' Benefits

In all claims for compensation, except occupational pneumoconiosis or other occupational diseases, the application and proofs of dependency in fatal cases must be filed within six months from and after the employee's date of death. In occupational pneumoconiosis claims, the application for compensation and proofs of dependency in fatal cases must be filed by the dependents of the employee within two years from and after the employee's death. In occupational disease claims other than occupational pneumoconiosis, the application for compensation and proofs of dependency in fatal cases must be filed by the dependents of the employee within one year from and after the employee's death. NOTE: THESE TIMES FOR FILING ARE A CONDITION THAT MUST BE MET OR THE RIGHT TO COMPENSATION WILL BE FOREVER BARRED.

Section I	**Deceased Employee Information**
Employee:	**Employer:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Social Security No: - -	**Date of Injury:** / /
Date of Death: / /	**Date of Birth:** / /
I, _____ hereby apply for fatal dependents' benefits. My relation to the deceased is: _____ (Name of Applicant)	
Please provide claim number, if applicable:	

Section II	**Dependents' Information – Please See Instructions on the Back of This Form**
TO BE COMPLETED BY SURVIVING SPOUSE:	
Current Address (Include City, State, Zip):	**Social Security No.:** - -
What was your name before marriage to the deceased?	**Date and Place of Marriage:** / /
Date and Place of Birth: / /	**Driver's License Number and State of Issuance:**
Did you live with the deceased from the date of marriage to the date of death? ☐ Yes ☐ No **If no, please explain:**	
Was the deceased ever previously married? ☐ Yes ☐ No **If yes, how was the marriage dissolved:**	
Were you actually dependent on the earnings of the deceased at the date of death? ☐ Yes ☐ No	
Were you pregnant with the deceased's child at the time of death? ☐ Yes ☐ No **If yes, provide expected birth date:** / /	

PLEASE IDENTIFY ALL SURVIVING DEPENDENT CHILDREN – TO BE COMPLETED BY SURVIVING SPOUSE OR GUARDIAN:

Name	Social Security No.	Date of Birth	Full Time Student Driver's License No. and State	18-25 or Disabled?
	- -	/ /		
	- -	/ /		
	- -	/ /		
	- -	/ /		

Please note: Full-time students between the ages of 18 and 25 must complete a student contract application to receive benefits. If you have an invalid child you must provide medical evidence. If any surviving dependent children are not in the immediate care and custody of the surviving spouse, see instructions on reverse side and explain. Also, please list those children in the space provided above.

Rev. 1/11

PLEASE IDENTIFY ALL SURVIVING DEPENDENTS OTHER THAN A SPOUSE OR CHILD (SIBLINGS, PARENTS, GRANDPARENTS, ETC.):

Name	Social Security No.	Date of Birth	Driver's License No. and State	Relationship to Deceased	Medical Evidence of Invalidism Enclosed?
	- -	/ /			
	- -	/ /			
	- -	/ /			

Are you aware of any other surviving dependents? If so, please provide as much information as possible about them:

Were you fully dependent upon the earnings of the deceased at the date of death? ☐ **Yes** ☐ **No**
If yes, provide documentation of dependency (i.e., tax returns, proof of health insurance, trustee accounts, etc.)

Were you partially dependent upon the earnings of the deceased at the date of death? ☐ **Yes** ☐ **No**

Did you reside in the same household as the deceased at the date of death? ☐ **Yes** ☐ **No**
If no, provide current address:

What weekly amount was contributed to your support by the deceased at the date of death? $

Were you incapable of self-support? ☐ **Yes** ☐ **No**
If yes, why?

Other Income: List all amounts and sources and provide documentation:

Signature of Applicant:	**Telephone Number: ( ) -**
Signature of Witness	**Signature of Witness:**

Sworn and subscribed before me, the undersigned authority, on the _____ day of _____, _____

Officer Taking Acknowledgment:	**Date:**	**My Commission Expires:**

INSTRUCTIONS

IMPORTANT: To avoid delay in considering your claim, be sure to answer all questions that apply and attach the appropriate certificates and documents to your application. Please note that the form must be notarized.

Certified copies of the following documents must be submitted where applicable:

Death Certificate Autopsy Report Marriage Certificate Divorce Decree Birth Certificate

A certified copy of the death certificate showing the cause of death must be submitted. If an autopsy was performed, a complete copy of the autopsy report must be submitted.

A certified copy of the marriage certificate must be filed. If either the surviving spouse or the deceased employee was previously married and divorced, a certified copy of the divorce decree must be submitted. If the former marriage dissolved by death, a certified copy of the death certificate must be submitted.

If surviving children are to receive benefits, a birth certificate must be submitted for surviving children under 18 years of age. Children under 25 years of age attending school full-time may qualify for benefits if a statement verifying their attendance is sent to your insurance carrier by the registrar of an accredited school.

If dependent children are living in a different household from that of the deceased, information must be submitted including their name, date of birth, Social Security number, driver's license number (if applicable), address and the dependency circumstances involved. Their legal guardian must file an application on behalf of such children and must include a copy of the guardianship appointment.

Benefits must be paid for an invalid child if appropriate medical information is filed that proves that the child is an invalid.

Other dependents (parents, grandparents, siblings, etc.) must submit proof of dependency, in affidavit form, with their application for compensation. Individuals having knowledge that the applicants were dependent upon the earnings of the deceased for support, and describing the amount of contribution and the dates and methods of contribution should make affidavits. Also, a statement must be filed by the applicant explaining all the amounts and sources of other income.

Services invoice must be completed to apply for funeral expenses. You may request a printed form by calling the number listed below.

If you have any questions or need assistance with this form, please contact the employer, employer's carrier or third-party administrator that issued the decision granting the decedent a permanent total disability award. You may also call the OIC at 888-879-9842 for assistance.

Rev. 1/11

AMCS
American Mining Claims Service
WEST VIRGINIA UNIT

Physician's Report of Occupational Pneumoconiosis

Return completed form to:
American Mining Claims Service
P.O. Box 660988
Birmingham, AL 35266-0988

AMCS Use Only
Silicosis
OP
OD

Claimant's Name (First, Middle, Last)

Claimant's Address

City, State, Zip

Date of Birth (Month, Day, Year) ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed Social Security Number

Date of first treatment or examination (Month, Day, Year) Diagnosis

In your opinion has claimant contracted occupational pneumoconiosis? ☐ Yes ☐ No

How long has claimant been suffering from the disease of occupational pneumoconiosis?

Has the claimant's capacity for work been impaired by occupational pneumoconiosis? ☐ Yes ☐ No

If yes, to what extent?

History: Has the claimant ever had

	Yes	No	Date		Yes	No	Date
Pneumonia	☐	☐		Angina Pectoris	☐	☐	
Pleurisy	☐	☐		Coronary Occlusion	☐	☐	
Asthma	☐	☐		Rheumatic Heart Disease	☐	☐	
Tuberculosis	☐	☐		Congestive Heart Failure	☐	☐	
				Arthritis	☐	☐	

Other serious illnesses ☐ Yes ☐ No Date and describe

Surgery ☐ Yes ☐ No Date and describe

Accidents ☐ Yes ☐ No Date and describe

Present complaints and duration of complaints

Has the sputum of the claimant been examined for tubercle bacillus? ☐ Yes ☐ No

If yes, by whom?

What lab?

Findings?

Where are the lab reports filed?

If employee is deceased, was an autopsy performed? ☐ Yes ☐ No

Has claimant participated in any OP treatment program? ☐ Yes ☐ No

Have x-rays been made of the claimants lungs? ☐ Yes ☐ No

Right lung ☐ Yes ☐ No | Left Lung ☐ Yes ☐ No | If yes to either, please answer below.

Hospital or Doctor	Date	Where Filed	Findings

Have pulmonary function studies, blood gas studies or other pertinent clinical examinations been performed? ☐ Yes ☐ No If yes, please answer below.

Hospital or Doctor	Date	Where Filed	Findings

Appearance: ☐ Good ☐ Fair ☐ Poor

Height: ft. in.

Weight: lbs. One year ago: lbs.

Breath Sounds: ☐ Normal ☐ Suppressed ☐ Rales ☐ Wheezing

Findings:

Heart: Blood Pressure:

Pulse:

Sounds: ☐ Normal ☐ Abnormal

Murmurs:

Findings:

Other significant physical abnormalities:

Signature

Address

Date

Workers' Compensation
Diagnosis Update

Return completed application to the Third-Party Administrator
American Mining Claims Service
PO Box 660988
Birmingham, AL 35266-0988

Instructions: This form is intended for use by the physician of record to update appropriate diagnostic information. Complete claimant and physician information. List ICD9-CM codes in order of severity with corresponding descriptions. Show clinical findings upon which the diagnosis is based. **Sign and date the form and mail to American Mining Claims Service, the third-party administrator.**

1. Claimant Name	2. Claim Number	3. Social Security Number	4. Date of Injury
_____	_____	____-____-_____	___/___/___

5. Treating Physician Name and Address

_____
_____
_____
_____

6. ICD9-CM Diagnosis Numerical Code(s)

1. Primary: _____
2. Secondary: _____
3. Secondary: _____
4. Secondary: _____

7. Physician's FEIN: _____

8. Diagnosis Description

1. Primary: _____
2. Secondary: _____
3. Secondary: _____
4. Secondary: _____

9. Provide clinical findings on which current diagnosis is based and advise how the present condition relates to the compensable injury.

_____
_____
_____
_____
_____
_____
_____

10. Physician Signature	11. Date
_____	_____

OFFICE OF JUDGES

REQUEST FOR ORDER COMPELLING EMPLOYER'S INSURANCE CARRIER TO ACT UPON CLAIM

CLAIMANT'S NAME: _____ SSN: ___-__-____
DOI: _____
SUBMITTED BY: _____ CI.# _____

CLAIMANT'S ADDRESS: _____

_____

CLAIMANT'S PHONE: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

_____

EMPLOYER'S CARRIER: _____

WHAT HAVE YOU ASKED EMPLOYER TO DO?

- ❑ Initial Ruling on New Claim Filed
- ❑ Rule on Reopening Request
- ❑ Arrange for Permanent Partial Disability Evaluation
- ❑ Authorize Treatment
- ❑ Supply Copy of Claim Records
- ❑ Enter Award Based upon Doctor's Report
- ❑ Reimburse for Travel Expenses
- ❑ Other (briefly state what you asked for) _____

_____

_____

DATE YOU MADE REQUEST TO,
OR FILED CLAIM WITH, EMPLOYER: _____

NAME AND ADDRESS TO WHOM YOU
SENT OR SUBMITTED REQUEST: _____

_____

cc: _____ _____

_____

WEST VIRGINIA WORKERS' COMPENSATION OFFICE OF JUDGES

DOCUMENT SUBMISSION FORM

CLAIMANT: _____ EMPLOYER(S): _____

JCN: _____ CCN: _____

DOI/DLE _____

SUBMITTED BY: _____ REPRESENTING: _____

REFERENCE: _____ ORDER DATE(S)

SHORT DESCRIPTION OF ORDER(S) _____

PLEASE SELECT ONE OF THE FOLLOWING CATEGORIES *ATTACH ONLY (1) DOCUMENT PER FORM*

◯ **PROTEST** ☐ **LATE PROTEST** ☐ ***RESUBMITTED PROTEST** (PREVIOUSLY DENIED)

◯ **EVIDENCE:** AUTHOR: _____ ☐ ***RESUBMITTED EVIDENCE** (PREVIOUSLY DENIED)

DATE OF REPORT: _____

◯ **NOTICE OF RELEVANT DOCUMENT(S)*** (EVIDENCE PREVIOUSLY SUBMITTED ON PRIOR PROTEST IN SAME CLAIM)

◯ **ARGUMENT IN LIEU OF EVIDENCE** (MUST BE FILED WITHIN PROTESTING PARTY'S TIME FRAME)

◯ **CLOSING ARGUMENT/CASE SUMMATION** (MAY BE FILED WITHIN 10 DAYS OF TFO EXPIRATION)

◯ **NOTICE OF APPEARANCE**

◯ **MOTION** ☐ ***RESUBMITTED MOTION** (PREVIOUSLY DENIED)

- A) EXTENSION OF TIME FRAME ☐
- B) PROTEST(S) WITHDRAWAL ☐
- C) MISCELLANEOUS MOTION ☐
- D) SUBMIT ☐
- E) HEARING CONTINUANCE ☐
- F) HEARING REQUEST ☐

Please select: ☐

DATE: SIGNATURE: _____

CC:

**THIS FORM SHOULD BE SUBMITTED IN ADDITION TO YOUR REGULAR CORRESPONDENCE LETTER THAT ACCOMPANIES YOUR SUBMISSIONS OF DOCUMENTS. THIS FORM IS BEING USED TO ASSIST IN THE EDMS INDEXING PROCESS.

OFFICE OF JUDGES

REQUEST FOR AWARD OF CLAIMANT'S ATTORNEY FEES and EXPENSES

WV Code §23-2C-21(c)

CLAIMANT'S NAME: _____

SSN: _____-____-_____ **DOI:** _____

CI.# _____ **OOJ Case ID#** _____

EMPLOYER: _____

DATE OF CLAIM ADMINISTRATOR'S "UNREASONABLE" ORDER: _____

REVERSED BY: **DATE REVERSED:** _____

- ☐ Office of Judges
- ☐ Board of Review (attach decision)
- ☐ Supreme Court (attach mandate)

Submitted by (please print): _____

Bar ID# _____

Address: _____

_____

Date Form Submitted: _____

cc:

PETITION for STAY of PAYMENT of ALJ DECISION

(File with Office of Judges, at One Players Club Dr., Charleston WV 25311 or P.O. Box 2233, Charleston WV 25328)

Claimant Name: _____ **OOJ Case ID#** _____

ALJ NAME: _____ **Decision Date:** _____

Award Made: _____

ATTACH ARGUMENTS FOR OR AGAINST GRANTING STAY TO THIS FORM

Submitted by: _____ **Date:** _____
(print name)

Representing: **[] Carrier**
[] Employer
[] Claimant

I verify that a copy of this form and any attachments was submitted in person or by U.S. mail to the opposing side or their counsel on this same date.

Signed: _____

Cc: _____
_____

BOR – 1
Revised 3/21/06

NOTICE OF APPEAL TO THE
WORKERS' COMPENSATION BOARD OF REVIEW

OOJ ID# _____
CARRIER ID# _____
Claim No. _____
SSN No. _____

Case Style _____

vs.

_____

Appellant: Claimant Employer Insurance Commission (Please circle)

The appellant appeals from the final ALJ Decision enclosed dated _____.

For OP claims in which the appeal relates to the non-medical issue, an appeal may be filed if the claim was rejected or if the permanent partial disability issue is final by claims administrator order that was not protested or by ALJ Decision. Include the following:
ALJ's non-medical Decision enclosed dated_____.
Final permanent partial disability order enclosed dated _____.

Date _____

_____
Appellant

_____

_____
Address

_____
Counsel

_____

_____
Address

A copy of the relevant Decision(s) must be enclosed (not stapled).

NOTE: One (1) copy of this or a similar form of notice must be filed with the Workers' Compensation Board of Review within thirty (30) days of receipt of notice of the ALJ Decision or in any event within sixty (60) days of the date of the ALJ Decision, regardless of notice. You do not need to submit a copy of the Notice of Appeal to the OOJ. Copies must be sent to all parties/attorneys.

Mail to: Workers' Compensation Board of Review
P. O. Box 2628
Charleston, WV 25329-2628

Appendix B – Revised Rules of Appellate Procedure

WORKERS' COMPENSATION APPEALS DOCKETING STATEMENT

Complete Case Title: Fred Flintstone v. Barney Rubble

Petitioner: Fred Flintstone Respondent: Barney Rubble

Counsel: Fred Counsel: _____

Claim No.: 100342454243 Board of Review No.: 123123123123

Date of Injury/Last Exposure: 12/2/2001 Date Claim Filed: 12/1/2004

Date and Ruling of the Office of Judges: _____

Date and Ruling of the Board of Review: _____

Issue and Relief requested on Appeal: _____

CLAIMANT INFORMATION

Claimant's Name: _____

Nature of Injury:

Age: _____ Is the Claimant still working? ■Yes ☐No. If yes, where: _____

Occupation: No. of Years:

Was the claim found to be compensable? ■Yes ☐No If yes, order date: _____

ADDITIONAL INFORMATION FOR PTD REQUESTS

Education (highest): _____ Old Fund or New Fund (please circle one)

Date of Last Employment:

Total amount of prior PPD awards: _____ (add dates of orders on separate page)

Finding of the PTD Review Board:

List all compensable conditions under this claim number: _____
(Attach a separate sheet if necessary)

Are there any related petitions currently pending or previously considered by the Supreme Court?
☐Yes ■No
(If yes, cite the case name, docket number and the manner in which it is related on a separate sheet.)

Are there any related petitions currently pending below? ☐Yes ■No
(If yes, cite the case name, tribunal and the manner in which it is related on a separate sheet.)

If an appealing party is a corporation an extra sheet must list the names of parent corporations and the name of any public company that owns ten percent or more of the corporation's stock. If this section is not applicable, please so indicate below.

☐ The corporation who is a party to this appeal does not have a parent corporation and no publicly held company owns ten percent or more of the corporation's stock.

Do you know of any reason why one or more of the Supreme Court Justices should be disqualified from this case? ☐Yes ☐No
If so, set forth the basis on an extra sheet. Providing the information required in this section does not relieve a party from the obligation to file a motion for disqualification in accordance with Rule 33.

Here are the citations for some important court decisions.

Gill v. City of Charleston, 236 W. Va. 737, 783 S.E.2d 857 (2016)

SWVA, Inc. v. Birch, 237 W. Va. 393, 787 S.E.2d 664 (2016)

Hale v. W. Virginia Office of Ins. Com'r, 228 W. Va. 781, 724 S.E.2d 752 (2012)

Bowers v. W. Virginia Office of Ins. Com'r, 224 W. Va. 398, 686 S.E.2d 49 (2009)

Simpson v. W. Virginia Office of Ins. Com'r, 223 W. Va. 495, 678 S.E.2d 1 (2009)

Pioneer Pipe, Inc. v. Swain, 237 W. Va. 722, 791 S.E.2d 168 (2016)

Pennington v. West Virginia Office of the Insurance Commissioner, No. 17-1060, 17-1061, 17-1063, 17-1123, ___W. Va. ___, S.E.2d ____ (Filed November 2, 2018)