DEPARTMENT OF
WORKFORCE DEVELOPMENT

WORKER'S COMPENSATION ACT OF WISCONSIN

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WORKER'S COMPENSATION DIVISION

MISSION

To effectively and efficiently:

- Promote healthy, safe work environments.
- Maintain a balanced system of services.
- Ensure compliance with the provision of the Wisconsin Worker's Compensation Act.

DWD is an equal opportunity employer and service provider. If you have a disability and need assistance with this information, please dial 7-1-1 for Wisconsin Relay Service. Please contact the Worker's Compensation Division at (608) 266-1340 to request information in an alternate format, including translated to another language.

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Table of Contents

TEXT OF CH. 102, WITH 2011-19 AMENDMENTS **1**

102.01 DEFINITIONS 3
102.03 CONDITIONS OF LIABILITY 4
102.04 DEFINITION OF EMPLOYER 13
102.05 ELECTION BY EMPLOYER, WITHDRAWAL 14
102.06 JOINT LIABILITY OF EMPLOYER AND CONTRACTOR 15
102.07 EMPLOYEE DEFINED 15
102.075 ELECTION BY SOLE PROPRIETOR, PARTNER OR MEMBER 21
102.076 ELECTION BY CORPORATE OFFICER 21
102.077 ELECTION BY SCHOOL DISTRICT OR PRIVATE SCHOOL 21
102.078 ELECTION BY REAL ESTATE FIRM 22
102.08 ADMINISTRATION FOR STATE EMPLOYEES 22
102.11 EARNINGS, METHOD OF COMPUTATION 23
102.12 NOTICE OF INJURY, EXCEPTION, LACHES 25
102.123 STATEMENT OF EMPLOYEE 26
102.125 FRAUD REPORTING, INVESTIGATION, AND PROSECUTION 26
102.13 EXAMINATION; COMPETENT WITNESSES; EXCLUSION OF EVIDENCE; AUTOPSY 27
102.14 JURISDICTION OF DEPARTMENT AND DIVISION; ADVISORY COMMITTEE 30
102.15 RULES OF PROCEDURE; TRANSCRIPTS 30
102.16 SUBMISSION OF DISPUTES, CONTRIBUTIONS BY EMPLOYEES 31
102.17 PROCEDURE; NOTICE OF HEARING; WITNESSES, CONTEMPT; TESTIMONY, MEDICAL EXAMINATION 36
102.175 APPORTIONMENT OF LIABILITY 43
102.18 FINDINGS, ORDERS AND AWARDS 44
102.19 ALIEN DEPENDENTS; PAYMENTS THROUGH CONSULAR OFFICERS 50
102.195 EMPLOYEES CONFINED IN INSTITUTIONS; PAYMENT OF BENEFITS 50
102.20 JUDGMENT ON AWARD 50
102.21 PAYMENT OF AWARDS BY LOCAL GOVERNMENTAL UNITS 50
102.22 PENALTY FOR DELAYED PAYMENTS; INTEREST 50
102.23 JUDICIAL REVIEW 51
102.24 REMANDING RECORD 54
102.25 APPEAL FROM JUDGMENT ON AWARD 55
102.26 FEES AND COSTS 55
102.27 CLAIMS AND AWARDS PROTECTED; EXCEPTIONS 56
102.28 PREFERENCE OF CLAIMS; WORKER'S COMPENSATION INSURANCE 56
102.29 THIRD PARTY LIABILITY 61
102.30 OTHER INSURANCE NOT AFFECTED; LIABILITY OF INSURED EMPLOYER 68
102.31 WORKER'S COMPENSATION INSURANCE; POLICY REGULATIONS 69
102.315 WORKER'S COMPENSATION INSURANCE; EMPLOYEE LEASING COMPANIES 71
102.32 CONTINUING LIABILITY; GUARANTEE SETTLEMENT, GROSS PAYMENT 76
102.33 FORMS AND RECORDS; PUBLIC ACCESS 77
102.35 PENALTIES 80
102.37 EMPLOYERS' RECORDS 81
102.38 RECORDS AND REPORTS OF PAYMENTS 81
102.39 RULES AND GENERAL ORDERS; APPLICATION OF STATUTES 81
102.40 REPORTS NOT EVIDENCE IN ACTIONS 81
102.42 INCIDENTAL COMPENSATION 82
102.425 PRESCRIPTION AND NONPRESCRIPTION DRUG TREATMENT 84
102.43 WEEKLY COMPENSATION SCHEDULE 87
102.44 MAXIMUM LIMITATIONS 90
102.45 BENEFITS PAYABLE TO MINORS; HOW PAID 94

102.46 DEATH BENEFIT 95
102.47 DEATH BENEFIT, CONTINUED 95
102.475 DEATH BENEFIT; LAW ENFORCEMENT AND CORRECTIONAL OFFICERS, FIRE FIGHTERS, RESCUE SQUAD MEMBERS, DIVING TEAM MEMBERS, NATIONAL OR STATE GUARD MEMBERS AND EMERGENCY MANAGEMENT PERSONNEL 95
102.48 DEATH BENEFIT, CONTINUED 96
102.49 ADDITIONAL DEATH BENEFIT FOR CHILDREN, STATE FUND 97
102.50 BURIAL EXPENSES 98
102.51 DEPENDENTS 98
102.52 PERMANENT PARTIAL DISABILITY SCHEDULE 100
102.53 MULTIPLE INJURY VARIATIONS 101
102.54 INJURY TO DOMINANT HAND 101
102.55 APPLICATION OF SCHEDULES 102
102.555 OCCUPATIONAL DEAFNESS; DEFINITIONS 102
102.56 DISFIGUREMENT 103
102.565 TOXIC OR HAZARDOUS EXPOSURE; MEDICAL EXAMINATION; CONDITIONS OF LIABILITY 104
102.57 VIOLATIONS OF SAFETY PROVISIONS, PENALTY 105
102.58 DECREASED COMPENSATION 105
102.59 PREEXISTING DISABILITY, INDEMNITY 106
102.60 MINOR ILLEGALLY EMPLOYED 107
102.61 INDEMNITY UNDER REHABILITATION LAW 108
102.62 PRIMARY AND SECONDARY LIABILITY; UNCHANGEABLE 110
102.63 REFUNDS BY STATE 111
102.64 ATTORNEY GENERAL SHALL REPRESENT STATE AND COMMISSION 111
102.65 WORK INJURY SUPPLEMENTAL BENEFIT FUND 112
102.66 PAYMENT OF CERTAIN BARRED CLAIMS 113
102.75 ADMINISTRATIVE EXPENSES 113
102.80 UNINSURED EMPLOYERS FUND 114
102.81 COMPENSATION FOR INJURED EMPLOYEE OF UNINSURED EMPLOYER 116
102.82 UNINSURED EMPLOYER PAYMENTS 117
102.83 COLLECTION OF UNINSURED EMPLOYER PAYMENTS 118
102.835 LEVY FOR DELINQUENT PAYMENTS 120
102.84 PREFERENCE OF REQUIRED PAYMENTS 1222
102.85 UNINSURED EMPLOYERS; PENALTIES 122
102.87 CITATION PROCEDURE 123
102.88 PENALTIES; REPEATERS 1255
102.89 PARTIES TO A VIOLATION 125

TEXT OF OTHER STATUTES RELATING TO WORKER'S COMPENSATION 127

CHAPTER 15, STRUCTURE OF THE EXECUTIVE BRANCH 1277
CHAPTER 19, GENERAL DUTIES OF PUBLIC OFFICIALS 127
CHAPTER 20, APPROPRIATIONS AND BUDGET MANAGEMENT 127
CHAPTER 40, PUBLIC EMPLOYEE TRUST FUND 128
CHAPTER 46, SOCIAL SERVICES 132
CHAPTER 49, PUBLIC ASSISTANCE AND CHILDREN AND FAMILY SERVICES 133
CHAPTER 59, COUNTIES 134
CHAPTER 62, CITIES 134
CHAPTER 101, DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES – REGULATION OF INDUSTRY, BUILDINGS, AND SAFETY 135
CHAPTER 106, APPRENTICE, EMPLOYMENT AND EQUAL RIGHTS PROGRAMS 138
CHAPTER 108, UNEMPLOYMENT INSURANCE AND RESERVES 138
CHAPTER 227, ADMINISTRATIVE PROCEDURE AND REVIEW 140
CHAPTER 303, PRISON LABOR 142

CHAPTER 626, RATE REGULATION IN WORKER'S COMPENSATION INSURANCE 1433
CHAPTER 814, COURT COSTS, FEES AND SURCHARGES 1433
CHAPTER 891, PRESUMPTIONS 1444
CHAPTER 943, CRIMES AGAINST PROPERTY 145

RULES OF PRACTICE - ADMINISTRATIVE CODE 146

CHAPTER DWD 80, WORKER'S COMPENSATION 146
CHAPTER DWD 81, WORKER'S COMPENSATION TREATMENT GUIDELINES 188
CHAPTER HA 4, PROCEDURE AND PRACTICE FOR WORKER'S COMPENSATION AND RELATED CASES 246
CHAPTER LIRC 1, GENERAL 253
CHAPTER LIRC 3, WORKER'S COMPENSATION 257

SUBJECT INDEX 261

APPENDICES 279

MAXIMUM WAGE CHART 280
MILEAGE RATES 281
PRIVATE REHABILITATION COUNSELOR FEE FOR SERVICES 282
PAYMENTS DUE WORK INJURY SUPPLEMENTAL BENEFIT FUND §102.49 AND §102.59 283

SUGGESTED FORMS FOR PROCEDURE 287

WKC-7 HEARING APPLICATION & INSTRUCTIONS 288
WKC-12 EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE 291
WKC-13 SUPPLEMENTARY REPORT ON ACCIDENTS AND INDUSTRIAL DISEASES 293
WKC-13-A WAGE INFORMATION SUPPLEMENT 295
WKC-16 MEDICAL REPORT ON INDUSTRIAL INJURY 297
WKC-16-B PRACTITIONER'S REPORT ON ACCIDENT OR INDUSTRIAL DISEASE IN LIEU OF TESTIMONY 299
WKC-28 STATE OF WISCONSIN LABOR AND INDUSTRY REVIEW COMMISSION PETITION FOR REVIEW OF FINDINGS AND ORDER OF ADMINISTRATIVE LAW JUDGE 301
WKC-170 THIRD PARTY PROCEEDS DISTRIBUTION AGREEMENT 302
WKC-176 COMPROMISE AGREEMENT 303
WKC-6743 VOCATIONAL EXPERT REPORT 304
WKC-7359 TPD WORKSHEET FOR WKC-13 306
WKC-9488 VOLUNTARY AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION 307
SUGGESTED FORM OF COMPLAINT FOR JUDICIAL REVIEW OF AN ORDER OF THE LABOR AND INDUSTRY REVIEW COMMISSION 309

Text of Ch. 102, with 2011-19 Amendments

CHAPTER 102
WORKER'S COMPENSATION

102.01	Definitions.
102.03	Conditions of liability.
102.04	Definition of employer.
102.05	Election by employer, withdrawal.
102.06	Joint liability of employer and contractor.
102.07	Employee defined.
102.075	Election by sole proprietor, partner or member.
102.076	Election by corporate officer.
102.077	Election by school district or private school.
102.078	Election by real estate firm.
102.08	Administration for state employees.
102.11	Earnings, method of computation.
102.12	Notice of injury, exception, laches.
102.123	Statement of employee.
102.125	Fraud reporting, investigation, and prosecution.
102.13	Examination; competent witnesses; exclusion of evidence; autopsy.
102.14	Jurisdiction of department and division; advisory committee.
102.15	Rules of procedure; transcripts.
102.16	Submission of disputes, contributions by employees.
102.17	Procedure; notice of hearing; witnesses, contempt; testimony, medical examination.
102.175	Apportionment of liability.
102.18	Findings, orders and awards.
102.19	Alien dependents; payments through consular officers.
102.195	Employees confined in institutions; payment of benefits.
102.20	Judgment on award.
102.21	Payment of awards by local governmental units.
102.22	Penalty for delayed payments; interest.
102.23	Judicial review.
102.24	Remanding record.
102.25	Appeal from judgment on award.
102.26	Fees and costs.
102.27	Claims and awards protected; exceptions.
102.28	Preference of claims; worker's compensation insurance.
102.29	Third party liability.
102.30	Other insurance not affected; liability of insured employer.
102.31	Worker's compensation insurance; policy regulations.
102.315	Worker's compensation insurance; employee leasing companies.
102.32	Continuing liability; guarantee settlement, gross payment.
102.33	Forms and records; public access.
102.35	Penalties.
102.37	Employers' records.
102.38	Records and reports of payments.
102.39	Rules and general orders; application of statutes.
102.40	Reports not evidence in actions.
102.42	Incidental compensation.
102.425	Prescription and nonprescription drug treatment.
102.43	Weekly compensation schedule.
102.44	Maximum limitations.
102.45	Benefits payable to minors; how paid.
102.46	Death benefit.
102.47	Death benefit, continued.

102.475	Death benefit; law enforcement and correctional officers, fire fighters, rescue squad members, diving team members, national or state guard members and emergency management personnel.
102.48	Death benefit, continued.
102.49	Additional death benefit for children, state fund.
102.50	Burial expenses.
102.51	Dependents.
102.52	Permanent partial disability schedule.
102.53	Multiple injury variations.
102.54	Injury to dominant hand.
102.55	Application of schedules.
102.555	Occupational deafness; definitions.
102.56	Disfigurement.
102.565	Toxic or hazardous exposure; medical examination; conditions of liability.
102.57	Violations of safety provisions, penalty.
102.58	Decreased compensation.
102.59	Preexisting disability, indemnity.
102.60	Minor illegally employed.
102.61	Indemnity under rehabilitation law.
102.62	Primary and secondary liability; unchangeable.
102.63	Refunds by state.
102.64	Attorney general shall represent state and commission.
102.65	Work injury supplemental benefit fund.
102.66	Payment of certain barred claims.
102.75	Administrative expenses.
102.80	Uninsured employers fund.
102.81	Compensation for injured employee of uninsured employer.
102.82	Uninsured employer payments.
102.83	Collection of uninsured employer payments.
102.835	Levy for delinquent payments.
102.84	Preference of required payments.
102.85	Uninsured employers; penalties.
102.87	Citation procedure.
102.88	Penalties; repeaters.
102.89	Parties to a violation.

Cross-reference: See also ch. DWD 80, Wis. adm. code.

102.01 Definitions.

(1) This chapter may be referred to as the "Worker's Compensation Act" and allowances, recoveries and liabilities under this chapter constitute "Worker's Compensation".

(2) In this chapter:

(ad) "Administrator" means the administrator of the division of hearings and appeals in the department of administration.[1]

(af) "Commission" means the labor and industry review commission.

(ag) "Commissioner" means a member of the commission.

(am) "Compensation" means worker's compensation.

(ap) "Department" means the department of workforce development.

(ar) "Division" means the division of hearings and appeals in the department of administration.[2]

(bm) "General order" means such order as applies generally throughout the state to all persons, employments, places of employment or public buildings, or all persons, employments or places of employment or public buildings of a class under the jurisdiction of the department. All other orders of the department shall be considered special orders.

(c) "Injury" means mental[3] or physical harm to an employee caused by accident or disease, and also means damage to or destruction of artificial members, dental appliances, teeth, hearing aids and eyeglasses, but, in the case of hearing aids or eyeglasses, only if such damage or destruction resulted from accident which also caused personal injury entitling the employee to compensation therefor either for disability or treatment.[4]

(d) "Local governmental unit" means a political subdivision of this state; a special purpose district or taxing jurisdiction, as defined in s. 70.114 (1) (f), in this state; an instrumentality, corporation, combination, or subunit of any of the foregoing; or any other public or quasi-public corporation.[5]

(dm) "Order" means any decision, rule, regulation, direction, requirement, or standard of the department or the division, or any other determination arrived at or decision made by the department or the division.

(e) "Primary compensation and death benefit" means compensation or indemnity for disability or death benefit, other than increased, double or treble compensation or death benefit.

(eg) "Religious sect" means a religious body of persons, or a division of a religious body of persons, who unite in holding certain special doctrines or opinions concerning religion that distinguish those persons from others holding the same general religious beliefs.

(em) "Secretary" means the secretary of workforce development.

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[1] This definition was created by 2015 Wis. Act 55, as part of the 2015-2016 budget bill. The budget bill transferred the adjudicatory functions of the worker's compensation division to the division of hearings and appeals in the department of administration effective January 1, 2016. By mutual agreement of the departments, the transfer took effect January 11, 2016.

[2] This definition was created by 2015 Wis. Act 55, effective January 1, 2016. See also prior footnote.

[3] The definition of mental injury had included the phrase "if it arises from exposure to conditions or circumstances beyond those common to occupational or non-occupational life." This language was ambiguous and resulted in conflicting court interpretations. Therefore, this language was deleted by Wis. Act 179, effective April 1, 1988. The language as previously interpreted by the court in School District No. 1 v. ILHR Dept., 62 Wis.2d 370 (1974), is restored. This requires that a non-traumatic mental injury must have resulted from a situation of greater dimensions than the day-to-day emotional strain and tension all employees must experience.

[4] As to eyeglasses and hearing aids, damage or destruction must result from an accident which also causes personal injury entitling the employee to medical treatment or payment of compensation. If an employee merely slips and eyeglasses or hearing aids drop to the floor and break, but no personal injury results to the employee, there will be no payment for damage to eyeglasses or hearing aids.

[5] This definition was created by 2015 Wis. Act 180, effective March 2, 2016. The intent is to include all special purpose districts, political subdivisions and taxing jurisdictions in the meaning of "local government unit."

(f) "Temporary help agency" means an employer who places its employee with or leases its employees to another employer who controls the employee's work activities and compensates the first employer for the employee's services, regardless of the duration of the services.[6]

(g) Except as provided in s. 102.555 with respect to occupational deafness, "time of injury", "occurrence of injury", or "date of injury" means:

1. In the case of accidental injury, the date of the accident which caused the injury.

2. In the case of disease, the date of disability or, if that date occurs after the cessation of all employment that contributed to the disability, the last day of work for the last employer whose employment caused disability.[7]

(gm) "Wisconsin compensation rating bureau" means the bureau provided for in s. 626.06.

(h) "Uninsured employer" means an employer that is in violation of s. 102.28 (2).

(j) "Uninsured employers fund" means the fund established under s. 102.80 (1).

(jm) "Uninsured employer surcharge" means the surcharge under s. 102.85 (4).

(k) "Workweek" means a calendar week, starting on Sunday and ending on Saturday.[8]

History: 1975 c. 147 ss. 7 to 13, 54; 1975 c. 200; 1979 c. 89, 278; 1981 c. 92; 1983 a. 98, 189; 1985 a. 83; 1987 a. 179; 1989 a. 64; 1995 a. 27 ss. 3737 to 3741, 9130 (4); 1995 a. 117, 417; 1997 a. 3; 1999 a. 9, 14; 2001 a. 37; 2003 a. 139; 2007 a. 20; 2015 a. 55, 180.

In an occupational disease claim, the examiner may find the date of injury to be other than the last day of work. Royal-Globe Insurance Co. v. DILHR, 82 Wis. 2d 90, 260 N.W.2d 670 (1978).

An intentionally inflicted injury, unexpected and unforeseen by the injured party, is an accident under sub. (2) (c). Jenson v. Employers Mutual Casualty Co. 161 Wis. 2d 253, 468 N.W.2d 1 (1991).

Cessation of employment under sub. (2) (g) 2. does not require that the employee no longer be employed, but requires that the employee no longer be employed in the employment that contributed to the disability. If that is the case, the employer that caused the injury is responsible. North River Insurance Co. v. Manpower Temporary Services, 212 Wis. 2d 63, 568 N.W.2d 15 (Ct. App. 1997), 96-2000.

102.03 Conditions of liability.

(1) Liability under this chapter shall exist against an employer only where the following conditions concur:

(a) Where the employee sustains an injury.

(b) Where, at the time of the injury, both the employer and employee are subject to the provisions of this chapter.

(c) 1. Where, at the time of the injury, the employee is performing service growing out of and incidental to his or her employment.

2. Any employee going to and from his or her employment in the ordinary and usual way,[9] while on the premises of the employer, or while in the immediate vicinity of those premises if the injury results from an occurrence on the premises; any employee going between an employer's designated parking lot and the employer's work premises while on a direct route and in the ordinary and usual way; any volunteer fire fighter, emergency medical responder, emergency medical services practitioner, rescue squad member, or diving team member while responding to a call for assistance, from the time

[6] Leasing agencies that lease employees to other employers would be responsible for worker's compensation benefits in the same way that temporary help agencies are. An employee continues to be the employee of the original employer, though that employee may have been loaned or leased to another employer, if the original employer continues to retain at least some rights or obligations of the original employment contract such as payment of wages or the power to terminate the employee. This corrects the situation that can occur when employees leased to another employer are injured during the leasing period and the employers litigate who is responsible for the benefits while the employee waits for his or her compensation. This clarification also eliminates the double collection of premiums by insurance carriers on the wages of the employee from both the leasing agency and the employer to whom the employee is leased.

[7] Compensation benefits may be recovered for disability which occurs after the severance of the employer-employee relationship, even though there was neither wage loss, nor time loss during the time that the employee was in service.

[8] This section was created by 2001 Wis. Act 37, effective January 1, 2002, and defines workweek as a calendar week starting on Sunday and ending on Saturday.

[9] This extends coverage to injuries on a public street or sidewalk where injury occurs while the employee is on a direct route between the employer's designated parking lot after parking there and the employer's work premises.

of the call for assistance to the time of his or her return from responding to that call, including traveling to and from any place to respond to and return from that call, but excluding any deviations for private or personal purposes;[10] or any fire fighter or municipal utility employee responding to a call for assistance outside the limits of his or her city or village, unless that response is in violation of law, is performing service growing out of and incidental to employment.

3. An employee is not performing service growing out of and incidental to his or her employment while going to or from employment in a private or group or employer-sponsored car pool, van pool, commuter bus service, or other ride-sharing program in which the employee participates voluntarily and the sole purpose of which is the mass transportation of employees to and from employment.[11] An employee is not performing service growing out of and incidental to employment while engaging in a program, event, or activity designed to improve the physical well-being of the employee, whether or not the program, event, or activity is located on the employer's premises, if participation in the program, event, or activity is voluntary and the employee receives no compensation for participation.[12]

4. The premises of the employer include the premises of any other person on whose premises the employee performs service.

5. To enhance the morale and efficiency of public employees in this state and attract qualified personnel to the public service, it is the policy of the state that the benefits of this chapter shall extend and be granted to employees in the service of the state or of any municipality therein on the same basis, in the same manner, under the same conditions, and with like right of recovery as in the case of employees of persons, firms or private corporations. Accordingly, the same considerations, standards, and rules of decision shall apply in all cases in determining whether any employee under this chapter, at the time of the injury, was performing service growing out of and incidental to the employee's employment. For the purposes of this subsection no differentiation shall be made among any of the classes of employers enumerated in s. 102.04 or of employees enumerated in s. 102.07; and no statutes, ordinances, or administrative regulations otherwise applicable to any employees enumerated in s. 102.07 shall be controlling.

(d) Where the injury is not intentionally self-inflicted.

(e) Where the accident or disease causing injury arises out of the employee's employment.

(f) Every employee whose employment requires the employee to travel shall be deemed to be performing service growing out of and incidental to the employee's employment at all times while on a trip, except when engaged in a deviation for a private or personal purpose. Acts reasonably necessary for living or incidental thereto shall not be regarded as such a deviation. Any accident or disease arising out of a hazard of such service shall be deemed to arise out of the employee's employment.[13]

(g) Members of the state legislature are covered by this chapter when they are engaged in performing their duties as state legislators including:

1. While performing services growing out of and incidental to their function as legislators;

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[10] This amendment provides that volunteer firefighters, first responders, emergency medical technicians, rescue squad members and diving team members are in the course of employment for worker's compensation purposes while responding to calls from the time of the call to the time of return from the call, except for deviations for private and personal purposes. Created by 2009 Wis. Act 206, effective May 1, 2010.

[11] If an employer assists in organizing or financing a carpool or vanpool, the employer is not liable for injuries incurred going to or coming from work unless there is a specific agreement for transportation as part of the contract of hire.

[12] This excludes injuries to employees engaged in well-being programs if the participation is voluntary and uncompensated. This subdivision was amended by 2005 Wis. Act 172, effective April 1, 2006, to include well-being activities and events in addition to programs.

[13] Accident or disease must arise out of a hazard of employment, and accidents and diseases not caused by reason of incidents of service are not to be compensated. Injuries, whether accidental or otherwise, must therefore arise out of the business circumstances of the trip and not merely occur because of a personal condition or disability bearing no relation whatsoever to service.

2. While performing their official duties as members of committees or other official bodies created by the legislature;
3. While traveling to and from the state capital to perform their duties as legislators; and
4. While traveling to and from any place to perform services growing out of and incidental to their function as legislators, regardless of where the trip originated, and including acts reasonably necessary for living but excluding any deviations for private or personal purposes except that acts reasonably necessary for living are not deviations.
(2) Where such conditions exist the right to the recovery of compensation under this chapter shall be the exclusive remedy against the employer, any other employee of the same employer and the worker's compensation insurance carrier. This section does not limit the right of an employee to bring action against any coemployee for an assault intended to cause bodily harm, or against a coemployee for negligent operation of a motor vehicle not owned or leased by the employer, or against a coemployee of the same employer to the extent that there would be liability of a governmental unit to pay judgments against employees under a collective bargaining agreement or a local ordinance.[14]
(3) Providing or failing to provide any safety inspection or safety advisory service incident to a contract for worker's compensation insurance or to a contract for safety inspections or safety advisory services does not by itself subject an insurer, an employer, an insurance service organization, a union, a union member or any agent or employee of the insurer, employer, insurance service organization or union to liability for damages for an injury resulting from providing or failing to provide the inspection or services.

(4) The right to compensation and the amount of the compensation shall in all cases be determined in accordance with the provisions of law in effect as of the date of the injury except as to employees whose rate of compensation is changed as provided in s. 102.43 (5) (c) or (7) or 102.44 (1) or (5) and employees who are eligible to receive private rehabilitative counseling and rehabilitative training under s. 102.61 (1m)[15] and except as provided in s. 102.555 (12) (b).
(5) If an employee, while working outside the territorial limits of this state, suffers an injury on account of which the employee, or in the event of the employee's death, his or her dependents, would have been entitled to the benefits provided by this chapter had such injury occurred within this state, such employee, or in the event of the employee's death resulting from such injury, the dependents of the employee, shall be entitled to the benefits provided by this chapter, if at the time of such injury any of the following applies:
(a) His or her employment is principally localized in this state.
(b) He or she is working under a contract of hire made in this state in employment not principally localized in any state.
(c) He or she is working under a contract made in this state in employment principally localized in another state whose worker's compensation law is not applicable to that person's employer.
(d) He or she is working under a contract of hire made in this state for employment outside the United States.
(e) He or she is a Wisconsin law enforcement officer acting under an agreement authorized under s. 175.46.
(6)[FN] **(a)** In this subsection, "first responder" means an employee of or volunteer for an employer that provides fire fighting, law enforcement, or medical treatment of COVID−19, and who has regular, direct contact with, or is regularly in close proximity to, patients or other members of the public requiring

[14] The exceptions permit the right of recovery against a fellow employee of the same employer who was negligent in the operation of a motor vehicle owned by or leased to the fellow employee. The exception does not apply to a vehicle owned or leased by the employer. The employee has a right of recovery against a fellow employee of the same employer for an assault intended to cause bodily harm. The exception also extends to governmental units if a collective bargaining agreement or a local ordinance provides for payment.

[15] This allows employees who cannot be served by the DVR to receive rehabilitative training under s. 102.61(1m) regardless of the date of injury.
[FN] This was created by 2019 Wis. Act 185, effective on 4/17/2020, as part of the state government response to the COVID-19 pandemic.

emergency services, within the scope of the individual's work for the employer.

(b) For the purposes of benefits under this chapter, where an injury to a first responder is found to be caused by COVID−19 during the public health emergency declared by the governor under s. 323.10 on March 12, 2020, by executive order 72, and ending 30 days after the termination of the order, and where the employee has been exposed to persons with confirmed cases of COVID−19 in the course of employment, the injury is presumed to be caused by the individual's employment.

(c) An injury claimed under par. (b) must be accompanied by a specific diagnosis by a physician or by a positive COVID−19 test.

(d) An injury claimed under par. (b) may be rebutted by specific evidence that the injury was caused by exposure to COVID−19 outside of the first responder's work for the employer.

History: 1971 c. 148, 307, 324; 1975 c. 147 ss. 15, 54; 1977 c. 195, 272, 418; 1979 c. 278; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1993 a. 49, 370, 490, 492; 2005 a. 172; 2007 a. 185; 2009 a. 206; 2011 a. 183; 2015 a. 180; 2017 a. 12; 2019 a. 185.
https://docs.legis.wisconsin.gov/2019/related/acts/185.pdf

Committee Note, 1971: The Wisconsin Supreme Court in the case of Halama v. ILHR Department, 48 Wis. 2d 328 (1970), suggested that consideration be given to extending coverage to an employee who is injured while going to or from work on a direct route between two portions of the employer's premises, i.e., parking lot and work premises. [Bill 371-A]

The department correctly found on a claim for death benefits for an employee murdered while she alone remained in an office that had been vacated by all other employees, that the accident arose out of the deceased's employment since the isolated work environment in which the deceased worked constituted a zone of special danger, and hence the positional risk doctrine was applicable. Allied Manufacturing, Inc. v. DILHR, 45 Wis. 2d 563, 173 N.W.2d 690 (1970).

The holding in *Brown v. Ind. Comm*, 9 Wis. 2d 555, that causation legally sufficient to support compensation does not require a showing of strain or exertion greater than that normally required by the employee's work efforts, was not intended to preclude a doctor determining causation, from considering whether the employee was engaged in usual work at the time of injury. However, the doctor should not automatically conclude each time an employee is injured while performing a task previously performed on a regular basis that the injury was caused by a preexisting condition rather than employment. Pitsch v. DILHR, 47 Wis. 2d 55, 176 N.W.2d 390 (1970).

When a herniated disc was diagnosed within a few days after the claimed injury, the evidence did not justify the department's finding that the employee did not meet the burden of proof. Erickson v. DILHR, 49 Wis. 2d 114, 181 N.W.2d 495 (1970).

The department cannot divide liability for compensation among successive employers for the effects of successive injuries in the absence of evidence to sustain a finding that the disability arose from the successive injuries, nor can it assess all liability against one of several employers nor divide liability equally among each of several employers if there is no evidence to support a finding that the injury or injuries contributed to the disability in that manner. Semons Department Store v. DILHR, 50 Wis. 2d 518, 184 N.W.2d 871 (1971).

While susceptibility to further injury does not necessarily establish a permanent disability under the "as is" doctrine, an employee's predisposition to injury does not relieve a present employer from liability if the employee becomes injured due to the employment even though the injury may not have caused disability in another person. Semons Department Store v. DILHR, 50 Wis. 2d 518, 184 N.W.2d 871 (1971).

A salesperson on a trip who deviated to the extent of spending several hours in a tavern before being killed on his ordinary route home may have been in the course of employment, in which case his estate would be entitled to compensation. Lager v. DILHR, 50 Wis. 2d 651, 185 N.W.2d 300 (1971).

A wife cannot assert a separate and independent cause of action against her husband's employer for loss of consortium due to injuries sustained by the husband in an industrial accident covered by this chapter. Rosencrans v. Wisconsin Telephone Co. 54 Wis. 2d 124, 194 N.W.2d 643 (1972).

A commission finding that the deceased was performing services when killed while walking on a Milwaukee street at 3 a.m. while intoxicated was sustained. Phillips v. DILHR, 56 Wis. 2d 569, 202 N.W.2d 249 (1972).

Members of a partnership are employers of the employees of the partnership. An employee cannot bring a 3rd-party action against a member of the employing partnership. Candler v. Hardware Dealers Mutual Insurance Co. 57 Wis. 2d 85, 203 N.W.2d 659 (1973).

The "exclusive remedy" provision in sub. (2) does not prevent an action for personal injuries against a supervisory coemployee on the basis of negligence by common law standards. It makes no difference that the coemployee is brought in by means of a 3rd-party complaint. Lampada v. State Sand & Gravel Co. 58 Wis. 2d 315, 206 N.W.2d 138 (1973).

A salesperson, employed on a part-salary and part-commission basis, who travelled each day from his home, servicing and soliciting orders within a prescribed territory, using a delivery truck furnished by his employer whose office he was not required to report to, was performing services incidental to employment when he fell on his icy driveway going to his delivery truck to leave for his first call. Black River Dairy Products, Inc. v. DILHR, 58 Wis. 2d 537, 207 N.W.2d 65 (1973).

Since the decedent's employment status for services rendered in this state was substantial and not transitory, and the relationship was not interrupted by cessation of work for the Wisconsin employer, the department erred when it predicated its denial of benefits on the employer's

conflicting testimony that during the year in which the employee met his death his working time in Wisconsin had been reduced to 10 percent. Simonton v. DILHR, 62 Wis. 2d 112, 214 N.W.2d 302 (1974).

Under sub. (1) (f), no purpose of the employer was served by an extended deviation to test road conditions in bad weather to determine if visiting a boyfriend or going on a hunting trip the next day would be feasible, nor was it a reasonably necessary for living or incidental thereto. Hunter v. DILHR, 64 Wis. 2d 97, 218 N.W.2d 314 (1974).

Under the 4-element test for deciding whether a worker was a loaned or special employee, the 1st element, actual or implied consent to work for the special employer, was negated by the existence of a work order providing that the plaintiff would not be employed by the special employer for a period of 90 days, and by the absence of any other evidence indicating consent; hence, the plaintiff was a business invitee and not an employee at the time of the accident. Nelson v. L. & J. Press Corp. 65 Wis. 2d 770, 223 N.W.2d 607 (1974).

Nontraumatically caused mental injury is compensable only if it results from a situation of greater dimensions than the day-to-day mental stresses and tensions that all employees must experience. Swiss Colony, Inc. v. DILHR, 72 Wis. 2d 46, 240 N.W.2d 128 (1976).

A provider of medical services to an employee did not have a cause of action under the worker's compensation act against the employer when the employer denied liability and compromised an employee's claim. La Crosse Lutheran Hospital v. Oldenburg, 73 Wis. 2d 71, 241 N.W.2d 875 (1976).

The doctrines of required travel, dual purpose, personal comfort, and special mission are discussed. Sauerwein v. DILHR, 82 Wis. 2d 294, 262 N.W.2d 126 (1978).

The personal comfort doctrine did not apply to an employee while going to lunch off of the employer's premises and not during specific working hours; a denial of benefits for an injury received while eating lunch off the premises did not deny equal protection. Marmolejo v. DILHR, 92 Wis. 2d 674, 285 N.W.2d 650 (1979).

The presumption in favor of traveling employees does not modify the requirements for employer liability. Goranson v. DILHR, 94 Wis. 2d 537, 289 N.W.2d 270 (1980).

That sub. (2) denies 3rd-party tort-feasors the right to a contribution action against a negligent employer who was substantially more at fault does not render the statute unconstitutional. Mulder v. Acme-Cleveland Corp. 95 Wis. 2d 173, 290 N.W.2d 276 (1980).

Use of the parking lot is a prerequisite for coverage under sub. (1) (c) 1. [now (1) (c) 2.]. Injury on a direct path between the lot and the work premises is insufficient. Jaeger Baking Co. v. Kretschmann, 96 Wis. 2d 590, 292 N.W.2d 622 (1980).

Sub. (2) is constitutional. Oliver v. Travelers Insurance Co. 103 Wis. 2d 644, 309 N.W.2d 383 (Ct. App. 1981).

The provision by an employer of alleged negligent medical care to an employee injured on the job by persons employed for that purpose did not subject the employer to tort liability for malpractice. Jenkins v. Sabourin, 104 Wis. 2d 309, 311 N.W.2d 600 (1981).

Repeated work-related back trauma was compensable as an occupational disease. Shelby Mutual Insurance Co. v. DILHR, 109 Wis. 2d 655, 327 N.W.2d 178 (Ct. App. 1982).

Injury due to horseplay was compensable. The "positional risk" doctrine applied. That doctrine provides that an accident arises out of employment when the connection between employment and the accident is such that the obligations of the employment place the employee in the particular place at the time the employee is injured by a force not personal to him or her. Bruns Volkswagen, Inc. v. DILHR, 110 Wis. 2d 319, 328 N.W.2d 886 (Ct. App. 1982).

When an employee who witnessed an injury to another was an active work-related participant in the tragedy, resulting nontraumatic psychic injury was compensable. International Harvester v. LIRC, 116 Wis. 2d 298, 341 N.W.2d 721 (Ct. App. 1983).

The "horseplay" rule barred recovery when the decedent jokingly placed his head inside a mold compression machine and accidentally started it. Nigbor v. DILHR, 115 Wis. 2d 606, 340 N.W.2d 918 (Ct. App. 1983); aff'd 120 Wis. 2d 375, 355 N.W.2d 532 (1984).

An employee injured by machinery manufactured by a corporation that had merged with the employer prior to the accident could recover in tort against the employer under the "dual persona" doctrine. Schweiner v. Hartford Accident & Indemnity Co. 120 Wis. 2d 344, 354 N.W.2d 767 (Ct. App. 1984).

Under the "positional risk" doctrine, the murder of an employee by a coemployee off work premises was an injury arising out of employment. Applied Plastics, Inc. v. LIRC, 121 Wis. 2d 271, 359 N.W.2d 168 (Ct. App. 1984).

Worker's compensation provides the exclusive remedy for injuries sustained as the result of a company doctor's negligence. Franke v. Durkee, 141 Wis. 2d 172, 413 N.W.2d 667 (Ct. App. 1987).

The "dual persona" doctrine is adopted, replacing the "dual capacity" doctrine. A 3rd-party may recover from an employer only when the employer has operated in a distinct persona as to the employee. Henning v. General Motors Assembly, 143 Wis. 2d 1, 419 N.W.2d 551 (1988).

The legal distinction between a corporation/employer and a partnership/landlord that leased the factory to the corporation, although both entities were composed of the same individuals, eliminated the partners' immunity as individuals under the exclusivity doctrine for negligence in maintaining the leased premises. Couillard v. Van Ess, 152 Wis. 2d 62, 447 N.W.2d 391 (Ct. App. 1989).

The injured employee, and not an injuring coemployee, must have been acting within the scope of employment at the time of injury. Jenson v. Employers Mutual Casualty Co. 161 Wis. 2d 253, 468 N.W.2d 1 (1991).

An assault under sub. (2) must be more than verbal; it must be physical. Jenson v. Employers Mutual Casualty Co. 161 Wis. 2d 253, 468 N.W.2d 1 (1991).

A parent corporation can be liable as a 3rd-party tortfeasor to an employee of a subsidiary when the parent negligently undertakes to render services to the subsidiary that the parent should have recognized were necessary for the protection of the subsidiary's employees. Miller v. Bristol-Myers, 168 Wis. 2d 863, 485 N.W.2d 31 (1992).

A compromise of a worker's compensation claim based on an allegation that an injury was job related precluded the

claimant from pursuing a discrimination claim against the same employer on the theory that the injury was not job related. Marson v. LIRC, 178 Wis. 2d 118, 503 N.W.2d 582 (Ct. App. 1993).

A coemployee of the plaintiff who closed a car door on the plaintiff's hand was not engaged in the "operation of a motor vehicle" under sub. (2). Hake v. Zimmerlee, 178 Wis. 2d 417, 504 N.W.2d 411 (Ct. App. 1993).

A corporation's president who purchased and leased a machine to the corporation as an individual held a dual persona and was subject to tort liability. Rauch v. Officine Curioni, S.P.A. 179 Wis. 2d 539, 508 N.W.2d 12 (Ct. App. 1993).

This section does not bar an employee from seeking arbitration under a collective bargaining agreement to determine whether termination following an injury violated the agreement. This section only excludes tort actions for injuries covered by the act. County of Lacrosse v. WERC, 182 Wis. 2d 15, 513 N.W.2d 708 (1994).

A contract "made in this state" under sub. (5) (b) is determined by where the contract was accepted. A contract accepted by telephone is made where the acceptor speaks. Horton v. Haddow, 186 Wis. 2d 174, 519 N.W.2d 736 (Ct. App. 1994).

Settlement of an employee's worker's compensation claim for a work related injury precluded the assertion of the employee's claim that she was entitled to leave for the injury under the Family Medical Leave Act, s. 103.10. Finell v. DILHR, 186 Wis. 2d 187, 519 N.W.2d 731 (Ct. App. 1994).

Employer payment of travel expenses does not alone render commuting a part of employment subject to coverage. When travel is a substantial part of employment and the employer provides a vehicle under its control and pays costs, coverage may be triggered. Doering v. LIRC, 187 Wis. 2d 471, 523 N.W.2d 142 (Ct. App. 1994).

Whether physical contact of a sexual nature was an assault by a coemployee not subject to the exclusive remedy provision of sub. (2) is a question of fact. A reasonable juror could conclude that sexual conduct could be so offensive that a reasonable person would have understood that physical injury such as loss of sleep, weight loss, or ulcers was substantially certain to follow. West Bend Mutual Insurance Co. v. Berger, 192 Wis. 2d 743, 531 N.W.2d 636 (Ct. App. 1995).

An employee's claims of defamation by an employer are preempted by this section. Claims for tortious interference with contract are not for injuries covered by the worker's compensation act and are not precluded. Wolf v. F & M Banks, 193 Wis. 2d 439, 534 N.W.2d 877 (Ct. App. 1995).

Nothing in this chapter precludes an employer from agreeing with employees to continue salaries for injured workers in excess of worker's compensation benefits. Excess payments are not worker's compensation and may be conditioned on the parties' agreement. City of Milwaukee v. DILHR, 193 Wis. 2d 626, 534 N.W.2d 903 (Ct. App. 1995).

A waiver of employer immunity from suit under this section may be made by an express agreement of indemnification. Schaub v. West Bend Mutual, 195 Wis. 2d 181, 536 N.W.2d 123 (Ct. App. 1995), 94-2174.

If an employer injures an employee through intentional sexual harassment, the injury is not an accident under sub. (1) (e) and not subject to the exclusivity provision of sub. (2). Lentz v. Young, 195 Wis. 2d 457, 536 N.W.2d 451 (Ct. App. 1995), 94-3335.

An employee must prove unusual stress in order to receive benefits for a nervous disability that resulted from emotional stress. Milwaukee v. LIRC, 205 Wis. 2d 255, 556 N.W.2d 340 (Ct. App. 1996), 95-0541.

An attack that occurs during employment arising from a personal relationship outside the employment arises out of the employment if employment conditions contribute to the attack. Emotional injury from harassing phone calls by an ex-spouse to the employee at her place of work, after her employer unwittingly gave out her phone number, was an injury in the course of employment. Weiss v. City of Milwaukee, 208 Wis. 2d 95, 559 N.W.2d 558 (1997), 94-0171.

The elements of proof placed on a claimant alleging physical injury as a result of emotional stress in the workplace requires that work activity precipitate, aggravate, or accelerate beyond normal progression a progressively deteriorating or degenerative condition. Unlike emotional injury from stress, showing "unusual stress" is not required. UPS v. Lust, 208 Wis. 2d 306, 560 N.W.2d 301 (Ct. App. 1997), 96-0137.

The exclusive remedy provision in s. 102.03 (2) does not bar a complainant whose claim is covered by worker's compensation from pursuing an employment discrimination claim under the Fair Employment Act, subch. II of ch. 111. Byers v. LIRC, 208 Wis. 2d 388, 561 N.W.2d 678 (1997), 95-2490.

An employee terminated for misrepresenting his or her medical condition while receiving disability benefits for a concededly work-related injury continues to be entitled to benefits. Brakebush Brothers, Inc. v. LIRC, 210 Wis. 2d 623, 563 N.W.2d 512 (1997), 95-2586.

A work-related injury that plays any role in a second injury is properly considered a substantial factor in the reinjury. To find a work-related injury not a factor in a second injury, it must be found that the claimant would have suffered the same injury, to the same extent, despite the first injury. New symptoms alone do not suggest an unrelated second injury. Lange v. LIRC, 215 Wis. 2d 561, 573 N.W.2d 856 (Ct. App. 1997), 97-0865.

The *Seaman* loaned employee test is a 3-element test that is often miscast because the *Seaman* court indicated that there are 4 "vital questions" that must be answered. The 3 elements are: 1) consent by the employee; 2) entry by the employee upon work for the special employer; and 3) power of the special employer to control details of the work. The distinction between employee consent to perform certain acts and consent to enter into a new employment relationship is important. Borneman v. Corwyn Transport, Ltd. 219 Wis. 2d 346, 580 N.W.2d 253 (1998), 96-2511.

Under sub. (1) (f), there is a presumption that a travelling employee performs services incidental to employment at all times on a trip. The burden of proving a personal deviation on the trip is on the party asserting the deviation. Recreational activities may be considered a usual and proper part of the trip but do not always fit the

presumption. CBS, Inc. v. LIRC, 219 Wis. 2d 564, 579 N.W.2d 668 (1998), 96-3707.

LIRC's determination of "scope of employment" is given great weight deference. Whether any agency's determination is given great weight depends on whether it has experience in interpreting a particular statutory scheme and not on whether it has ruled on the specific facts. Town of Russell Volunteer Fire Department v. LIRC, 223 Wis. 2d 723, 589 N.W.2d 445 (Ct. App. 1998), 98-0734.

A compensable injury must arise out of employment, which refers to the causal origin of the injury, and occur while the employee performs a service growing out of and incidental to employment, which refers to the time, place, and circumstances of the injury. Ide v. LIRC, 224 Wis. 2d 159, 589 N.W.2d 363 (1999), 97-1649.

Intentional harm to an employee is an "accident" subject to this chapter if caused by acts of a coemployee, but not if caused by acts of an employer. Intentionally self-inflicted injury is not subject to this chapter, but death by suicide is not necessarily "intentionally self-inflicted" and is subject to this chapter if the suicide results from a work-related injury without an independent intervening cause. Cohn v. Apogee, Inc. 225 Wis. 2d 815, 593 N.W.2d 921 (Ct. App. 1999), 97-3817.

Sub. (1) (f) does not establish a bright line rule that if a travelling employee stays over past the conclusion of a business part of a trip, there is a personal deviation. An employee is not required to seek immediate seclusion in a hotel and to remain away from human beings at the risk of being charged with deviating from employment. Wisconsin Electric Power Co. v. LIRC, 226 Wis. 2d 778, 595 N.W.2d 23 (1999), 97-2747.

Injuries did not arise out of employment when the injured party was injured while collecting a paycheck as a matter of personal convenience. Secor v. LIRC, 2000 WI App 11, 232 Wis. 2d 519, 606 N.W.2d 175, 99-0123.

An employee's claim under s. 134.01 against fellow employees for injury to reputation and profession was preempted by this section. Mudrovich v. Soto, 2000 WI App 174, 238 Wis. 2d 162, 617 N.W.2d 242, 99-1410.

Under sub. (2), recovery of compensation is the exclusive remedy against a worker's compensation carrier and the carrier's agents. Walstrom v. Gallagher Bassett Services, Inc. 2000 WI App 247, 239 Wis. 2d 473, 620 N.W.2d 223, 00-1334.

It was reasonable for LIRC to hold that an employee had temporarily abandoned his job and was not performing services incidental to employment under sub. (1) (c) 1. when he left the workplace to seek medical attention for an immediate need that was not related to his employment, even though intending to return. Fry v. LIRC, 2000 WI App 239, 239 Wis. 2d 574, 620 N.W.2d 449, 00-0523.

Whether a traveling employee's multiple drinks at a tavern was a deviation was irrelevant when the employee was injured while engaged in a later act reasonably necessary to living. Under s. 102.58, intoxication does not defeat a worker's compensation claim but only decreases the benefits. Heritage Mutual Insurance Co. v. Larsen, 2001 WI 30, 242 Wis. 2d 47, 624 N.W.2d 129, 98-3577.

Under the private errand doctrine, if a person in authority over the employee asks the employee to perform a service for the personal benefit of the employer or the employee's superior and the employee is injured while performing the task, the injury grew out of and was incidental to employment unless the request is clearly unauthorized. Begel v. LIRC, 2001 WI App 134, 246 Wis. 2d 345, 631 N.W.2d 220, 00-1875.

Under the "dual persona" doctrine, the employer's second role must be so unrelated to its role as an employer that it constitutes a separate legal person. St. Paul Fire & Marine Insurance Co. v. Keltgen, 2003 WI App 53, 260 Wis. 2d 523, 659 N.W.2d 906, 02-1249.

When one company was the injured employee's employer on the date of the injury, but another company contracted to become the employer retroactive to a date prior to the injury, the former and its insurer were the responsible for providing benefits under ch. 102. Epic Staff Management, Inc. v. LIRC, 2003 WI App 143, 266 Wis. 2d 369, 667 N.W.2d 765, 02-2310.

Under the last exception in sub. (2), an employee who receives worker's compensation benefits may also file suit against a coemployee when a governmental unit is obligated to pay judgments against that employee pursuant to a collective bargaining agreement or a local ordinance. Keller v. Kraft, 2003 WI App 212, 267 Wis. 2d 444, 671 N.W.2d 361, 02-3377.

A claim of negligent hiring, training, and supervision against an employer for injuries caused by a sexual assault committed by a coemployee is precluded by the exclusivity provision in sub. (2). This chapter's purpose, history, and application demonstrate that the court is not a proper authority to create a public policy exception to the exclusivity provision. Peterson v. Arlington Hospitality Staffing, Inc. 2004 WI App 199, 276 Wis. 2d 746, 689 N.W.2d 61, 03-2811.

A Labor and Industry Review Commission's (LIRC) determination that an employee who sustained a knee injury while playing softball during a paid break period deserved worker's compensation benefits was reasonable. LIRC reasonably relied upon a treatise that holds that recreational activities are within the course of employment when they have gone on long enough to become an incident of employment. E. C. Styberg Engineering v. LIRC, 2005 WI App 20, 278 Wis. 2d 540, 692 N.W.2d 322, 04-1039.

A state session law that was never adopted by the common council or any other local legislative body as an ordinance, but was numbered and reprinted in the Milwaukee City Charter because it was not a local ordinance under sub. (2). Keller v. Kraft, 2005 WI App 102, 381 Wis. 2d 784, 698 N.W.2d 843, 04-1315.

When two employees, who each work for separate temporary help agencies are both placed with the same client of the temporary help agencies, sub. (2) does not prevent the employee who is injured by the conduct of the other employee from suing the latter's temporary help agency under a theory of *respondeat superior*. Warr v. QPS Companies, 2007 WI App 14, 298 Wis. 2d 440, 728 N.W.2d 39, 06-0208.

The exception to coemployee immunity due to negligent operation of a vehicle in sub. (2) must be narrowly construed. The distinction between operation and maintenance or repairs should apply in the context of the exception. When the action under consideration is undertaken to service or repair a vehicle, and the condition

of the vehicle is such that it could not then be driven on a public roadway, the action does not constitute operation of a motor vehicle. McNeil v. Hansen, 2007 WI 56, 300 Wis. 2d 358, 731 N.W.2d 273, 05-0423.

An injured employee was entitled to temporary total disability (TTD) benefits after being terminated for violating plant safety rules while assigned to light duty work while within his healing period and without having regained the use of a hand. The employee suffered a wage loss while his injury limited his ability to work, meeting the statutory criteria for TTD. This chapter contains no exception to liability for an injured employee who is subsequently terminated, even for good cause. Emmpak Foods, Inc. v. LIRC, 2007 WI App 164, 303 Wis. 2d 771, 737 N.W.2d 60, 06-0729.

Wisconsin's worker's compensation jurisprudence clearly recognizes that an in-state injury in the course of employment will give rise to coverage under the act. When an out-of-state employer sends an out-of-state employee to Wisconsin and the employee is injured or killed in Wisconsin in the course of employment, Wisconsin's act is applicable. Therefore, a coemployee has no liability for the employee's death and the coemployee's insurers were properly dismissed from the case. Estate of Torres v. Empire Fire and Marine Insurance Company, 2008 WI App 113, 313 Wis. 2d 371, 756 N.W.2d 662, 07-1519.

The negligent operation of a motor vehicle exception to the exclusive remedy provision in sub. (2) did not apply to the incorrect placement of a vehicle on a hoist for repairs. The alleged negligence here was the way the vehicle was positioned on the hoist, which is independent of how the vehicle was operated. Under any definition of operation, the defendant's manipulation of or control over the vehicle, its movement, or its instruments was not negligent in and of itself. Kuehl v. Sentry Select Insurance Company, 2009 WI App 38, 316 Wis. 2d 506, 765 N.W.2d 860, 08-1681.

When an employee was required to report to a job site not owned or controlled by the employer to render services to a customer and the making of the journey was not part of the service for which the employee was paid, there was nothing to distinguish the employee's regular commute to work from that of any employees who leave their home to travel to their place of employment where the workday begins. The employee was not a traveling employee under sub. (1) (f). The travel contemplated by sub. (1) (f) must be something more and something different than a daily commute to or from work at an established job site. McRae v. Porta Painting, Inc. 2009 WI App 89, 320 Wis. 2d 178, 769 N.W.2d 74, 08-1946.

Under *Jenson,* the tort of intentional infliction of mental distress is barred by the exclusivity provision of the Worker's Compensation Act. The *Jenson* court did not make or discuss the distinction between acts that occurred during employment and after termination. Farady-Sultze v. Aurora Medical Center of Oshkosh, Inc. 2010 WI App 99, 327 Wis. 2d 110, 787 N.W.2d 433, 09-2429.

Sub. (1) (d) exists to prevent fraud in the system, i.e., a deliberately inflicted injury for the purpose of recovering worker's compensation benefits. It did not apply when the claimant suffered injuries while performing cake decorating when the claimant was asked to do so by her superiors, despite the fact that the employer was aware of medical restrictions prohibiting that activity. Pick 'n Save Roundy's v. LIRC, 2010 WI App 130, 329 Wis. 2d 674, 791 N.W.2d 216, 09-2594.

The key to the application of the "well-being activity" exclusion under sub. (1) (c) 3. is whether the employee was being compensated for engaging in his or her employer's business at the time of the injury. If the employer was compensating the employee when the injury occurred, it is the employer's acknowledgement that the employee was engaged in the employer's business and the exception does not apply. City of Kenosha v. LIRC, 2011 WI App 51, 332 Wis. 2d 448, 797 N.W.2d 885, 10-0883.

Post-termination defamation by an employer is not covered by ch. 102 and is not subject to the exclusive remedy provision. Anderson v. Hebert, 2011 WI App 56, 332 Wis. 2d 432, 798 N.W.2d 275, 10-1992.

Because an injured employee entered into a compromise agreement with his employer, the exclusive remedy provision under sub. (2) precludes the injured employee from bringing a subsequent negligence action against a fellow employee for the injuries that were the subject of the worker's compensation claim. Martine v. Williams, 2011 WI App 68, 333 Wis. 2d 203, 799 N.W.2d 449, 10-1426.

The logical corollary to sub. (1) (c) 3. is that an employee is performing services growing out of and incidental to employment if the employee's injury occurs while participating in a well-being program, event, or activity that is not voluntary or for which the employee is receiving compensation. An employee who was performing push-ups at his residence in preparation for a mandatory fitness test, for which extra pay could be awarded for excellence and discipline imposed for failure, was reasonably found to be acting in the course of his employment and entitled to benefits. City of Appleton Police Department v. Labor and Industry Review Commission, 2012 WI App 50, 340 Wis. 2d 720, 813 N.W.2d 237, 11-2008.

While s. 895.46 (1) (a) requires governments to pay judgments taken against their officers and employees for liability incurred though the performance of their official duties, the statute is not encompassed within the language of sub. (2). The coemployee exception of sub. (2) specifically eliminated a local government unit's obligation to pay judgments under s. 895.46. Flores v. Goeman, 2013 WI App 110, 350 Wis. 2d 454, 839 N.W.2d 409, 12-2272.

The exclusive remedy provision does not bar a ship owner from asserting a right to indemnification against the employer of the injured worker even though he has been paid compensation. Bagrowski v. American Export Isbrantsen Lines, Inc. 440 F.2d 502 (1971).

Emotional distress injury due to sexual harassment was exclusively compensable under this section. Zabkowicz v. West Bend Co., Div. Dart Industries, 789 F.2d 540 (1986).

When 2 employees left their place of employment to fight each other, neither was acting within the scope of employment. There was no cause of action against the employer under ch. 102 or tort or agency law. Johnson v. Hondo, Inc. 125 F.3d 408 (1997).

Sexual harassment was an accident under sub. (1) (e) and subject to the exclusivity provision of sub. (2). *Lentz,* 195 Wis. 2d 457, is distinguished. Hibben v. Nardone, 137 F.3d 480 (1998).

A 3rd-party was required to pay 95 percent of the damages even though only 25 percent negligent because an employer was shielded by sub. (2). Schuldies v. Service Machine Co. 448 F. Supp. 1196 (1978).

The plaintiff was a special employee of a 3rd-party defendant and a 3rd-party action was barred by the exclusivity provisions of this section. Simmons v. Atlas Vac Mach. Co. 493 F. Supp. 1082 (1980).

Although the employer of an injured employee was found to be at fault, a manufacturer who was also found to be at fault was not entitled to contribution from the employer. Ladwig v. Ermanco, Inc. 504 F. Supp. 1229 (1981).

Unauthorized sexual touching did not constitute an assault intended to cause bodily harm under sub. (2). Hrabak v. Marquip, Inc. 798 F. Supp. 550 (1992).

The exclusivity provision of the worker's compensation act does not bar a claim for invasion of privacy under s. 895.50. Marino v. Arandell Corp. 1 F. Supp. 2d 947 (1998).

Worker's Compensation Act No Longer Protects Against Employment Discrimination Claims. Skinner. Wis. Law. March 1998.

102.04 Definition of employer.

(1) The following shall constitute employers subject to the provisions of this chapter, within the meaning of s. 102.03:

(a) The state and each local governmental unit in this state.

(b) 1. Every person who usually employs 3 or more employees for services performed in this state, whether in one or more trades, businesses, professions, or occupations, and whether in one or more locations.[16] [17]

2. Every person who usually employs less than 3 employees, provided the person has paid wages of $500 or more in any calendar quarter for services performed in this state. Such employer shall become subject on the 10th day of the month next succeeding such quarter.

3. This paragraph shall not apply to farmers or farm labor.

(c) Every person engaged in farming who on any 20 consecutive or nonconsecutive days during a calendar year employs 6 or more employees, whether in one or more locations. The provisions of this chapter shall apply to such employer 10 days after the twentieth such day.

(d) Every joint venture electing under s. 102.28 (2) (a) to be an employer.

(e) Every person to whom pars. (a) to (d) are not applicable, who has any person in service under any contract of hire, express or implied, oral or written, and who, at or prior to the time of the injury to the employee for which compensation may be claimed, shall, as provided in s. 102.05, have elected to become subject to the provisions of this chapter, and who shall not, prior to such accident, have effected a withdrawal of such election.

(2) Except with respect to a partner or member electing under s. 102.075, members of partnerships or limited liability companies shall not be counted as employees.[18] Except as provided in s. 102.07 (5) (a), a person under contract of hire for the performance of any service for any employer subject to this section is not the employer of any other person with respect to that service, and that other person shall, with respect to that service, be an employee only of the employer for whom the service is being performed.[19]

(2m) A temporary help agency is the employer of an employee whom the temporary help agency has placed with or leased to another employer that compensates the temporary help agency for the employee's services. A temporary help agency is liable under s. 102.03 for all compensation and other payments payable under this chapter to or with respect to that employee, including any payments required under s. 102.16 (3), 102.18 (1) (b) 3. or (bp), 102.22 (1), 102.35 (3), 102.57, or 102.60. Except as permitted under s. 102.29, a temporary help agency may not seek or receive reimbursement from another employer for any payments made as a result of that liability.[20]

(2r) For purposes of this chapter, a franchisor, as defined in 16 CFR 436.1 (k), is not considered to be an employer of a franchisee, as defined in 16 CFR 436.1 (i), or of an employee of a franchisee, unless any of the following applies:[21]

(a) The franchisor has agreed in writing to assume that role.

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[16] This amendment was created by 2009 Wis. Act 206, effective May 1, 2010, to include a territorial limitation for the service of three or more employees to be performed in Wisconsin to make the employer subject to this chapter.

[17] The court in Stapleton v. Industrial Comm., 249 Wis. 133 (1947) held that employment of three persons for a single moment, even though some of the employees may have been only casual employees, is sufficient to make the employer subject to the WC Act. Based on the holding in Stapleton, an employer is subject to the Act immediately upon the employment of three or more persons.

[18] This gives the members of limited liability companies the same status as partners.

[19] A possible dual status of employer and employee is objectionable because of confusion, delay, and expense caused in determining who is actually to assume liability. This provision makes it clear that an employee cannot also be an employer.

[20] This clarifies that the agency also pays the penalties in addition to compensation.

[21] This section was created by 2015 Wis. Act 203, effective March 2, 2016, to exclude a franchisor as an employer of a franchisee or of an employee of a franchisee unless certain conditions are met. This section applies to work performed after the effective date. A franchisor will be the employer if the franchisor agrees in writing to be the employer or the franchisor is found by the department to have exercised control not normally exercised in a franchisor/franchisee relationship.

(b) The franchisor has been found by the department or the division to have exercised a type or degree of control over the franchisee or the franchisee's employees that is not customarily exercised by a franchisor for the purpose of protecting the franchisor's trademarks and brand.

(3) As used in this chapter "farming" means the operation of farm premises owned or rented by the operator. "Farm premises" means areas used for operations herein set forth, but does not include other areas, greenhouses or other similar structures unless used principally for the production of food and farm plants. "Farmer" means any person engaged in farming as defined. Operation of farm premises shall be deemed to be the planting and cultivating of the soil thereof; the raising and harvesting of agricultural, horticultural or arboricultural crops thereon; the raising, breeding, tending, training and management of livestock, bees, poultry, fur-bearing animals, wildlife or aquatic life, or their products, thereon; the processing, drying, packing, packaging, freezing, grading, storing, delivering to storage, to market or to a carrier for transportation to market, distributing directly to consumers or marketing any of the above-named commodities, substantially all of which have been planted or produced thereon; the clearing of such premises and the salvaging of timber and management and use of wood lots thereon, but not including logging, lumbering or wood cutting operations unless conducted as an accessory to other farming operations; the managing, conserving, improving and maintaining of such premises or the tools, equipment and improvements thereon and the exchange of labor, services or the exchange of use of equipment with other farmers in pursuing such activities. The operation for not to exceed 30 days during any calendar year, by any person deriving the person's principal income from farming, of farm machinery in performing farming services for other farmers for a consideration other than exchange of labor shall be deemed farming. Operation of such premises shall be deemed to include also any other activities commonly considered to be farming whether conducted on or off such premises by the farm operator.[22]

History: 1975 c. 199; 1983 a. 98; 1989 a. 64; 1993 a. 112; 1997 a. 38; 1999 a. 9; 2001 a. 37; 2005 a. 172; 2007 a. 20; 2009 a. 206; 2015 a. 180, 203.

When an employee simultaneously performs service for 2 employers under their joint control and the service for each is the same or closely related, both employers are liable for worker's compensation. Insurance Co. of North America v. DILHR 45 Wis. 2d 361, 173 N.W.2d 192 (1970).

Wisconsin's worker's compensation jurisprudence clearly recognizes that an in-state injury in the course of employment will give rise to coverage under the act. When an out-of-state employer sends an out-of-state employee to Wisconsin and the employee is injured or killed in Wisconsin in the course of employment, Wisconsin's act is applicable. Therefore, a coemployee has no liability for the employee's death and the coemployee's insurers were properly dismissed from the case. Estate of Torres v. Empire Fire and Marine Insurance Company, 2008 WI App 113, 313 Wis. 2d 371, 756 N.W.2d 662, 07-1519.

The county was found to be the employer, for worker's compensation purposes, of a care giver for a service recipient under the long-term support community options waiver program under s. 46.27 (11). County of Barron v. Labor and Industry Review Commission, 2010 WI App 149, 330 Wis. 2d 203, 792 N.W.2d 584, 09-1845.

Using dictionary definitions of "usually" in sub. (1) (b) 1., an "employer" is a person who ordinarily, customarily, or habitually employs 3 or more employees or who more often than not employs 3 or more employees. Noyce v. Aggressive Metals, Inc. 2016 WI App 58, ___ Wis. 2d ___, ___ N.W.2d ___, 14-2143.

102.05 Election by employer, withdrawal.

(1) An employer who has had no employee at any time within a continuous period of 2 years shall be deemed to have effected withdrawal, which shall be effective on the last day of such period.[23] An employer who has not usually employed 3 employees and who has not paid wages of at least $500 for employment in this state in every calendar quarter in a calendar year may file a withdrawal notice with the department, which withdrawal shall take effect 30 days after the date of such filing or at such later date as is specified in the notice. If an employer who is subject to this chapter only

[22] Commercial threshers, clover hullers, silo fillers, corn shredders, and other employers who work for farmers are not considered to be engaging in farming operations and become subject to this chapter as do other non-farming employers.

[23] 1999 Wis. Act 14 clarified that an employer may withdraw only if the employer did not pay $500 in wages in each of the four calendar quarters during an entire calendar year.

because the employer elected to become subject to this chapter under sub. (2) cancels or terminates his or her contract for the insurance of compensation under this chapter, that employer is deemed to have effected withdrawal, which shall be effective on the day after the contract is canceled or terminated.[24]

(2) Any employer who shall enter into a contract for the insurance of compensation, or against liability therefor, shall be deemed thereby to have elected to accept the provisions of this chapter, and such election shall include farm laborers, domestic servants and employees not in the course of a trade, business, profession or occupation of the employer if such intent is shown by the terms of the policy. Such election shall remain in force until withdrawn in the manner provided in sub. (1).

(3) Any person engaged in farming who has become subject to this chapter may withdraw by filing with the department a notice of withdrawal, if the person has not employed 6 or more employees as defined by s. 102.07 (5) on 20 or more days during the current or previous calendar year. Such withdrawal shall be effective 30 days after the date of receipt by the department, or at such later date as is specified in the notice. Such person may again become subject to this chapter as provided by s. 102.04 (1) (c) and (e).

History: 1983 a. 98 s. 31; 1993 a. 81, 492; 1999 a. 14.

An injured worker who never had individuals in his service as employees and did not otherwise fulfill the statutory definition of an employer was not an employer, because he had parachuted a worker's compensation policy. Lloyd Frank Logging v. Healy, 2007 WI App 249, 306 Wis. 2d 385, 742 N.W.2d 337, 07-0692.

102.06 Joint liability of employer and contractor. An employer shall be liable for compensation to an employee of a contractor or subcontractor under the employer who is not subject to this chapter, or who has not complied with the conditions of s. 102.28 (2) in any case where such employer would have been liable for compensation if such employee had been working directly for the employer, including also work in the erection, alteration, repair or demolition of improvements or of fixtures upon premises of such employer which are used or to be used in the operations of such employer. The contractor or subcontractor, if subject to this chapter, shall also be liable for such compensation, but the employee shall not recover compensation for the same injury from more than one party. The employer who becomes liable for and pays such compensation may recover the same from such contractor, subcontractor or other employer for whom the employee was working at the time of the injury if such contractor, subcontractor or other employer was an employer as defined in s. 102.04.[25] This section does not apply to injuries occurring on or after the first day of the first July beginning after the day that the secretary files the certificate under s. 102.80 (3) (a), except that if the secretary files the certificate under s. 102.80 (3) (ag) this section does apply to claims for compensation filed on or after the date specified in that certificate.[26]

History: 1975 c. 147 s. 54; 1975 c. 199; 1989 a. 64; 1995 a. 117.

A "contractor under the employer" is one who regularly furnishes to a principal employer materials or services that are integrally related to the finished product or service provided by that principal employer. Green Bay Packaging, Inc. v. DILHR, 72 Wis. 2d 26, 240 N.W.2d 422 (1976).

A franchisee was a "contractor under" a franchisor within the meaning of this section. Maryland Casualty Co. v. DILHR, 77 Wis. 2d 472, 253 N.W.2d 228 (1977).

Liability of principal employer for injuries to employees of his contractors or subcontractors. 1977 WLR 185.

102.07 Employee defined. "Employee" as used in this chapter means:

(1) (a) Every person, including all officials, in the service of the state, or of any local governmental unit in this state, whether elected or under any appointment or contract of hire, express or implied, and whether a resident of the state or employed or injured within or without the state. The state and any local governmental unit may require a bond from a contractor to protect the state or local governmental unit against compensation to employees of the contractor or to employees of a subcontractor under the contractor. This paragraph does not

[24] This simplifies the withdrawal procedure for employers who elected coverage.

[25] This provision is not intended to limit the other provisions of the section, but to make clear that if work is being performed under the circumstances stated, liability will exist against the principal employer.

[26] This section is suspended while the uninsured employers fund is accepting claims.

apply beginning on the first day of the first July beginning after the day that the secretary files the certificate under s. 102.80 (3) (a), except that if the secretary files the certificate under s. 102.80 (3) (ag) this paragraph does apply to claims for compensation filed on or after the date specified in that certificate.

(b) Every person, including all officials, in the service of the state, or of any local governmental unit in this state, whether elected or under any appointment or contract of hire, express or implied, and whether a resident of the state or employed or injured within or without the state. This paragraph first applies on the first day of the first July beginning after the day that the secretary files the certificate under s. 102.80 (3) (a), except that if the secretary files the certificate under s. 102.80 (3) (ag) this paragraph does apply to claims for compensation filed on or after the date specified in that certificate.

(2) Any peace officer shall be considered an employee while engaged in the enforcement of peace or in the pursuit and capture of those charged with crime.

(3) Nothing in this chapter prevents a local governmental unit from paying a teacher, police officer, fire fighter, or any other employee his or her full salary during a period of disability, nor interferes with any pension fund, nor prevents payment to a teacher, police officer, fire fighter, or any other employee from a pension fund.

(4) (a) Every person in the service of another under any contract of hire, express or implied, all helpers and assistants of employees, whether paid by the employer or employee, if employed with the knowledge, actual or constructive, of the employer, including minors, who shall have the same power of contracting as adult employees, but not including the following:

1. Domestic servants.

2. Any person whose employment is not in the course of a trade, business, profession or occupation of the employer, unless as to any of said classes, the employer has elected to include them.

(b) Par. (a) 2. shall not operate to exclude an employee whose employment is in the course of any trade, business, profession or occupation of the employer, however casual, unusual, desultory or isolated the employer's trade, business, profession or occupation may be.

(4m) For the purpose of determining the number of employees to be counted under s. 102.04 (1) (b), but for no other purpose, a member of a religious sect is not considered to be an employee if the conditions specified in s. 102.28 (3) (b) have been satisfied with respect to that member.

(5) For the purpose of determining the number of employees to be counted under s. 102.04 (1) (c), but for no other purpose, the following definitions shall apply:

(a) Farmers or their employees working on an exchange basis shall not be deemed employees of a farmer to whom their labor is furnished in exchange.

(b) The parents, spouse, child, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of a farmer shall not be deemed the farmer's employees.

(c) A shareholder-employee of a family farm corporation shall be deemed a "farmer" for purposes of this chapter and shall not be deemed an employee of a farmer. A "family farm corporation" means a corporation engaged in farming all of whose shareholders are related as lineal ancestors or lineal descendants, whether by blood or by adoption, or as spouses, brothers, sisters, uncles, aunts, cousins, sons-in-law, daughters-in-law, fathers-in-law, mothers-in-law, brothers-in-law or sisters-in-law of such lineal ancestors or lineal descendants.

(d) A member of a religious sect is not considered to be an employee of a farmer if the conditions specified in s. 102.28 (3) (b) have been satisfied with respect to that member.

(7) (a) Every member of a volunteer fire company or fire department organized under ch. 213, a legally organized rescue squad, or a legally organized diving team[27] is considered to

[27] A legally organized diving team is a team of people, organized and operating under the general direction of a law enforcement officer, who dive or directly assist a diver, to help the law enforcement official in the performance of his or her legal duties. The term “legally organized” refers to direction and control by a law enforcement official, not to a formal organizational status by a team. Created by 1999 Wis. Act 14, effective January 1, 2000.

be an employee of that company, department, squad, or team. Every member of a company, department, squad, or team described in this paragraph, while serving as an auxiliary police officer at an emergency, is also considered to be an employee of that company, department, squad, or team. If a company, department, squad, or team described in this paragraph has not insured its liability for compensation to its employees, the political subdivision within which that company, department, squad, or team was organized shall be liable for that compensation.[28]

(b) The department may issue an order under s. 102.31 (1) (b) permitting the county within which a volunteer fire company or fire department organized under ch. 213, a legally organized rescue squad, an ambulance service provider, as defined in s. 256.01 (3), or a legally organized diving team is organized to assume full liability for the compensation provided under this chapter of all volunteer members of that company, department, squad, provider or team.[29]

Cross-reference: See also s. DWD 80.30, Wis. adm. code.

(7m) An employee, volunteer, or member of an emergency management program is considered an employee for purposes of this chapter as provided in s. 323.40, a member of a regional emergency response team who is acting under a contract under s. 323.70 (2) is considered an employee of the state for purposes of this chapter as provided in s. 323.70 (5), and a practitioner is considered an employee of the state for purposes of this chapter as provided in s. 257.03.[30]

(8) (a) Except as provided in pars. (b) and (bm), every independent contractor is, for the purpose of this chapter, an employee of any employer under this chapter for whom he or she is performing service in the course of the trade, business, profession or occupation of such employer at the time of the injury.

(b) An independent contractor is not an employee of an employer for whom the independent contractor performs work or services if the independent contractor meets all of the following conditions:[31]

1. Maintains a separate business with his or her own office, equipment, materials and other facilities.

2. Holds or has applied for a federal employer identification number with the federal internal revenue service or has filed business or self-employment income tax returns with the federal internal revenue service based on that work or service in the previous year.[32]

3. Operates under contracts to perform specific services or work for specific amounts of money and under which the independent contractor controls the means of performing the services or work.

4. Incurs the main expenses related to the service or work that he or she performs under contract.

5. Is responsible for the satisfactory completion of work or services that he or she contracts to perform and is liable for a failure to complete the work or service.

6. Receives compensation for work or service performed under a contract on a commission or per job or competitive bid basis and not on any other basis.

7. May realize a profit or suffer a loss under contracts to perform work or service.

8. Has continuing or recurring business liabilities or obligations.

9. The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.[33]

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[28] Volunteer firefighters and members of rescue squads are to be considered employees and entitled to benefits in event of injury. If the company or department has not insured liability of its members, the municipality becomes liable for compensation.

[29] This authorizes counties to assume full liability for coverage for these volunteers.

[30] This section was created by 2001 Wis. Act 37, effective January 1, 2002, and provides that an employee, volunteer, member of an emergency management unit or a member of a regional emergency response team is an employee for worker's compensation purposes.

[31] 2015 Wis. Act 180, effective March 2, 2016, repealed s. 102.07(6), and now provides that persons selling or distributing newspapers or magazines on the street or door-to-door will now be subject to the nine point test for independent contractors. However, the publisher can endorse coverage if it chooses. See footnote 172.

[32] The added language was taken from the unemployment insurance definition of independent contractors.

[33] This nine-part test applies to independent contractors who are not statutory employees. Created by Chapter 64, Laws of 1989, effective January 1, 1990.

(bm) A real estate broker or salesperson who is excluded under s. 452.38 is not an employee of a firm, as defined in s. 452.01 (4w), for whom the real estate broker or salesperson performs services unless the firm elects under s. 102.078 to name the real estate broker or salesperson as its employee.[34]

(c) The division may not admit in evidence any state or federal law, regulation, or document granting operating authority, or license when determining whether an independent contractor meets the conditions specified in par. (b) 1. or 3.

(8m) An employer who is subject to this chapter is not an employee of another employer for whom the first employer performs work or service in the course of the other employer's trade, business, profession or occupation.

(9) Members of the national guard and state defense force, when on state active duty under direction of appropriate authority, but only in case federal laws, rules or regulations provide no benefits substantially equivalent to those provided in this chapter.

(10) Further to effectuate the policy of the state that the benefits of this chapter shall extend and be granted to employees in the service of the state, or of any local governmental unit in this state, on the same basis, in the same manner, under the same conditions, and with like right of recovery as in the case of employees of persons, firms, or private corporations, any question whether any person is an employee under this chapter shall be governed by and determined under the same standards, considerations, and rules of decision in all cases under subs. (1) to (9). Any statute, ordinance, or rule that may be otherwise applicable to the classes of employees enumerated in sub. (1) shall not be controlling in deciding whether any person is an employee for the purposes of this chapter.

(11) The department may by rule prescribe classes of volunteer workers who may, at the election of the person for whom the service is being performed, be deemed to be employees for the purposes of this chapter. Election shall be by endorsement upon the worker's compensation insurance policy with written notice to the department. In the case of an employer exempt from insuring liability, election shall be by written notice to the department. The department shall by rule prescribe the means and manner in which notice of election by the employer is to be provided to the volunteer workers.[35]

(11m) Subject to sub. (11), a volunteer for a nonprofit organization described in section 501 (c) of the internal revenue code, as defined in s. 71.01 (6), that is exempt or eligible for exemption from federal income taxation under section 501 (a) of the internal revenue code who receives from that nonprofit organization nominal payments of money or other things of value totaling not more than $10 per week is not considered to be an employee of that nonprofit organization for purposes of this chapter.[36]

(12) A student in a technical college district while, as a part of a training program, he or she is engaged in performing services for which a school organized under ch. 38 collects a fee or is engaged in producing a product sold by such a school is an employee of that school.[37]

(12m) (a) In this subsection:[38]

1. "Institution of higher education" means an institution within the University of Wisconsin System, a technical college, a tribally controlled college controlled by an Indian tribe that has elected under s. 102.05 (2) to become subject to this chapter, a school approved under s. 440.52, or a private, nonprofit institution of higher education located in this state.

2. "Private school" has the meaning given in s. 115.001 (3r).

3. "Public school" means a school described in s. 115.01 (1).

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[34] This definition of real estate broker and salesperson was created by 2015 Wis. Act 258, effective March 3, 2016. See also s.102.078 and footnote 48.

[35] To date no rule prescribes any class of volunteer to be deemed employees.

[36] This keeps "volunteer" status for persons who receive items of minimal value.

[37] Students in a vocational school who perform services for which the school charges a fee for producing a product that the school sells as part of the training program are employees of the school while engaged in those activities.

[38] This section was created by 2015 Wis. Act 55, effective January 1, 2016, to define "institution of higher learning" to include university system campuses, technical colleges, tribal colleges if the tribe has elected coverage, and other private or nonprofit colleges located in the state and for these institutions to accept worker's compensation liability for students performing services in work training, work experience, and work study programs.

(b) A student of a public school, a private school, or an institution of higher education, while he or she is engaged in performing services as part of a school work training, work experience, or work study program, and who is not on the payroll of an employer that is providing the work training or work experience or who is not otherwise receiving compensation on which a worker's compensation carrier could assess premiums on that employer, is an employee of a school district, private school, or institution of higher education that elects under s. 102.077 to name the student as its employee.[39]

(13) A juvenile performing uncompensated community service work as a result of a deferred prosecution agreement under s. 938.245, a consent decree under s. 938.32 or an order under s. 938.34 is an employee of the county in which the court ordering the community service work is located. No compensation may be paid to that employee for temporary disability during the healing period.[40]

(14) An adult performing uncompensated community service work under s. 304.062, 943.017 (3), 971.38, 973.03 (3), 973.05 (3), 973.09 or 973.10 (1m) is an employee of the county in which the district attorney requiring or the court ordering the community service work is located or in which the place of assignment under s. 304.062 or 973.10 (1m) is located. No compensation may be paid to that employee for temporary disability during the healing period.[41]

(15) A sole proprietor or partner or member electing under s. 102.075 is an employee.[42]

(16) An inmate participating in a work release program under s. 303.065 (2) or in the transitional employment program is an employee of any employer under this chapter for whom he or she is performing service at the time of the injury.

(17) A prisoner of a county jail who is assigned to a work camp under s. 303.10 is not an employee of the county or counties providing the work camp while the prisoner is working under s. 303.10 (3).

(17g) A state employee who is on a leave of absence granted under s. 230.35 (3) (e) to provide services to the American Red Cross in a particular disaster is not an employee of the state for the purposes of this chapter during the period in which he or she is on the leave of absence, unless one of the following occurs:

(a) The American Red Cross specifies in its written request under s. 230.35 (3) (e) 2. c. that a unit of government in this state is requesting the assistance of the American Red Cross in the particular disaster and the state employee during the leave of absence provides services related to assisting the unit of government.

(b) The American Red Cross specifies in its written request under s. 230.35 (3) (e) 2. c. that it has been requested to provide assistance outside of this state in a particular disaster and there exists between the state of Wisconsin and the state in which the services are to be provided a mutual aid agreement, entered into by the governor, which specifies that the state of Wisconsin and the other state may assist each other in the event of a disaster and which contains provisions addressing worker's compensation coverage for the employees of the other state who provide services in Wisconsin.[43]

(17m) A participant in a trial employment match program job under s. 49.147 (3) is an employee of any employer under this chapter for whom the participant is performing service at the time of the injury.

(18) A participant in a community service job under s. 49.147 (4) or a transitional placement under s. 49.147 (5) is an employee of the Wisconsin works agency, as defined under s.

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[39] This allows school districts to accept liability for certain work experience students and extends the exclusive remedy protection to the worksite employers.

[40] When a juvenile is ordered by a court to perform uncompensated community service work, the juvenile is an employee of the county where the court is located while doing such work. No benefits are paid for temporary disability.

[41] Adult offenders sentenced to perform uncompensated community service work are also employees. See prior footnote.

[42] Sole proprietors and partners may elect to be eligible for worker's compensation benefits by endorsement to their existing policy or by securing a new policy. Members of limited liability companies may also elect coverage. They are not eligible for worker's compensation benefits unless they elect.

[43] This section was created by Chapter 118, Laws of 1997, effective May 1, 1998, regarding leaves of absence for certain state employees in providing disaster relief services.

49.001 (9), for the purposes of this chapter, except to the extent that the person for whom the participant is performing work provides worker's compensation coverage.

(20) An individual who is performing services for a person participating in the self-directed services option, as defined in s. 46.2897 (1), for a person receiving long-term care benefits under s. 46.275 or 46.277 or under any children's long-term support waiver program on a self-directed basis, or for a person receiving the Family Care benefit, as defined in s. 46.2805 (4), or benefits under the Family Care Partnership program, as described in s. 49.496 (1) (bk) 3., on a self-directed basis and who does not otherwise have worker's compensation coverage for those services is considered to be an employee of the entity that is providing financial management services for that person.[44]

History: 1975 c. 147 s. 54; 1975 c. 224; 1977 c. 29; 1979 c. 278; 1981 c. 325; 1983 a. 27, 98; 1985 a. 29, 83, 135; 1985 a. 150 s. 4; 1985 a. 176, 332; 1987 a. 63; 1989 a. 31, 64, 359; 1993 a. 16, 81, 112, 399; 1995 a. 24, 77, 96, 117, 225, 281, 289, 417; 1997 a. 35, 38, 118; 1999 a. 14, 162; 2001 a. 37; 2005 a. 96; 2007 a. 130; 2009 a. 28, 42, 288; 2011 a. 123; 2013 a. 20; 2015 a. 55, 180, 258, 334; 2017 a. 59; 2019 a. 9.

A truck owner who fell and sustained injuries in a company's truck parking area while in the process of repairing his truck was properly found under sub. (8) to be a statutory employee of the company at the time of his injury although he was an independent contractor who worked exclusively for the trucking company under a lease agreement. Employers Mutual Liability Insurance Co. v. DILHR, 52 Wis. 2d 515, 190 N.W.2d 907 (1971).

There was no employment when a member of an organization borrowed a refrigerated truck from a packing company for use at a picnic and was injured when returning it. Kress Packing Co. v. Kottwitz, 61 Wis. 2d 175, 212 N.W.2d 97 (1973).

Nothing in this chapter precludes an employer from agreeing with employees to continue salaries for injured workers in excess of worker's compensation benefits. Excess payments are not worker's compensation and may be conditioned on the parties' agreement. City of Milwaukee v. DILHR, 193 Wis. 2d 626, 534 N.W.2d 903 (Ct. App. 1995).

Sub. (8) (b) supplants the common law and provides the sole test for determining whether a worker is an independent contractor for purposes of ch. 102. Jarrett v. LIRC, 2000 WI App 46, 233 Wis. 2d 174, 607 N.W.2d 326, 99-1413.

A person injured upon the premises of a temporary help agency prior to receiving a work assignment was an employee under this section when the agency operated essentially as a hiring hall contracting with persons seeking work assignments and requiring that the persons seeking work physically present themselves each day at the hall and remain there until they have a work assignment. Labor Ready, Inc. v. LIRC, 2005 WI App 153, 285 Wis. 2d 506, 702 N.W.2d 27, 04-1440.

The primary test for determining an employer-employee relationship is whether the alleged employer has a right to control the details of the work. In assessing the right to control, 4 secondary factors are considered: 1) direct evidence of the exercise of the right of control; 2) the method of payment of compensation; 3) the furnishing of equipment or tools for the performance of the work; and 4) the right to terminate the employment relationship. Acuity Mutual Insurance Company v. Olivas, 2007 WI 12, 298 Wis. 2d 640, 726 N.W.2d 258, 05-0685.

Sub. (8m) allows for a distinction between a person as an employee and as the proprietor of a side business that the employee runs separately. Acuity Insurance Company v. Whittingham, 2007 WI App 210, 305 Wis. 2d 613, 740 N.W.2d 154, 06-2379.

The county was found to be the employer, for worker's compensation purposes, of a care giver for a service recipient under the long-term support community options waiver program under s. 46.27 (11). County of Barron v. Labor and Industry Review Commission, 2010 WI App 149, 330 Wis. 2d 203, 792 N.W.2d 584, 09-1845.

Members of state boards, committees, commissions, or councils who are compensated by per diem or by actual and necessary expense are covered employees. 58 Atty. Gen. 10.

[44] This section was created by 2015 Wis. Act 180, effective March 2, 2016, to allow fiscal management service agencies to cover all individuals under a single WC insurance policy of the fiscal agency. All individuals performing services for elderly or disabled people will be employees of the fiscal agent for WC purposes where the elderly or disabled do not have their own WC insurance coverage.

102.075 Election by sole proprietor, partner or member.

(1) Any sole proprietor, partner or member of a limited liability company engaged in a vocation, profession or business on a substantially full-time basis may elect to be an employee under this chapter by procuring insurance against injury sustained in the pursuit of that vocation, profession or business. This coverage may be obtained by endorsement on an existing policy of worker's compensation insurance or by issuance of a separate policy to the sole proprietor, partner or member on the same basis as any other policy of worker's compensation insurance.[45]

(2) For the purpose of any insurance policy other than a worker's compensation insurance policy, no sole proprietor, partner or member may be considered eligible for worker's compensation benefits unless he or she elected to be an employee under this section.

(3) Any sole proprietor, partner or member who elected to be an employee under this section may withdraw that election upon 30 days' prior written notice to the insurance carrier and the Wisconsin compensation rating bureau.

History: 1983 a. 98; 1993 a. 112.

102.076 Election by corporate officer.

(1) Not more than 2 officers of a corporation having not more than 10 stockholders may elect not to be subject to this chapter. If the corporation has been issued a policy of worker's compensation insurance, an officer of the corporation may elect not to be subject to this chapter and not to be covered under the policy at any time during the period of the policy. Except as provided in sub. (2), the election shall be made by an endorsement, on the policy of worker's compensation insurance issued to that corporation, naming each officer who has so elected. The election is effective for the period of the policy and may not be reversed during the period of the policy. An officer who so elects is an employee for the purpose of determining whether the corporation is an employer under s. 102.04 (1) (b).[46]

(2) If a corporation has not more than 10 stockholders, not more than 2 officers and no other employees and is not otherwise required under this chapter to have a policy of worker's compensation insurance, an officer of that corporation who elects not to be subject to this chapter shall file a notice of that election with the department on a form approved by the department. The election is effective until the officer rescinds it by notifying the department in writing.[47]

History: 1985 a. 83; 1987 a. 115, 179; 1989 a. 64; 1991 a. 85; 1997 a. 38.

102.077 Election by school district or private school.

(1) A school district, private school, or institution of higher education may elect to name as its employee for purposes of this chapter a student described in s. 102.07 (12m) (b) by an endorsement on its policy of worker's compensation insurance or, if the school district, private school, or institution of higher education is exempt from the duty to insure under s. 102.28 (2) (a), by filing a declaration with the department in the manner provided in s. 102.31 (2) (a) naming the student as an employee of the school district, private school, or institution of higher education for purposes of this chapter. A declaration under this subsection shall list the name of the student to be covered under this chapter, the name and address of the employer that is providing the work training or work experience for that student, and the title, if any, of the work training, work experience, or work study program in which the student is participating.

(2) A school district, private school, or institution of higher education may revoke a declaration under sub. (1) by providing written notice to the department in the manner provided in s. 102.31 (2) (a), the student, and the employer who is providing the work training or work experience for that student. A revocation

[45] This gives members of limited liability companies the same status as sole proprietors and partners.

[46] This permits one or two officers of small, closely-held corporations to elect not to receive benefits under a worker's compensation policy. The amendment allows them to non-elect any time during the policy period, but once they do so they may not reelect for that period.

[47] The purpose of this section is to avert the necessity of buying a policy if the employer is not otherwise subject to the law.

under this subsection is effective 30 days after the department receives notice of that revocation.

History: 1995 a. 117; 1997 a. 38; 1999 a. 14; 2001 a. 37; 2015 a. 55.

102.078 Election by real estate firm. [48]

(1) A firm, as defined in s. 452.01 (4w), may elect to name as its employee for purposes of this chapter a real estate broker or salesperson who is excluded under s. 452.38 by an endorsement on its policy of worker's compensation insurance or, if the firm is self-insured under s. 102.28 (2) (b), by filing a declaration with the department in the manner provided in s. 102.31 (2) (a) naming the real estate broker or salesperson as an employee of the firm for purposes of this chapter. A declaration under this subsection shall state all of the following:

(a) The name of the real estate broker or salesperson to be covered under this chapter.

(b) That a written agreement has been entered into that provides that the real estate broker or salesperson shall not be treated as an employee for federal and state tax purposes.

(c) That 75 percent or more of the compensation related to sales or other output, as measured on a calendar year basis, paid to the real estate broker or salesperson under the written agreement specified in par. (b) is directly related to the brokerage services performed by the real estate broker or salesperson on behalf of the firm.

(2) A firm, as defined in s. 452.01 (4w), may revoke a declaration under sub. (1) by providing written notice to the department in the manner provided in s. 102.31 (2) (a) and to the real estate broker or salesperson named in the declaration. A revocation under this subsection is effective 30 days after the department receives notice of that revocation.

History: 2015 a. 258.

[48] This section was created by 2015 Wis. Act 258, effective March 3, 2016, to provide that real estate brokers and salespersons are not employees of a real estate firm unless certain conditions are met. See also footnote 34. A real estate broker or salesperson is not an employee of the brokerage firm unless the firm elects coverage or 75 percent or more of the sales by the broker/salesperson are done on behalf of the firm.

102.08 Administration for state employees.

The department of administration has responsibility for the timely delivery of benefits payable under this chapter to employees of the state and their dependents and other functions of the state as an employer under this chapter. The department of administration may delegate this authority to employing departments and agencies and require such reports as it deems necessary to accomplish this purpose. The department of administration or its delegated authorities shall file with the department of workforce development the reports that are required of all employers. The department of workforce development shall monitor the delivery of benefits to state employees and their dependents and shall consult with and advise the department of administration in the manner and at the times necessary to ensure prompt and proper delivery.

History: 1981 c. 20; 1995 a. 27 s. 9130 (4); 1997 a. 3.

102.11 Earnings, method of computation.

(1) The average weekly earnings for temporary disability, permanent total disability, or death benefits for injury in each calendar year on or after January 1, 1982, shall be not less than $30 nor more than the wage rate that results in a maximum compensation rate of 110 percent of the state's average weekly earnings as determined under s. 108.05 as of June 30 of the previous year.[49] The average weekly earnings for permanent partial disability shall be not less than $30 and, for permanent partial disability for injuries occurring on or after March 2, 2016, and before January 1, 2017, not more than $513, resulting in a maximum compensation rate of $342, and, for permanent partial disability for injuries occurring on or after January 1, 2017, not more than $543, resulting in a maximum compensation rate of $362. Between such limits the average weekly earnings shall be determined as follows:[50] [51]

(a) 1. Daily earnings shall mean the daily earnings of the employee at the time of the injury in the employment in which the employee was then engaged. In determining daily earnings under this subdivision, any hours worked beyond the normal full-time working day as established by the employer, whether compensated at the employee's regular rate of pay or at an increased rate of pay, shall not be considered.

2. a. In this subdivision, "part time for the day" means Saturday half days and any other day during which an employee works less than the normal full-time working hours established by the employer.

b. If at the time of the injury the employee is working part time for the day, the employee's daily earnings shall be arrived at by dividing the amount received, or to be received by the employee for such part-time service for the day, by the number of hours and fractional hours of the part-time service, and multiplying the result by the number of hours of the normal full-time working day established by the employer for the employment involved.

3. The average weekly earnings shall be arrived at by multiplying the employee's hourly earnings by the hours in the normal full-time workweek as established by the employer, or by multiplying the employee's daily earnings by the number of days and fractional days in the normal full-time workweek as established by the employer, at the time of the injury in the business operation of the employer for the

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[49] The intent of this provision is that earnings on a normal full-time basis shall be the basis for payment of compensation. Where board or lodging is furnished the employee as a part of the consideration, the fair value of these benefits is to be added to the money wage in computing the compensation due. Any bonus, tip or premium is also part of the wage and must be reported as such by the employer in the first report of injury (form WKC-12).

Where the worker at the time of injury is working part-time, the wage is to be extended to a normal full time basis by multiplying the hourly basis by the number of hours of the full time working day for the employment involved, and by multiplying the daily earnings by the number of days and fractional days normally worked per week at the time of the injury in the business operation of the employer for the particular employment in which the employee was engaged at the time of the injury.

Special treatment is provided for seasonal employment. Seasonal employment is defined as employment which can be conducted only during certain times of the year, and in no event is such employment to be considered seasonal if it extends over a period of more than 14 weeks within a calendar year.

In the case of persons performing service without fixed earnings, usual going earnings paid for similar services on a normal full time basis in the same or similar employment are to be utilized.

In no case is less than actual average weekly earnings to be taken, provided the employee has worked within each week of at least six calendar weeks during the 52 weeks preceding the injury in the business in the kind of employment and for the employer for whom he or she worked when injured. Except for this provision, overtime is not taken into consideration.

The court has held that where a given number of hours per week are worked the total number of hours is to be taken and that "premium" wage is to be considered in determining weekly wage for compensation purposes. "Overtime" means only time beyond the number of hours usually worked by the employee.

In no case shall average weekly earnings be less than 24 times normal hourly earnings at the time of injury.

The maximum benefit rate for total disability and death benefits is determined by 110 percent of the state's average weekly earnings from the prior year. This amendment was effected by 2005 Wis. Act 172, effective April 1, 2006.

[50] Permanent partial disability maximum weekly rates are $342 for injuries on and after March 2, 2016 and $362 effective January 1, 2017. 2015 Wis Act 180, effective March 2, 2016.

[51] 2001 Wis. Act 37, effective January 1, 2002, created and renumbered these subsections to clarify that the employer's normal full-time scheduled workweek rather than the days and hours actually worked by the employee is used to calculate the average weekly wage.

particular employment in which the employee was engaged at the time of the employee's injury, whichever is greater.

4. It is presumed, unless rebutted by reasonably clear and complete documentation, that the normal full-time workweek established by the employer is 24 hours for a flight attendant, 56 hours for a firefighter, and not less than 40 hours for any other employee. If the employer has established a multi-week schedule with regular hours alternating between weeks, the normal full-time workweek is the average number of hours worked per week under the multi-week schedule.[52]

(am) In the case of an employee who is a member of a regularly-scheduled class of part-time employees, average weekly earnings shall be arrived at by the method prescribed in par. (a), except that the number of hours of the normal working day and the number of hours and days of the normal workweek shall be the hours and days established by the employer for that class. An employee is a member of a regularly-scheduled class of part-time employees if all of the following conditions are met:[53]

1. The employee is a member of a class of employees that does the same type of work at the same location and, in the case of an employee in the service of the state, is employed in the same office, department, independent agency, authority, institution, association, society, or other body in state government or, if the department or the division determines appropriate, in the same subunit of an office, department, independent agency, authority, institution, association, society, or other body in state government.

2. The minimum and maximum weekly hours regularly scheduled by the employer for the members of the class during the 13 weeks immediately preceding the date of the injury vary by no more than 5 hours. Subject to this requirement, the members of the class do not need to work the same days or the same shift to be considered members of a regularly-scheduled class of part-time employees.

3. At least 10 percent of the employer's workforce doing the same type of work are members of the class.

4. The class consists of more than one employee.

(b) In case of seasonal employment, average weekly earnings shall be arrived at by the method prescribed in par. (a), except that the number of hours of the normal full-time working day and the number of days of the normal full-time workweek shall be the hours and the days in similar service in the same or similar nonseasonal employment. Seasonal employment shall mean employment that can be conducted only during certain times of the year, and in no event shall employment be considered seasonal if it extends during a period of more than fourteen weeks within a calendar year.

(c) In the case of a person performing service without fixed earnings, or when normal full-time days or weeks are not maintained by the employer in the employment in which the employee worked when injured, or when, for other reason, earnings cannot be determined under the methods prescribed by par. (a) or (b), the earnings of the injured person shall, for the purpose of calculating compensation payable under this chapter, be taken to be the usual going earnings paid for similar services on a normal full-time basis in the same or similar employment in which earnings can be determined under the methods set out in par. (a) or (b).

(d) Except in situations where par. (b) applies, average weekly earnings shall in no case be less than actual average weekly earnings of the employee for the 52 calendar weeks before his or her injury within which the employee has been employed in the business, in the kind of employment and for the employer for whom the

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[52] 2001 Wis. Act 37, effective January 1, 2002, created rebuttable presumptions that the normal full-time workweek for flight attendants is 24 hours, 56 hours for firefighters, not less than 40 hours for other employees and the average number of hours worked per week for multi-week schedules with regular hours alternating between weeks.

[53] 2001 Wis. Act 37, effective January 1, 2002, defines part-time employees who are part of a class. To be part of a class an employee must perform the same type of work at the same location, the scheduled working hours do not vary by more than five per week in the 13 weeks preceding the injury date, at least 10 percent of the employer's workforce perform the same type of work and a class must consist of more than one employee.

employee worked when injured.[54] Calendar weeks within which no work was performed shall not be considered under this paragraph. This paragraph applies only if the employee has worked within a total of at least 6 calendar weeks during the 52 calendar weeks before his or her injury in the business, in the kind of employment and for the employer for whom the employee worked when injured. For purposes of this section, earnings for part-time services performed for a labor organization pursuant to a collective bargaining agreement between the employer and that labor organization shall be considered as part of the total earnings in the preceding 52 calendar weeks, whether payment is made by the labor organization or the employer.

(e) Where any things of value are received in addition to monetary earnings as a part of the wage contract, they shall be deemed a part of earnings and computed at the value thereof to the employee.

(f) 1. Except as provided in subd. 2., average weekly earnings may not be less than 24 times the normal hourly earnings at the time of injury.

2. The weekly temporary disability benefits for a part-time employee who restricts his or her availability in the labor market to part-time work and is not employed elsewhere may not exceed the average weekly wages of the part-time employment.[55]

(g) If an employee is under 27 years of age, the employee's average weekly earnings on which to compute the benefits accruing for permanent disability or death shall be determined on the basis of the earnings that the employee, if not disabled, probably would earn after attaining the age of 27 years. Unless otherwise established, the projected earnings determined under this paragraph shall be taken as equivalent to the amount upon which maximum weekly indemnity is payable.

(2) The average annual earnings when referred to in this chapter shall consist of 50 times the employee's average weekly earnings. Subject to the maximum limitation, average annual earnings shall in no case be taken at less than the actual earnings of the employee in the year immediately preceding the employee's injury in the kind of employment in which the employee worked at the time of injury.

(3) The weekly wage loss referred to in this chapter shall be the percentage of the average weekly earnings of the injured employee computed under this section that fairly represents the proportionate extent of the impairment of the employee's earning capacity in the employment in which the employee was working at the time of the injury and other suitable employments. Weekly wage loss shall be fixed as of the time of the injury, but shall be determined in view of the nature and extent of the injury.

History: 1971 c. 148; 1973 c. 150; 1975 c. 147; 1977 c. 195; 1979 c. 278; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1987 a. 179; 1989 a. 64; 1991 a. 85; 1993 a. 81, 492; 1995 a. 117; 1997 a. 38, 253; 2001 a. 37, 107; 2005 a. 172; 2007 a. 185; 2009 a. 206; 2011 a. 123, 183, 257; 2013 a. 165; 2015 a. 55, 180.

Cross-reference: See also s. DWD 80.51, Wis. adm. code.

It was reasonable for the commission to determine that health insurance premiums were not "things of value (that) are received in addition to monetary earnings" under sub. (1) (e). Theuer v. LIRC, 2001 WI 26, 242 Wis. 2d 29, 624 N.W.2d 110, 00-1085.

102.12 Notice of injury, exception, laches. No claim for compensation may be maintained unless, within 30 days after the occurrence of the injury or within 30 days after the employee knew or ought to have known the nature of his or her disability and its relation to the employment, actual notice was received by the employer or by an officer, manager or designated representative of an employer. If no representative has been designated by posters placed in one or more conspicuous places where notices to employees are customarily posted, then notice received by any superior is sufficient. Absence of notice does not bar recovery if it is found that the employer was not misled by that absence. Regardless of whether

[54] This returns to using the preceding 52 weeks to determine the average weekly wage rather than the four calendar quarters used from 1985 through 1997.

[55] 1987 Wis. Act 179, effective April 1, 1988, returns the right to receive the full-time wage as calculated under section 102.11(1)(a) to part-time employees who do not restrict their availability in the labor market to part-time employment and who are employed elsewhere.

notice was received, if no payment of compensation, other than medical treatment or burial expense, is made, and if no application is filed with the department within 2 years after the date of the injury or death or the date the employee or his or her dependent knew or ought to have known the nature of the disability and its relation to the employment, the right to compensation for the injury or death is barred, except that the right to compensation is not barred if the employer knew or should have known, within the 2-year period, that the employee had sustained the injury on which the claim is based. Issuance of notice of a hearing on the motion of the department or the division has the same effect for the purposes of this section as the filing of an application. This section does not affect any claim barred under s. 102.17 (4).

History: 1983 a. 98; 2015 a. 55.

102.123 Statement of employee. If an employee provides to the employer or the employer's insurer a signed statement relating to a claim for compensation by the employee, the employer or insurer shall provide a copy of the statement to the employee within a reasonable time after the statement is made. If an employer or insurer uses a recording device to take a statement from an employee relating to a claim for compensation by the employee, the employer or insurer, on the request of the employee or the employee's attorney or other authorized agent, shall reduce the statement to writing and provide a written copy of the entire statement to the employee, attorney, or agent within a reasonable time after the statement is taken. The employer or insurer shall also make the actual recording of the statement available as an exhibit if a hearing on the claim is held. An employer or insurer that fails to provide an employee with a copy of the employee's statement as required by this section or that fails to make available as an exhibit the actual recording of a statement recorded by a recording device as required by this section may not use that statement in any manner in connection with the employee's claim for compensation.[56]

History: 2001 a. 37.

102.125 Fraud reporting, investigation, and prosecution. (1) FRAUDULENT CLAIMS REPORTING AND INVESTIGATION. If an insurer or self-insured employer has evidence that a claim is false or fraudulent in violation of s. 943.395 and if the insurer or self-insured employer is satisfied that reporting the claim to the department will not impede its ability to defend the claim, the insurer or self-insured employer shall report the claim to the department. The department may require an insurer or self-insured employer to investigate an allegedly false or fraudulent claim and may provide the insurer or self-insured employer with any records of the department relating to that claim. An insurer or self-insured employer that investigates a claim under this subsection shall report on the results of that investigation to the department.

(2) ASSISTANCE BY DEPARTMENT OF JUSTICE. The department of workforce development may request the department of justice to assist the department of workforce development in an investigation under sub. (1) or in the investigation of any other suspected fraudulent activity on the part of an employer, employee, insurer, health care provider, or other person related to worker's compensation.[57]

(3) PROSECUTION. If based on an investigation under sub. (1) or (2) the department has a reasonable basis to believe that a violation of s. 943.20, 943.38, 943.39, 943.392, 943.395, 943.40, or any other criminal law has occurred, the department shall refer the results of the investigation to the department of justice or to

[56] 2001 Wis. Act 37, effective January 1, 2002, creates the requirement that when employee provides the employer or insurance carrier a signed statement relating to the claim the employer or insurer must give a copy to the employee within a reasonable time. When the statement is recorded the employer or insurer must reduce the statement to writing after a request by the employee or his or her attorney or agent and provide a copy within a reasonable time after the statement is taken. The statement of the employee cannot be used in any manner in connection with the claim if the employer or insurer fails to comply.

[57] 2016 Wis. Act 180, effective March 2, 2016, provides that the department shall fund one position in the department of justice to assist with the investigation and prosecution of fraud committed by employees, employers, insurance carriers, and health care providers.

the district attorney of the county in which the alleged violation occurred for prosecution.

History: 1993 a. 81; 2001 a. 37; 2015 a. 180.

102.13 Examination; competent witnesses; exclusion of evidence; autopsy.

(1) (a) Except as provided in sub. (4), whenever compensation is claimed by an employee, the employee shall, upon the written request of the employee's employer or worker's compensation insurer, submit to reasonable examinations by physicians, chiropractors, psychologists, dentists, physician assistants, advanced practice nurse prescribers,[58] or podiatrists provided and paid for by the employer or insurer. No employee who submits to an examination under this paragraph is a patient of the examining physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist for any purpose other than for the purpose of bringing an action under ch. 655, unless the employee specifically requests treatment from that physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist.

(am) When compensation is claimed for loss of earning capacity under s. 102.44 (2) or (3), the employee shall, on the written request of the employee's employer or insurer, submit to reasonable examinations by vocational experts provided and paid for by the employer or insurer.[59]

(b) An employer or insurer who requests that an employee submit to reasonable examination under par. (a) or (am) shall tender to the employee, before the examination, all necessary expenses including transportation expenses.[60] The employee is entitled to have a physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist provided by himself or herself present at the examination and to receive a copy of all reports of the examination that are prepared by the examining physician, chiropractor, psychologist, podiatrist, dentist, physician assistant, advanced practice nurse prescriber, or vocational expert immediately upon receipt of those reports by the employer or worker's compensation insurer. The employee is also entitled to have a translator provided by himself or herself present at the examination if the employee has difficulty speaking or understanding the English language.[61] The employer's or insurer's written request for examination shall notify the employee of all of the following:[62]

1. The proposed date, time, and place of the examination and the identity and area of specialization of the examining physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, or vocational expert.

2. The procedure for changing the proposed date, time and place of the examination.

3. The employee's right to have his or her physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist present at the examination.

4. The employee's right to receive a copy of all reports of the examination that are prepared by the examining physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, or vocational expert immediately upon receipt of these reports by the employer or worker's compensation insurer.[63]

5. The employee's right to have a translator provided by himself or herself present at the examination if the employee has difficulty speaking or understanding the English language.

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[58] The employer or insurer may also request that a dentist examine an employee. 2003 Wis. Act 144, effective March 30, 2004, permits employers and insurers to request that a physician assistant or advanced practice nurse prescriber examine an employee.

[59] When an employee claims loss of earning capacity, he or she must submit to reasonable examination by a vocational expert chosen by the employer or insurer.

[60] This provides that any necessary expenses the employee will incur in submitting to the examination must be tendered in advance. These expenses include wage loss. If the employee loses time from work to attend the examination, he or she is entitled to full wage replacement rather than the temporary disability rate.

[61] The employee may have his or her own language translator present during the examination.

[62] The employer must furnish in writing the specific information required any time an examination is requested.

[63] Reports are to be sent to the injured employee immediately rather than waiting until he or she requests them.

(c) So long as the employee, after a written request of the employer or insurer that complies with par. (b), refuses to submit to or in any way obstructs the examination, the employee's right to begin or maintain any proceeding for the collection of compensation is suspended, except as provided in sub. (4). If the employee refuses to submit to the examination after direction by the department, the division, or an examiner, or in any way obstructs the examination, the employee's right to the weekly indemnity that accrues and becomes payable during the period of that refusal or obstruction, is barred, except as provided in sub. (4).

(d) Subject to par. (e):

1. Any physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, or vocational expert who is present at any examination under par. (a) or (am) may be required to testify as to the results of the examination.

2. Any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist who attended a worker's compensation claimant for any condition or complaint reasonably related to the condition for which the claimant claims compensation may be required to testify before the division when the division so directs. [64]

3. Notwithstanding any statutory provisions except par. (e), any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist attending a worker's compensation claimant for any condition or complaint reasonably related to the condition for which the claimant claims compensation may furnish to the employee, employer, worker's compensation insurer, department, or division information and reports relative to a compensation claim.

4. The testimony of any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist who is licensed to practice where he or she resides or practices in any state and the testimony of any vocational expert may be received in evidence in compensation proceedings.

(e) No person may testify on the issue of the reasonableness of the fees of a licensed health care professional unless the person is licensed to practice the same health care profession as the professional whose fees are the subject of the testimony. This paragraph does not apply to the fee dispute resolution process under s. 102.16 (2).[65]

(f) If an employee claims compensation under s. 102.81 (1), the department or the division may require the employee to submit to physical or vocational examinations under this subsection.

(2) (a) An employee who reports an injury alleged to be work-related or files an application for hearing waives any physician-patient, psychologist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding ss. 51.30 and 146.82 and any other law, any physician, chiropractor, psychologist, dentist, podiatrist, physician assistant, advanced practice nurse prescriber, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, worker's compensation insurer, department, or division, or its representative, provide that person with any information or written material reasonably related to any injury for which the employee

[64] Practitioners under general statutory provisions are not allowed to disclose information that they may acquire while attending a patient in their professional capacity. A practitioner who attends a worker's compensation claimant is privileged to furnish to the employee, employer, worker's compensation insurance carrier, or the department, information and reports relative to a compensation claim. It is a practical necessity that practitioners attending injured workers be permitted to furnish information to the department upon which compensation can be based. Physicians will not be required, however, to disclose confidential communications communicated to them for the purpose of treatment unless such information is necessary to a proper disposition of the claim. The department regards the practitioner who treats the employee at the request of the employer for all intents and purposes as the practitioner of the injured worker. Testimony before department should be absolutely fair, factual and unbiased.

[65] The requirement that a person be licensed in the same health care profession to testify on reasonableness of fees does not apply under the fee dispute resolution process provided in s. 102.16(2).

claims compensation.[66]

(b) A physician, chiropractor, podiatrist, psychologist, dentist, physician assistant, advanced practice nurse prescriber, hospital, or health service provider shall furnish a legible, certified duplicate of the written material requested under par. (a) in paper format upon payment of the actual costs of preparing the certified duplicate, not to exceed the greater of 45 cents per page or $7.50 per request, plus the actual costs of postage, or shall furnish a legible, certified duplicate of that material in electronic format upon payment of $26 per request.[67] Any person who refuses to provide certified duplicates of written material in the person's custody that is requested under par. (a) shall be liable for reasonable and necessary costs and, notwithstanding s. 814.04 (1), reasonable attorney fees incurred in enforcing the requester's right to the duplicates under par. (a).

(c) Except as provided in this paragraph, if an injured employee has a period of temporary disability that exceeds 3 weeks or a permanent disability, if the injured employee has undergone surgery to treat his or her injury, other than surgery to correct a hernia, or if the injured employee sustained an eye injury requiring medical treatment on 3 or more occasions off the employer's premises, the department may by rule require the insurer or self-insured employer to submit to the department a final report of the employee's treating practitioner. The department may not require an insurer or self-insured employer to submit to the department a final report of an employee's treating practitioner when the insurer or self-insured employer denies the employee's claim for compensation in its entirety and the employee does not contest that denial. A treating practitioner shall complete a final report on a timely basis and may charge a reasonable fee for the completion of the final report, not to exceed $100, but may not require prepayment of that fee. An insurer or self-insured employer that disputes the reasonableness of a fee charged for the completion of a treatment practitioner's final report may submit that dispute to the department for resolution under s. 102.16 (2).[68]

(3) If 2 or more physicians, chiropractors, psychologists, dentists, or podiatrists disagree as to the extent of an injured employee's temporary disability, the end of an employee's healing period, an employee's ability to return to work at suitable available employment or the necessity for further treatment or for a particular type of treatment,[69] the department or the division may appoint another physician, chiropractor, psychologist, dentist, or podiatrist to examine the employee and render an opinion as soon as possible. The department or the division shall promptly notify the parties of this appointment. If the employee has not returned to work, payment for temporary disability shall continue until the department or the division receives the opinion. The employer or its insurance carrier, or both, shall pay for the examination and opinion. The employer or insurance carrier, or both, shall receive appropriate credit for any overpayment to the employee determined by the department or the division after receipt of the opinion.[70]

(4) The right of an employee to begin or maintain proceedings for the collection of compensation and to receive weekly indemnities that accrue and become payable shall not be

[66] Any practitioner specified in this section, hospital or health care provider shall furnish reports reasonably related to a compensation claim upon request. The employee by claiming compensation waives the usual practitioner-patient privilege.

[67] 2015 Wis. Act 180, effective March 2, 2016, provides a fixed rate of $26 per request for medical records when the provider furnishes them in electronic format such as on a compact disc. The rate for records provided in paper format remains at a minimum charge of $7.50 plus postage.

[68] 2015 Wis. Act 180, effective March 2, 2016, provides that when a final treating practitioner's report is required the treating practitioner may not charge a fee greater than $100 for completion of the final medical report. 2011 Wis. Act. 183, effective April 17, 2012, requires a final treating practitioner's report when an employee sustains an eye injury requiring treatment on 3 or more occasions outside the employer's premises, and that the final treating practitioner's report is not required when there is a complete denial of the employee's claim for compensation and the employee does not contest the denial. The practitioner is prohibited from requiring pre-payment for the final report. 2005 Wis. Act 172, effective April 1, 2006.

[69] This adds questions of the necessity for treatment or of a particular type of treatment to the issues for which the department may appoint a "tie-breaker" examiner.

[70] If there is disagreement about the continuance of temporary disability between different practitioners, the department may authorize a "tie-breaker" examination.

suspended or barred under sub. (1) when an employee refuses to submit to a physical examination, upon the request of the employer or worker's compensation insurer or at the direction of the department, the division, or an examiner, that would require the employee to travel a distance of 100 miles or more from his or her place of residence, unless the employee has claimed compensation for treatment from a practitioner whose office is located 100 miles or more from the employee's place of residence or the department, division, or examiner determines that any other circumstances warrant the examination. If the employee has claimed compensation for treatment from a practitioner whose office is located 100 miles or more from the employee's place of residence, the employer or insurer may request, or the department, the division, or an examiner may direct, the employee to submit to a physical examination in the area where the employee's treatment practitioner is located.[71]

(5) The department or the division may refuse to receive testimony as to conditions determined from an autopsy if it appears that the party offering the testimony had procured the autopsy and had failed to make reasonable effort to notify at least one party in adverse interest or the department or the division at least 12 hours before the autopsy of the time and place at which the autopsy would be performed, or that the autopsy was performed by or at the direction of the coroner or medical examiner or at the direction of the district attorney for purposes not authorized under ch. 979. The department or the division may withhold findings until an autopsy is held in accordance with its directions.

[71] This provides that compensation may not be suspended or barred when the employee refuses to submit to an examination which would require him or her to travel a distance of 100 miles or more from his or her place of residence unless the department authorizes the examination. One hundred miles is determined from map miles as the crow flies from the place of the residence and not by highway mileage. The amendment effected by Chapter 81, Laws of 1993, effective January 1, 1994, waives the 100 mile limit if the employee has sought and claimed reimbursement for treatment from a practitioner beyond the 100 mile limit. In those cases the employer or insurer may request an examination in the same geographical area as the treating practitioner.

History: 1973 c. 272, 282; 1975 c. 147; 1977 c. 29; 1979 c. 102 s. 236 (3); 1979 c. 278; 1981 c. 92; 1983 a. 98, 279; 1985 a. 83; 1987 a. 179; 1989 a. 64, 359; 1991 a. 85; 1993 a. 81; 1997 a. 38; 2003 a. 144; 2005 a. 172; 2011 a. 183; 2015 a. 55, 180.

102.14 Jurisdiction of department and division; advisory committee.

(1) Except as otherwise provided, this chapter shall be administered by the department and the division.

(2) The council on worker's compensation shall advise the department and the division in carrying out the purposes of this chapter, shall submit its recommendations with respect to amendments to this chapter to each regular session of the legislature, and shall report its views upon any pending bill relating to this chapter to the proper legislative committee. At the request of the chairpersons of the senate and assembly committees on labor, the department shall schedule a meeting of the council with the members of the senate and assembly committees on labor to review and discuss matters of legislative concern arising under this chapter.

History: 1975 c. 147 s. 54; 1979 c. 278; 2015 a. 55.

102.15 Rules of procedure; transcripts.

(1) Subject to this chapter, the division may adopt its own rules of procedure and may change the same from time to time.

(2) The division may provide by rule the conditions under which transcripts of testimony and proceedings shall be furnished.

(3) All testimony at any hearing held under this chapter shall be taken down by a stenographic reporter, except that in case of an emergency, as determined by the examiner conducting the hearing, testimony may be recorded by a recording machine.

History: 1977 c. 418; 1989 a. 64; 2015 a. 55.

Cross-reference: See also ch. DWD 80, Wis. adm. code.

102.16 Submission of disputes, contributions by employees.

(1) (a) Any controversy concerning compensation or a violation of sub. (3),[72] including a controversy in which the state may be a party, shall be submitted to the department in the manner and with the effect provided in this chapter.

(b) In the case of a claim for compensation with respect to which no application has been filed under s. 102.17 (1) (a) 1. or with respect to which an application has been filed, but the application is not ready to be scheduled for a hearing, the department may review and set aside, modify, or confirm a compromise of the claim within one year after the date on which the compromise is filed with the department, the date on which an award has been entered based on the compromise, or the date on which an application for the office [department] to take any of those actions is filed with the department.

NOTE: The correct word is shown in brackets. Corrective legislation is pending.

(c) In the case of a claim for compensation with respect to which an application has been filed under s. 102.17 (1) (a) 1., if the application is ready to be scheduled for a hearing, the division may review and set aside, modify, or confirm a compromise of the claim within one year after the date on which the compromise is filed with the division, the date on which an award has been entered based on the compromise, or the date on which an application for the division to take any of those actions is filed with the division.

(d) Unless the word "compromise" appears in a stipulation of settlement, the settlement shall not be considered a compromise, and further claim is not barred except as provided in s. 102.17 (4) regardless of whether an award is made. The employer, insurer, or dependent under s. 102.51 (5) shall have equal rights with the employee to have a compromise or any other stipulation of settlement reviewed under this subsection. Upon petition filed with the department or the division under this subsection, the department or the division may set aside the award or otherwise determine the rights of the parties.[73]

Cross-reference: See also s. DWD 80.03, Wis. adm. code.

(1m) (a) If an insurer or self-insured employer concedes by compromise under sub. (1) or stipulation under s. 102.18 (1) (a) that the insurer or self-insured employer is liable under this chapter for any health services provided to an injured employee by a health service provider, but disputes the reasonableness of the fee charged by the health service provider, the department or the division may include in its order confirming the compromise or stipulation a determination made by the department under sub. (2) as to the reasonableness of the fee or, if such a determination has not yet been made, the department or the division may notify, or direct the insurer or self-insured employer to notify, the health service provider under sub. (2) (b) that the reasonableness of the fee is in dispute. The department or the division shall deny payment of a health service fee that the department determines under sub. (2) to be unreasonable. A health service provider and an insurer or self-insured employer that are parties to a fee dispute under this paragraph are bound by the department's determination under sub. (2) on the reasonableness of the disputed fee, unless that determination is set aside, reversed, or modified by the department under sub. (2) (f) or is set aside on judicial review as provided in sub. (2) (f).[74]

(b) If an insurer or self-insured employer concedes by compromise under sub. (1) or stipulation under s. 102.18 (1) (a) that the insurer or self-insured employer is liable under this chapter for any treatment provided to an

[72] This makes it clear that employees are not required to have a worker's compensation injury before they can claim reimbursement in an administrative proceeding before the department or the division for the illegal withholding of worker's compensation premiums from their earnings.

[73] Unless a genuine compromise is made and approved by the department or the division the employee will not be foreclosed except by the applicable statute of limitations. Unless disputes arise, parties should not attempt to make "compromise" agreements but should stipulate facts without making use of the word "compromise." In case of a stipulation of settlement (not compromise), the right to review is the same as heretofore, that is for the duration of the statute of limitations, from the date of the last payment of compensation under the stipulation. See also footnotes 106, 107, and 108 to s. 102.17(4) regarding the statute of limitations.

[74] This clarifies the department's authority to issue orders on treatment necessity or reasonableness of fees.

injured employee by a health service provider, but disputes the necessity of the treatment, the department or the division may include in its order confirming the compromise or stipulation a determination made by the department under sub. (2m) as to the necessity of the treatment or, if such a determination has not yet been made, the department or the division may notify, or direct the insurer or self-insured employer to notify, the health service provider under sub. (2m) (b) that the necessity of the treatment is in dispute. Before determining under sub. (2m) the necessity of treatment provided to an injured employee, the department may, but is not required to, obtain the opinion of an expert selected by the department who is qualified as provided in sub. (2m) (c). The standards promulgated under sub. (2m) (g) shall be applied by an expert and by the department in rendering an opinion as to, and in determining, necessity of treatment under this paragraph. In cases in which no standards promulgated under sub. (2m) (g) apply, the department shall find the facts regarding necessity of treatment. The department or the division shall deny payment for any treatment that the department determines under sub. (2m) to be unnecessary. A health service provider and an insurer or self-insured employer that are parties to a dispute under this paragraph over the necessity of treatment are bound by the department's determination under sub. (2m) on the necessity of the disputed treatment, unless that determination is set aside, reversed, or modified by the department under sub. (2m) (e) or is set aside on judicial review as provided in sub. (2m) (e).[75]

(c) If an insurer or self-insured employer concedes by compromise under sub. (1) or stipulation under s. 102.18 (1) (a) that the insurer or self-insured employer is liable under this chapter for the cost of a prescription drug dispensed under s. 102.425 (2) for outpatient use by an injured employee, but disputes the reasonableness of the amount charged for the prescription drug, the department or the division may include in its order confirming the compromise or stipulation a determination made by the department under s. 102.425 (4m) as to the reasonableness of the prescription drug charge or, if such a determination has not yet been made, the department or the division may notify, or direct the insurer or self-insured employer to notify, the pharmacist or practitioner dispensing the prescription drug under s. 102.425 (4m) (b) that the reasonableness of the prescription drug charge is in dispute. The department or the division shall deny payment of a prescription drug charge that the department determines under s. 102.425 (4m) to be unreasonable. A pharmacist or practitioner and an insurer or self-insured employer that are parties to a dispute under this paragraph over the reasonableness of a prescription drug charge are bound by the department's determination under s. 102.425 (4m) on the reasonableness of the disputed prescription drug charge, unless that determination is set aside, reversed, or modified by the department under s. 102.425 (4m) (e) or is set aside on judicial review as provided in s. 102.425 (4m) (e).[76]

(2) (a) Except as provided in this paragraph, the department has jurisdiction under this subsection, the department and the division have jurisdiction under sub. (1m) (a), and the division has jurisdiction under s. 102.17 to resolve a dispute between a health service provider and an insurer or self-insured employer over the reasonableness of a fee charged by the health service provider for health services provided to an injured employee who claims benefits under this chapter. A health service provider may not submit a fee dispute to the department under this subsection before all treatment by the health service provider of the employee's injury has ended if the amount in controversy, whether

[75] This amendment requires the department to apply the treatment guidelines in determining necessity of treatment disputes. 2005 Wis. Act 172, effective April 1, 2006. See Rule DWD 81.

[76] This amendment clarifies the department's authority to issue orders to resolve disputes over the reasonableness of charges for out patient use of prescription drugs. 2007 Wis. Act 185, effective April 1, 2008.

based on a single charge or a combination of charges for one or more days of service, is less than $25.[77] After all treatment by a health service provider of an employee's injury has ended, the health service provider may submit any fee dispute to the department, regardless of the amount in controversy. The department shall deny payment of a health service fee that the department determines under this subsection to be unreasonable.

(am) A health service provider and an insurer or self-insured employer that are parties to a fee dispute under this subsection are bound by the department's determination under this subsection on the reasonableness of the disputed fee, unless that determination is set aside on judicial review as provided in par. (f).

(b) An insurer or self-insured employer that disputes the reasonableness of a fee charged by a health service provider or the department or the division under sub. (1m) (a) or s. 102.18 (1) (bg) 1. shall provide reasonable written notice to the health service provider that the fee is being disputed. After receiving reasonable written notice under this paragraph or under sub. (1m) (a) or s. 102.18 (1) (bg) 1. that a health service fee is being disputed, a health service provider may not collect the disputed fee from, or bring an action for collection of the disputed fee against, the employee who received the services for which the fee was charged.[78]

(c) After a fee dispute is submitted to the department, the insurer or self-insured employer that is a party to the dispute shall provide to the department information on that fee and information on fees charged by other health service providers for comparable services. The insurer or self-insured employer shall obtain the information on comparable fees from a database that is certified by the department under par. (h). Except as provided in par. (e) 1., if the insurer or self-insured employer does not provide the information required under this paragraph, the department shall determine that the disputed fee is reasonable and order that it be paid. If the insurer or self-insured employer provides the information required under this paragraph, the department shall use that information to determine the reasonableness of the disputed fee.

(d) The department shall analyze the information provided to the department under par. (c) according to the criteria provided in this paragraph to determine the reasonableness of the disputed fee. Except as provided in 2011 Wisconsin Act 183, section 30 (2) (b), the department shall determine that a disputed fee is reasonable and order that the disputed fee be paid if that fee is at or below the mean fee for the health service procedure for which the disputed fee was charged, plus 1.2 standard deviations from that mean,[79] as shown by data from a database that is certified by the department under par. (h). Except as provided in 2011 Wisconsin Act 183, section 30 (2) (b), the department shall determine that a disputed fee is unreasonable and order that a reasonable fee be paid if the disputed fee is above the mean fee for the health service procedure for which the disputed fee was charged, plus 1.2 standard deviations from that mean, as shown by data from a database that is certified by the department under par. (h), unless the health service provider proves to the satisfaction of the department that a higher fee is justified because the service provided in the disputed case was more difficult or more complicated to provide than in the usual case.

(e) 1. Subject to subd. 2., if an insurer or self-insured employer that disputes the reasonableness of a fee charged by a health service provider cannot provide information on fees charged by other health service providers for comparable services because the database to which the insurer or self-insured employer subscribes is not able to provide accurate information for the health service procedure at issue, the department may use any other information that the department considers to be

[77] 2003 Wis. Act 144, effective March 30, 2004, creates a minimum threshold disputed amount of $25.00 based on a single charge or a combination of charges for one or more dates of service for utilizing the reasonableness of fees dispute resolution process. This minimum amount does not apply if treatment for the injury by the provider has ended.

[78] This amendment provides the requirement for written notice by an insurance carrier or self-insured employer to a health care provider that reasonableness of a fee was disputed. 2009 Wis. Act 206, effective May 1, 2010.

[79] 2011 Wis. Act 183, effective April 17, 2012, reduces the standard deviation from 1.4 to 1.2 for determining reasonableness of fee disputes.

reliable and relevant to the disputed fee to determine the reasonableness of the disputed fee.[80]

2. Notwithstanding subd. 1., the department may use only a hospital radiology database that has been certified by the department under par. (h) to determine the reasonableness of a hospital fee for radiology services.

(f) Within 30 days after a determination under this subsection, the department may set aside, reverse, or modify the determination for any reason that the department considers sufficient. Within 60 days after a determination under this subsection, the department may set aside, reverse, or modify the determination on grounds of mistake.[81] A health service provider, insurer, or self-insured employer that is aggrieved by a determination of the department under this subsection may seek judicial review of that determination in the same manner that compensation claims are reviewed under s. 102.23.[82]

(g) Section 102.13 (1) (e) does not apply to the fee dispute resolution process under this subsection.

(h) The department shall promulgate rules establishing procedures and requirements for the fee dispute resolution process under this subsection, including rules specifying the standards that health service fee databases must meet for certification under this paragraph. Using those standards, the department shall certify databases of the health service fees that various health service providers charge. In certifying databases under this paragraph, the department shall certify at least one database of hospital fees for radiology services, including diagnostic and interventional radiology, diagnostic ultrasound and nuclear medicine.[83]

Cross-reference: See also s. DWD 80.72, Wis. adm. code.

(2m) (a) Except as provided in this paragraph, the department has jurisdiction under this subsection, the department and the division have jurisdiction under sub. (1m) (b), and the division has jurisdiction under s. 102.17 to resolve a dispute between a health service provider and an insurer or self-insured employer over the necessity of treatment provided for an injured employee who claims benefits under this chapter. A health service provider may not submit a dispute over necessity of treatment to the department under this subsection before all treatment by the health service provider of the employee's injury has ended if the amount in controversy, whether based on a single charge or a combination of charges for one or more days of service, is less than $25.[84] After all treatment by a health service provider of an employee's injury has ended, the health service provider may submit any dispute over necessity of treatment to the department, regardless of the amount in controversy. The department shall deny payment for any treatment that the department determines under this subsection to be unnecessary.

(am) A health service provider and an insurer or self-insured employer that are parties to a dispute under this subsection over the necessity of treatment are bound by the department's determination under this subsection on the necessity of the disputed treatment, unless that determination is set aside on judicial review as provided in par. (e).

(b) An insurer or self-insured employer that disputes the necessity of treatment provided by a health service provider or the department or the division under sub. (1m) (b) or s. 102.18 (1) (bg) 2. shall provide reasonable written notice to the

[80] This clarifies the department's authority to consider information other than the formula amount if the database the insurer uses does not have reliable data for the disputed procedure.

[81] 2003 Wis. Act 144, effective March 30, 2004, permits the department to modify reasonableness of fee orders for any reason it deems sufficient within 30 days; and to modify such orders on grounds of mistake within 60 days.

[82] There is no administrative appeal to a determination of reasonableness under this section. However, the parties have the right to a review of the determination in the circuit court.

[83] This directs the department to develop a separate database for use in disputes regarding the reasonableness of radiology fees charged by hospitals.

[84] 2003 Wis. Act 144, effective March 30, 2004, creates a minimum threshold disputed amount of $25.00 based on a single charge or a combination of charges for one or more dates of service for utilizing the necessity of treatment dispute resolution process. This minimum amount does not apply if treatment for the injury by the provider has ended.

health service provider that the necessity of that treatment is being disputed. After receiving reasonable written notice under this paragraph or under sub. (1m) (b) or s. 102.18 (1) (bg) 2. that the necessity of treatment is being disputed, a health service provider may not collect a fee for that disputed treatment from, or bring an action for collection of the fee for that disputed treatment against, the employee who received the treatment.[85]

(c) Before determining under this subsection the necessity of treatment provided for an injured employee who claims benefits under this chapter, the department shall obtain a written opinion on the necessity of the treatment in dispute from an expert selected by the department. To qualify as an expert, a person must be licensed to practice the same health care profession as the individual health service provider whose treatment is under review and must either be performing services for an impartial health care services review organization or be a member of an independent panel of experts established by the department under par. (f). The standards promulgated under par. (g) shall be applied by an expert and by the department in rendering an opinion as to, and in determining, necessity of treatment under this paragraph. In cases in which no standards promulgated under sub. (2m) (g) apply, the department shall find the facts regarding necessity of treatment. The department shall adopt the written opinion of the expert as the department's determination on the issues covered in the written opinion, unless the health service provider or the insurer or self-insured employer present clear and convincing written evidence that the expert's opinion is in error.[86] [87]

(d) The department may charge a party to a dispute over the necessity of treatment provided for an injured employee who claims benefits under this chapter for the full cost of obtaining the written opinion of the expert under par. (c). The department shall charge the insurer or self-insured employer for the full cost of obtaining the written opinion of the expert for the first dispute that a particular individual health service provider is involved in, unless the department determines that the individual health service provider's position in the dispute is frivolous or based on fraudulent representations. In a subsequent dispute involving the same individual health service provider, the department shall charge the losing party to the dispute for the full cost of obtaining the written opinion of the expert.[88]

(e) Within 30 days after a determination under this subsection, the department may set aside, reverse, or modify the determination for any reason that the department considers sufficient. Within 60 days after a determination under this subsection, the department may set aside, reverse, or modify the determination on grounds of mistake. A health service provider, insurer, or self-insured employer that is aggrieved by a determination of the department under this subsection may seek judicial review of that determination in the same manner that compensation claims are reviewed under s. 102.23.[89]

(f) The department may contract with an impartial health care services review organization to provide the expert opinions required under par. (c), or establish a panel of experts to provide those opinions, or both. If the department establishes a panel of experts to provide the expert opinions required under par. (c), the department may pay the members of that panel a reasonable fee, plus actual and necessary

[85] This amendment provides the requirement for written notice by an insurance carrier or self-insured employer to a health care provider that treatment was unnecessary. 2009 Wis. Act 206, effective May 1, 2010.

[86] See Rule DWD 80.73(2)(c) for definition of those licensed to practice the same health care profession.

[87] This amendment requires experts selected by the department to apply the treatment guidelines in rendering necessity of treatment opinions. 2005 Wis. Act 172, effective April 1, 2006. See Rule DWD 81.

[88] When there is a dispute between a health care provider and an insurer or self-insurer regarding the necessity of treatment provided to an employee, this provision directs the department to obtain and adopt the opinion of an independent medical expert in the same profession. The losing party will pay the cost of obtaining the opinion, except for the first dispute involving a provider. Also see Rule DWD 80.73.

[89] 2003 Wis. Act 144, effective March 30, 2004, permits the department to modify its necessity of treatment orders for any reason it deems sufficient within 30 days; and to modify such orders on grounds of mistake within 60 days. There is no administrative appeal to a determination of necessity under this section. However, the parties have the right to a review of the determination in the circuit court.

expenses, for their services.

(g) The department shall promulgate rules establishing procedures and requirements for the necessity of treatment dispute resolution process under this subsection, including rules setting the fees under par. (f) and rules establishing standards for determining the necessity of treatment provided to an injured employee. Before the department may amend the rules establishing those standards, the department shall establish an advisory committee under s. 227.13 composed of health care providers providing treatment under s. 102.42 to advise the department and the council on worker's compensation on amending those rules.[90]

Cross-reference: See also s. DWD 80.73 and ch. DWD 81, Wis. adm. code.

(3) No employer subject to this chapter may solicit, receive, or collect any money from an employee or any other person or make any deduction from their wages, either directly or indirectly, for the purpose of discharging any liability under this chapter or recovering premiums paid on a contract described under s. 102.31 (1) (a) or a policy described under s. 102.315 (3), (4), or (5) (a); nor may any employer subject to this chapter sell to an employee or other person, or solicit or require the employee or other person to purchase, medical, chiropractic, podiatric, psychological, dental, or hospital tickets or contracts for medical, surgical, hospital, or other health care treatment that is required to be furnished by that employer.

(4) The department and the division have jurisdiction to pass on any question arising out of sub. (3) and to order the employer to reimburse an employee or other person for any sum deducted from wages or paid by him or her in violation of that subsection.[91] In addition to the penalty provided in s. 102.85 (1), any employer violating sub. (3) shall be liable to an injured employee for the reasonable value of the necessary services rendered to that employee under any arrangement made in violation of sub. (3) without regard to that employee's actual disbursements for those services.

(5) Except as provided in s. 102.28 (3), no agreement by an employee to waive the right to compensation is valid.

History: 1975 c. 147, 200; 1977 c. 195; 1981 c. 92, 314; 1983 a. 98; 1985 a. 83; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38; 1999 a. 14, 185; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2007 a. 185; 2009 a. 206; 2011 a. 183; 2015 a. 55.

The continuing obligation to compensate an employee for work related medical expenses under s. 102.42 does not allow agency review of compromise agreements after the one-year statute of limitations in s. 102.16 (1) has run if the employee incurs medical expenses after that time. Schenkoski v. LIRC, 203 Wis. 2d 109, 552 N.W.2d 120 (Ct. App. 1996), 96-0051.

An appeal under sub. (2m) (e) of a department determination may be served under s. 102.23 (1) (b) on the department or the commission. McDonough v. DWD, 227 Wis. 2d 271, 595 N.W.2d 686 (1999), 97-3711.

The Department of Workforce Development does not possess authority to independently determine, for worker's compensation purposes, the reasonableness and medical necessity of a protectively-placed injured employee's court-ordered transfer to the least restrictive environment under ch. 55. The department's authority is limited to resolving disputes regarding the reasonableness or necessity of treatment provided to an injured employee, which permits the department to evaluate the treatment an employee receives within a placement, but not the placement itself. LaBeree v. Wausau Insurance Companies, 2010 WI App 148, 330 Wis. 2d 101, 793 N.W.2d 77, 09-1628.

102.17 Procedure; notice of hearing; witnesses, contempt; testimony, medical examination.[92]

(1) (a) 1. Upon the filing with the department by any party in interest of any application in writing stating the general nature of any claim as to which any dispute or controversy may have arisen, the department shall mail a copy of the application to all other parties in interest, and the insurance carrier shall be considered a party in interest. The department or the division may bring in additional parties by service of a copy of the application.

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[90] The department is authorized to promulgate rules to establish treatment guidelines for determining necessity of treatment disputes. See Rule ch. DWD 81. 2007 Wis. Act 185, effective April 1, 2008 eliminated the requirement that the rules are to be consistent to the extent possible with the Minnesota worker's compensation treatment parameters.

[91] The department and the division have the authority to order reimbursement of sums illegally deducted.

[92] The practice before the department and division follows substantially the practice in courts of equity. The purpose is to secure the facts in as direct and simple a manner as possible. Parties will aid the department and division to make the administration of the act less expensive by stipulating all the facts not in dispute. In practice the department and division mails copies of its awards to both parties. If a mistake is found, the department or division may correct it upon having its attention called to the matter within 21 days after the date of the award.

2. Subject to subd. 3., the division shall cause notice of hearing on the application to be given to each interested party by service of that notice on the interested party personally or by mailing a copy of that notice to the interested party's last-known address at least 10 days before the hearing. If a party in interest is located without this state, and has no post-office address within this state, the copy of the application and copies of all notices shall be filed with the department of financial institutions and shall also be sent by registered or certified mail to the last-known post-office address of the party. Such filing and mailing shall constitute sufficient service, with the same effect as if served upon a party located within this state.

3. If a party in interest claims that the employer or insurer has acted with malice or bad faith as described in s. 102.18 (1) (b) 3. or (bp), that party shall provide written notice stating with reasonable specificity the basis for the claim to the employer, the insurer, the department, and the division before the division schedules a hearing on the claim of malice or bad faith.[93]

4. The hearing may be adjourned in the discretion of the division, and hearings may be held at such places as the division designates, within or without the state. The division may also arrange to have hearings held by the commission, officer, or tribunal having authority to hear cases arising under the worker's compensation law of any other state, of the District of Columbia, or of any territory of the United States, with the testimony and proceedings at any such hearing to be reported to the division and to be made part of the record in the case. Any evidence so taken shall be subject to rebuttal upon final hearing before the division.

(b) In any dispute or controversy pending before the division, the division may direct the parties to appear before an examiner for a conference to consider the clarification of issues, the joining of additional parties, the necessity or desirability of amendments to the pleadings, the obtaining of admissions of fact or of documents, records, reports, and bills that may avoid unnecessary proof, and such other matters as may aid in disposition of the dispute or controversy. After that conference the division may issue an order requiring disclosure or exchange of any information or written material that the division considers material to the timely and orderly disposition of the dispute or controversy. If a party fails to disclose or exchange that information within the time stated in the order, the division may issue an order dismissing the claim without prejudice or excluding evidence or testimony relating to the information or written material. The division shall provide each party with a copy of any order issued under this paragraph.[94]

(c) 1. Any party shall have the right to be present at any hearing, in person or by attorney or any other agent, and to present such testimony as may be pertinent to the controversy before the division. No person, firm, or corporation, other than an attorney at law who is licensed to practice law in the state, may appear on behalf of any party in interest before the division or any member or employee of the division assigned to conduct any hearing, investigation, or inquiry relative to a claim for compensation or benefits under this chapter, unless the person is 18 years of age or older, does not have an arrest or conviction record, subject to ss. 111.321, 111.322 and 111.335, is otherwise qualified, and has obtained from the department a license with authorization to appear in matters or proceedings before the division. Except as provided under pars. (cm), (cr), and (ct), the license shall be issued by the department under rules promulgated by the department. The department shall maintain in its office a current list of persons to whom licenses have been issued.

2. Any license issued under subd. 1. may be suspended or revoked by the department for fraud or serious misconduct on the part of an agent, may be denied, suspended, nonrenewed, or otherwise withheld by the department for failure to pay court-ordered payments as

[93] This amendment requires a party who claims an employer or insurance carrier acted in bad faith to provide written notice stating with reasonable specificity the basis for the claim to the employer, insurance carrier, department, and division before a hearing is scheduled in the claim. 2009 Wis. Act 206, effective May 1, 2010.

[94] After a prehearing conference the division may order disclosure of relevant information.

provided in par. (cm) on the part of an agent, and may be denied or revoked if the department of revenue certifies under s. 73.0301 that the applicant or licensee is liable for delinquent taxes or if the department determines under par. (ct) that the applicant or licensee is liable for delinquent unemployment insurance contributions. Before suspending or revoking the license of the agent on the grounds of fraud or misconduct, the department shall give notice in writing to the agent of the charges of fraud or misconduct and shall give the agent full opportunity to be heard in relation to those charges. In denying, suspending, restricting, refusing to renew, or otherwise withholding a license for failure to pay court-ordered payments as provided in par. (cm), the department shall follow the procedure provided in a memorandum of understanding entered into under s. 49.857.

3. Unless otherwise suspended or revoked, a license issued under subd. 1. shall be in force from the date of issuance until the June 30 following the date of issuance and may be renewed by the department from time to time, but each renewed license shall expire on the June 30 following the issuance of the renewed license.[95]

(cg) 1. Except as provided in subd. 2m., the department shall require each applicant for a license under par. (c) who is an individual to provide the department with the applicant's social security number, and shall require each applicant for a license under par. (c) who is not an individual to provide the department with the applicant's federal employer identification number, when initially applying for or applying to renew the license.

2. If an applicant who is an individual fails to provide the applicant's social security number to the department or if an applicant who is not an individual fails to provide the applicant's federal employer identification number to the department, the department may not issue or renew a license under par. (c) to or for the applicant unless the applicant is an individual who does not have a social security number and the applicant submits a statement made or subscribed under oath or affirmation as required under subd. 2m.

2m. If an applicant who is an individual does not have a social security number, the applicant shall submit a statement made or subscribed under oath or affirmation to the department that the applicant does not have a social security number. The form of the statement shall be prescribed by the department. A license issued in reliance upon a false statement submitted under this subdivision is invalid.

3. The department of workforce development may not disclose any information received under subd. 1. to any person except to the department of revenue for the sole purpose of requesting certifications under s. 73.0301 or the department of children and families for purposes of administering s. 49.22.

(cm) The department of workforce development shall deny, suspend, restrict, refuse to renew, or otherwise withhold a license under par. (c) for failure of the applicant or agent to pay court-ordered payments of child or family support, maintenance, birth expenses, medical expenses, or other expenses related to the support of a child or former spouse or for failure of the applicant or agent to comply, after appropriate notice, with a subpoena or warrant issued by the department of children and families or a county child support agency under s. 59.53 (5) and related to paternity or child support proceedings, as provided in a memorandum of understanding entered into under s. 49.857. Notwithstanding par. (c), an action taken under this paragraph is subject to review only as provided in the memorandum of understanding entered into under s. 49.857 and not as provided in ch. 227.[96]

(cr) The department shall deny an application for the issuance or renewal of a license under par. (c), or revoke such a license already issued, if the department of revenue certifies under s. 73.0301 that the applicant or licensee is liable for delinquent taxes. Notwithstanding par. (c), an action taken under this paragraph is subject to

[95] Any person other than a Wisconsin attorney who wishes to represent parties in compensation hearings is required to obtain a license under rules formulated by the department. See Rule DWD 80.20.

[96] Sections 102.17(1)(cg) & (cm) were created by 1997 Wis. Act 191 relative to enforcement of support payments. Section 102.17(1)(cr) was created by 1997 Wis. Act 237 relative to delinquent taxes.

review only as provided under s. 73.0301 (5) and not as provided in ch. 227.

(ct)[97] **1.** The department may deny an application for the issuance or renewal of a license under par. (c), or revoke such a license already issued, if the department determines that the applicant or licensee is liable for delinquent contributions, as defined in s. 108.227 (1) (d). Notwithstanding par. (c), an action taken under this subdivision is subject to review only as provided under s. 108.227 (5) and not as provided in ch. 227.

2. If the department denies an application or revokes a license under subd. 1., the department shall mail a notice of denial or revocation to the applicant or license holder. The notice shall include a statement of the facts that warrant the denial or revocation and a statement that the applicant or license holder may, within 30 days after the date on which the notice of denial or revocation is mailed, file a written request with the department to have the determination that the applicant or license holder is liable for delinquent contributions reviewed at a hearing under s. 108.227 (5) (a).

3. If, after a hearing under s. 108.227 (5) (a), the department affirms a determination under subd. 1. that an applicant or license holder is liable for delinquent contributions, the department shall affirm its denial or revocation. An applicant or license holder may seek judicial review under s. 108.227 (6) of an affirmation by the department of a denial or revocation under this subdivision.

4. If, after a hearing under s. 108.227 (5) (a), the department determines that a person whose license is revoked or whose application is denied under subd. 1. is not liable for delinquent contributions, as defined in s. 108.227 (1) (d), the department shall reinstate the license or approve the application, unless there are other grounds for revocation or denial. The department may not charge a fee for reinstatement of a license under this subdivision.

(d) 1. The contents of certified medical and surgical reports by physicians, podiatrists, surgeons, dentists, psychologists, physician assistants, advanced practice nurse prescribers,[98] and chiropractors licensed in and practicing in this state, and of certified reports by experts concerning loss of earning capacity under s. 102.44 (2) and (3), presented by a party for compensation constitute prima facie evidence as to the matter contained in those reports, subject to any rules and limitations the division prescribes.[99] Certified reports of physicians, podiatrists, surgeons, dentists, psychologists, physician assistants, advanced practice nurse prescribers, and chiropractors, wherever licensed and practicing, who have examined or treated the claimant, and of experts, if the practitioner or expert consents to being subjected to cross-examination, also constitute prima facie evidence as to the matter contained in those reports. Certified reports of physicians, podiatrists, surgeons, psychologists, and chiropractors are admissible as evidence of the diagnosis, necessity of the treatment, and cause and extent of the disability. Certified reports by doctors of dentistry, physician assistants, and advanced practice nurse prescribers are admissible as evidence of the diagnosis and necessity of treatment but not of the cause and extent of disability. Any physician, podiatrist, surgeon, dentist, psychologist, chiropractor, physician assistant, advanced practice nurse prescriber, or expert who knowingly makes a false statement of fact or opinion in a certified report may be fined or imprisoned, or both, under s. 943.395.

2. The record of a hospital or sanatorium in this state that is satisfactory to the division, established by certificate, affidavit, or testimony of the supervising officer of the hospital or sanitorium, any other person having charge of the record, or a physician, podiatrist, surgeon, dentist, psychologist, physician assistant, advanced practice nurse prescriber, or chiropractor to be the record of the patient in

[97] 2013 Act 36 created section 102.17(1) (ct) to provide that the department may deny a license or a license renewal under par (c) to a person who has delinquent unemployment insurance contributions under s. 108.227. This denial is reviewable under s. 108.227.

[98] 2003 Wis. Act 144, effective March 30, 2004, adds physician assistants and advance practice nurse prescribers as practitioners who can complete certified medical reports and are given the same status as dentists to provide certified reports as evidence of the diagnosis and necessity of treatment but not of the cause and extent of disability.

[99] Previously the law provided that some documents be verified. Now all documents need only be certified.

question, and made in the regular course of examination or treatment of the patient, constitutes prima facie evidence as to the matter contained in the record, to the extent that the record is otherwise competent and relevant.[100]

3. The division may, by rule, establish the qualifications of and the form used for certified reports submitted by experts who provide information concerning loss of earning capacity under s. 102.44 (2) and (3). The division may not admit into evidence a certified report of a practitioner or other expert or a record of a hospital or sanatorium that was not filed with the division and all parties in interest at least 15 days before the date of the hearing, unless the division is satisfied that there is good cause for the failure to file the report.[101]

4. A report or record described in subd. 1., 2., or 3. that is admitted or received into evidence by the division constitutes substantial evidence under s. 102.23 (6) as to the matter contained in the report or record.[102]

(e) The division may, with or without notice to any party, cause testimony to be taken, an inspection of the premises where the injury occurred to be made, or the time books and payrolls of the employer to be examined by any examiner, and may direct any employee claiming compensation to be examined by a physician, chiropractor, psychologist, dentist, or podiatrist. The testimony so taken, and the results of any such inspection or examination, shall be reported to the division for its consideration upon final hearing. All ex parte testimony taken by the division shall be reduced to writing, and any party shall have opportunity to rebut that testimony on final hearing.

(f) Sections 804.05 and 804.07 shall not apply to proceedings under this chapter, except as to a witness who is any of the following:

1. Beyond reach of the subpoena of the division.

2. About to go out of the state, not intending to return in time for the hearing.

3. So sick, infirm, or aged as to make it probable that the witness will not be able to attend the hearing.

4. A member of the legislature, if any committee of the legislature or of the house of which the witness is a member is in session and the witness waives his or her privilege.[103]

(g) Whenever the testimony presented at any hearing indicates a dispute or creates a doubt as to the extent or cause of disability or death, the division may direct that the injured employee be examined, that an autopsy be performed, or that an opinion be obtained without examination or autopsy, by or from an impartial, competent physician, chiropractor, dentist, psychologist or podiatrist designated by the division who is not under contract with or regularly employed by a compensation insurance carrier or self-insured employer. The expense of the examination, autopsy, or opinion shall be paid by the employer or, if the employee claims compensation under s. 102.81, from the uninsured employers fund. The report of the examination, autopsy, or opinion shall be transmitted in writing to the division and a copy of the report shall be furnished by the division to each party, who shall have an opportunity to rebut the report on further hearing.

(h) The contents of certified reports of investigation made by industrial safety specialists who are employed, contracted, or otherwise secured by the department or the division and who are available for cross-examination, if served upon the parties 15 days prior to hearing, shall constitute prima facie

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[100] It must be shown that the record was made in the regular course of examination or treatment of the patient. The record then constitutes prima facie evidence insofar as it may otherwise be competent and relevant.

[101] Reports are required in advance of the hearing to prevent confusion and delay of the hearing or the necessity for a continued hearing.

[102] This amendment provides that records and reports described under this paragraph that are admitted or received into evidence at hearings constitute substantial evidence. 2005 Wis. Act 172, effective April 1, 2006.

[103] This permits examinations of a witness beyond reach of the subpoena of the division, or when a witness shall be about to go out of the state not intending to return in time for hearing, or when the witness shall be so sick or infirm or aged as to make it probable that the witness will not be able to attend hearing, or in case of member of the legislature, if a committee or house of which the witness is a member is in session, provided the member is willing to waive his or her privilege. In other cases adverse examination before hearing is not permissible. This ensures a minimum of delay and expense, and that as far as possible all proceedings are to be had before the division which has necessary machinery and personnel to ensure prompt and proper procedure with little or no expense to the parties. See ch. 804.

evidence as to matter contained in those reports. A report described in this paragraph that is admitted or received into evidence by the division constitutes substantial evidence under s. 102.23 (6) as to the matter contained in the report.[104]

(2) If the division has reason to believe that the payment of compensation has not been made, the division may on its own motion give notice to the parties, in the manner provided for the service of an application, of a time and place when a hearing will be held for the purpose of determining the facts. The notice shall contain a statement of the matter to be considered. All provisions of this chapter governing proceedings on an application shall apply, insofar as applicable, to a proceeding under this subsection. When the division schedules a hearing on its own motion, the division does not become a party in interest and is not required to appear at the hearing.[105]

(2m) The division or any party, including the department, may require any person to produce books, papers, and records at the hearing by personal service of a subpoena upon the person along with a tender of witness fees as provided in ss. 814.67 and 885.06. Except as provided in sub. (2s), the subpoena shall be on a form provided by the division and shall give the name and address of the party requesting the subpoena.

(2s) A party's attorney of record may issue a subpoena to compel the attendance of a witness or the production of evidence. A subpoena issued by an attorney must be in substantially the same form as provided in s. 805.07 (4) and must be served in the manner provided in s. 805.07 (5). The attorney shall, at the time of issuance, send a copy of the subpoena to the hearing examiner or other representative of the division responsible for conducting the proceeding.

(3) Any person who shall willfully and unlawfully fail or neglect to appear or to testify or to produce books, papers and records as required, shall be fined not less than $25 nor more than $100, or imprisoned in the county jail not longer than 30 days. Each day such person shall so refuse or neglect shall constitute a separate offense.

(4) Except as provided in this subsection and s. 102.555 (12) (b), in the case of occupational disease, the right of an employee, the employee's legal representative, or a dependent to proceed under this section shall not extend beyond 12 years after the date of the injury or death or after the date that compensation, other than for treatment or burial expenses, was last paid, or would have been last payable if no advancement were made,[106] whichever date is latest, and in the case of traumatic injury, that right shall not extend beyond 6 years after that date.[107]

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[104] This paragraph was amended by 2001 Wis. Act 37, effective January 1, 2002, to include certified reports of investigation made by industrial safety specialists who are contracted by or otherwise secured by the department. 2005 Wis. Act 172, effective April 1, 2006 provided that reports described under this paragraph that are admitted or received into evidence at hearings constitute substantial evidence.

[105] This codifies a long-standing departmental policy.

[106] This makes clear that even though an advancement or lump sum is granted, the time for proceeding is not cut down but is limited only by the applicable statute of limitations from the date that compensation would have been last payable if no advancement or lump sum had been made. Payments for treatment or burial expense have no effect on the statute of limitations. Wis. Act 183, effective April 17, 2012.

[107] 2015 Wisconsin Act 180, effective March 2, 2016, provides that the statute of limitations for traumatic injuries shall be 6 years. This change applies to dates of injuries occurring on or after March 2, 2016. The statute of limitations for occupational injuries remains 12 years.

In the case of occupational disease; a traumatic injury resulting in the loss or total impairment of a hand or any part of the rest of the arm proximal to the hand or of a foot or any part of the rest of the leg proximal to the foot, any loss of vision, or any permanent brain injury; or a traumatic injury causing the need for an artificial spinal disc or a total or partial knee or hip replacement, there shall be no statute of limitations,[108] except that benefits or treatment expense for an occupational disease becoming due 12 years after the date of injury or death or last payment of compensation, other than for treatment or burial expenses, shall be paid from the work injury supplemental benefit fund under s. 102.65 and in the manner provided in s. 102.66 and benefits or treatment expense for such a traumatic injury becoming due 6 years after that date shall be paid from that fund and in that manner if the date of injury or death or last payment of compensation, other than for treatment or burial expenses, is before April 1, 2006. Payment of wages by the employer during disability or absence from work to obtain treatment shall be considered payment of compensation for the purpose of this section if the employer knew of the employee's condition and its alleged relation to the employment.

(5) This section does not limit the time within which the state may bring an action to recover the amounts specified in ss. 102.49 (5) and 102.59.

(6) If an employee or dependent shall, at the time of injury, or at the time the employee's or dependent's right accrues, be under 18 years of age, the limitations of time within which the employee or dependent may file application or proceed under this chapter, if they would otherwise sooner expire, shall be extended to one year after the employee or dependent attains the age of 18 years. If, within any part of the last year of any such period of limitation, an employee, the employee's personal representative, or surviving dependent be insane or on active duty in the armed forces of the United States such period of limitation shall be extended to 2 years after the date that the limitation would otherwise expire. The provision hereof with respect to persons on active duty in the armed forces of the United States shall apply only where no applicable federal statute is in effect.

(7) (a) Except as provided in par. (b), in a claim under s. 102.44 (2) and (3), testimony or certified reports of expert witnesses on loss of earning capacity may be received in evidence and considered with all other evidence to decide on an employee's actual loss of earning capacity.[109] [110]

(b) Except as provided in par. (c), the division shall exclude from evidence testimony or certified reports from expert witnesses under par. (a) offered by the party that raises the issue of loss of earning capacity if that party failed to notify the division and the other parties of interest, at least 60 days before the date of the hearing, of the party's intent to provide the testimony or reports and of the names of the expert witnesses involved. Except as provided in par. (c), the division shall exclude from evidence testimony or certified reports from expert witnesses under par. (a) offered by a party of interest in response to the party that raises the issue of loss of earning capacity if the responding party failed to notify the division and the other parties of interest, at least 45 days before the date of the hearing, of the party's

[108] There no longer is a statute of limitations for traumatic injuries resulting in the loss of total impairment of a hand or any part of the rest of the arm proximal to the hand, or of a foot, or any part of the rest of the leg proximal to the foot, any loss of vision, any permanent brain injury, a traumatic injury causing the need for an artificial spinal disc, or any injury causing the need for a total or partial knee or hip replacement. Claims for these injuries will be paid by self-insured employers and insurance carriers. This amendment was created by 2005 Wis. Act 172, effective April 1, 2006. Payments for treatment or burial expense have no effect on the statute of limitations for occupational diseases. Wis. Act 183, effective April 17, 2012.

[109] Now the reports need only be certified rather than verified.

[110] This gives the division the option of using or not using the testimony or reports of expert witnesses in determining the loss of earning capacity resulting from nonscheduled injuries. The determination is made by considering all evidence in the record.

intent to provide the testimony or reports and of the names of the expert witnesses involved.[111]

(c) Notwithstanding the notice deadlines provided in par. (b), the division may receive in evidence testimony or certified reports from expert witnesses under par. (a) when the applicable notice deadline under par. (b) is not met if good cause is shown for the delay in providing the notice required under par. (b) and if no party is prejudiced by the delay.

(8) Unless otherwise agreed to by all parties, an injured employee shall file with the division and serve on all parties at least 15 days before the date of the hearing an itemized statement of all medical expenses and incidental compensation under s. 102.42 claimed by the injured employee. The itemized statement shall include, if applicable, information relating to any travel expenses incurred by the injured employee in obtaining treatment including the injured employee's destination, number of trips, round trip mileage, and meal and lodging expenses. The division may not admit into evidence any information relating to medical expenses and incidental compensation under s. 102.42 claimed by an injured employee if the injured employee failed to file with the division and serve on all parties at least 15 days before the date of the hearing an itemized statement of the medical expenses and incidental compensation under s. 102.42 claimed by the injured employee, unless the division is satisfied that there is good cause for the failure to file and serve the itemized statement.[112]

History: 1971 c. 148; 1971 c. 213 s. 5; 1973 c. 150, 282; Sup. Ct. Order, 67 Wis. 2d 585, 774 (1975); 1975 c. 147 ss. 20, 54; 1975 c. 199, 200; 1977 c. 29, 195, 273; 1979 c. 278; 1981 c. 92, 314; 1981 c. 317 s. 2202; 1981 c. 380; 1981 c. 391 s. 211; 1985 a. 83; 1989 a. 64, 139, 359; 1991 a. 85; 1993 a. 81, 492; 1995 a. 27, 117; 1997 a. 38, 191, 237; 1999 a. 9; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2007 a. 185; 2009 a. 180, 206; 2011 a. 183; 2013 a. 36; 2015 a. 55, 180.

Cross-reference: See also ch. DWD 80, Wis. adm. code.

A plaintiff-employer was not deprived of any substantial due process rights by the department's refusal to invoke its rule requiring inspection of the opposing parties' medical reports when the plaintiff had ample notice of the nature of the employee's claim. Theodore Fleisner, Inc. v. DILHR, 65 Wis. 2d 317, 222 N.W.2d 600 (1974).

Under the facts of the case, a refusal to grant an employer's request for adjournment was a denial of due process. Bituminous Casualty Co. v. DILHR, 97 Wis. 2d 730, 295 N.W.2d 183 (Ct. App. 1980).

Sub. (1) (d) does not create a presumption that evidence presented by treating physicians is correct. The statute enforces the idea that LIRC determines the weight to be given medical witnesses. Conradt v. Mt. Carmel School, 197 Wis. 2d 60, 539 N.W.2d 713 (Ct. App. 1995), 94-2842.

LIRC's authority under sub. (1) (a) to control its calendar and manage its internal affairs necessarily implies the power to deny an applicant's motion to withdraw an application for hearing. An appellant's failure to appear at a hearing after a motion to withdraw the application was denied was grounds for entry of a default judgment under s. 102.18 (1) (a). Baldwin v. LIRC, 228 Wis. 2d 601, 599 N.W.2d 8 (Ct. App. 1999), 98-3090.

In the absence of testimony in conflict with a claimant's medical experts, LIRC may reject the expert evidence if there is countervailing testimony raising legitimate doubt about the employee's injury. Kowalchuk v. LIRC, 2000 WI App 85, 234 Wis. 2d 203, 610 N.W.2d 122, 99-1183.

It was reasonable for LIRC to conclude that the statute of limitations under sub. (4) for death benefits begins to run at the time of death, rather than the time of injury. International Paper Co. v. LIRC, 2001 WI App 248, 248 Wis. 2d 348, 635 N.W.2d 823, 01-0126.

Neither sub. (1) (g) or (d) provides a statutory right to cross-examine an independent physician appointed by the department. When the legislature drafted sub. (1) (g), it chose to use the general term "rebut." Because it did not specify the right to cross-examination, it appears the legislature left to the department's discretion whether to allow cross-examination in circumstances where it might provide relevant and probative evidence. Sub. (1) (d) governs experts that are presented by a party to establish a prima facie case, not experts appointed by the department to provide an impartial report. LIRC did not violate the plaintiff's due process rights when it declined to remand for cross-examination. Aurora Consolidated Health Care v. Labor and Industry Review Commission, 2012 WI 49, 340 Wis. 2d 367, 814 N.W.2d 824, 10-0208.

Prehearing discovery under Wisconsin's worker's compensation act. Towers. 68 MLR 597 (1985).

102.175 Apportionment of liability.

(1) If it is established at the hearing that 2 or more accidental injuries, for each of which a party to the proceedings is liable under this chapter, have each contributed to a physical or

[111] This section was created to provide that all parties have ample notice that loss of earning capacity is in issue so adequate time will be set aside for the hearing and that all parties will be prepared to proceed. In addition to the 60-day notice which the party raising the issue of loss of earning capacity must give, the responding party must give notice at least 45 days before the hearing date that it will also provide testimony or reports, including the names of its witnesses. There is authority to waive the notice requirement for good cause where neither party is prejudiced.

[112] This is required so the division and other parties know what is being claimed.

mental condition for which benefits would be otherwise due, liability for such benefits shall be apportioned according to the proof of the relative contribution to disability resulting from the injury.[113]

(2) If after a hearing or a prehearing conference the division determines that an injured employee is entitled to compensation but that there remains in dispute only the issue of which of 2 or more parties is liable for that compensation, the division may order one or more parties to pay compensation in an amount, time, and manner as determined by the division. If the division later determines that another party is liable for compensation, the division shall order that other party to reimburse any party that was ordered to pay compensation under this subsection.[114]

(3) (a) If it is established by the certified report of a physician, podiatrist, surgeon, psychologist, or chiropractor under s. 102.17 (1) (d) 1., a record of a hospital or sanitorium under s. 102.17 (1) (d) 2., or other competent evidence that an injured employee has incurred permanent disability, but that a percentage of that disability was caused by an accidental injury sustained in the course of employment with the employer against whom compensation is claimed and a percentage of that disability was caused by other factors, whether occurring before or after the time of the accidental injury, the employer shall be liable only for the percentage of permanent disability that was caused by the accidental injury. If, however, previous permanent disability is attributable to occupational exposure with the same employer, the employer is also liable for that previous permanent disability so established.[115]

(b) A physician, podiatrist, surgeon, psychologist, or chiropractor who prepares a certified report under s. 102.17 (1) (d) 1. relating to a claim for compensation for an accidental injury causing permanent disability that was sustained in the course of employment with the employer against whom compensation is claimed shall address in the report the issue of causation of the disability and shall include in the report an opinion as to the percentage of permanent disability that was caused by the accidental injury and the percentage of permanent disability that was caused by other factors, including occupational exposure with the same employer, whether occurring before or after the time of injury.

(c) Upon request of the department, the division, the employer, or the employer's worker's compensation insurer, an injured employee who claims compensation for an injury causing permanent disability shall disclose all previous findings of permanent disability or other impairments that are relevant to that injury.[116]

History: 1979 c. 278; 1993 a. 81; 2015 a. 55, 180.

102.18 Findings, orders and awards.

(1) (a) All parties shall be afforded opportunity for full, fair, public hearing after reasonable notice, but disposition of application may be made by compromise, stipulation, agreement, or default without hearing.[117]

(b) 1. Within 90 days after the final hearing and close of the record, the division shall make and file its findings upon the ultimate facts involved in the controversy, and its order, which shall state the division's determination as to the rights of the parties.[118] Pending the final determination of any controversy before it, the division, after

[113] This is to permit the division to make an apportionment of disability between two or more injuries according to proof of their relative contribution. Medical evidence on the exact percentage of contribution by each injury is not necessarily required.

[114] This authorizes the division to order interim payments in order to relieve the hardship for an injured employee where the only issue is which party is responsible for payment.

[115] 2015 Wis. Act 180, effective March 2, 2016, created this subsection to provide for the apportionment of permanent disabilities resulting from accidental injuries based on causation. A practitioner who prepares a report on permanent disability shall address the issue of causation of the permanent disability to include a determination of the percentage of permanent disability caused by the direct result of the work-related injury and the percentage attributable to other factors before and after the injury.

[116] An employee who claims a work-related injury shall upon request disclose all previous disabilities or physical impairment and the records needed to make an apportionment of permanent disability.

[117] This authorizes dismissal of application or award of benefits without requiring the expense and inconvenience of a formal hearing.

[118] The administrative law judge shall issue prompt orders and this clarifies that it should be done within 90 days of the close of the hearing record.

any hearing, may, in its discretion, make interlocutory findings, orders, and awards, which may be enforced in the same manner as final awards.

2. The division may include in any interlocutory or final award or order an order directing the employer or insurer to pay for any future treatment that may be necessary to cure and relieve the employee from the effects of the injury or to pay for a future course of instruction or other rehabilitation training services provided under a rehabilitation training program developed under s. 102.61 (1) or (1m).[119]

3. If the division finds that the employer or insurer has not paid any amount that the employer or insurer was directed to pay in any interlocutory order or award and that the nonpayment was not in good faith, the division may include in its final award a penalty not exceeding 25 percent of each amount that was not paid as directed.

4. When there is a finding that the employee is in fact suffering from an occupational disease caused by the employment of the employer against whom the application is filed, a final award dismissing the application upon the ground that the applicant has suffered no disability from the disease shall not bar any claim the employee may have for disability sustained after the date of the award.[120] [121] [122]

(bg) 1. If the division finds under par. (b) that an insurer or self-insured employer is liable under this chapter for any health services provided to an injured employee by a health service provider, but that the reasonableness of the fee charged by the health service provider is in dispute, the division may include in its order under par. (b) a determination made by the department under s. 102.16 (2) as to the reasonableness of the fee or, if such a determination has not yet been made, the division may notify, or direct the insurer or self-insured employer to notify, the health service provider under s. 102.16 (2) (b) that the reasonableness of the fee is in dispute.[123]

2. If the division finds under par. (b) that an employer or insurance carrier is liable under this chapter for any treatment provided to an injured employee by a health service provider, but that the necessity of the treatment is in dispute, the division may include in its order under par. (b) a determination made by the department under s. 102.16 (2m) as to the necessity of the treatment or, if such a determination has not yet been made, the division may notify, or direct the employer or insurance carrier to notify, the health service provider under s. 102.16 (2m) (b) that the necessity of the treatment is in dispute.[124]

3. If the division finds under par. (b) that an insurer or self-insured employer is liable under this chapter for the cost of a prescription drug dispensed under s. 102.425 (2) for outpatient use by an injured employee, but that the reasonableness of the amount charged for that prescription drug is in dispute, the division may include in its order under par. (b) a determination made by the department under s. 102.425 (4m) as to the reasonableness of the

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[119] Administrative law judges are now authorized to award payment for necessary medical treatment on a prospective basis. This section was amended by 2001 Wis. Act 37, effective January 1, 2002. 2015 Wis. Act 180, effective March 2, 2016, extends to administrative law judges the authority to award benefits for future courses of instruction or other rehabilitation training.

[120] This is procedural to avoid confusion. The administrative law judges, may, but are not required to, make findings of evidentiary facts. Findings necessary to support the ultimate facts may be implied from the credible evidence or reasonable inferences therefrom.

[121] This provision prevents the final closing of a claim for occupational disease in those cases in which no showing of disability can be made to the time of the administrative law judge's order but in which disability may develop at a date following such order. Sections 102.12 and 102.17 still apply however.

[122] This is intended to allow administrative law judges to reserve jurisdiction where the effect of injury may be uncertain or the medical evidence is considered inadequate.

[123] This clarifies the authority of the administrative law judges to determine reasonableness and necessity of treatment issues. This was created by 1997 Act 38, effective January 1, 1998.

[124] This clarifies the authority of the administrative law judges to determine reasonableness and necessity of treatment issues. This was created by 1997 Act 38, effective January 1, 1998. The department is not required but has the option of obtaining an expert opinion on the necessity of treatment before resolving a case by finding of fact order or by a compromise settlement. With the amendment by 2005 Wis. Act 172, effective April 1, 2006, administrative law judges are required to apply the treatment guidelines in deciding necessity of treatment disputes following hearings.

prescription drug charge or, if such a determination has not yet been made, the division may notify, or direct the insurer or self-insured employer to notify, the pharmacist or practitioner dispensing the prescription drug under s. 102.425 (4m) (b) that the reasonableness of the prescription drug charge is in dispute.[125]

(bp) If the division determines that the employer or insurance carrier suspended, terminated, or failed to make payments or failed to report an injury as a result of malice or bad faith, the division may include a penalty in an award to an employee for each event or occurrence of malice or bad faith. That penalty is the exclusive remedy against an employer or insurance carrier for malice or bad faith. If the penalty is imposed for an event or occurrence of malice or bad faith that causes a payment that is due an injured employee to be delayed in violation of s. 102.22 (1) or overdue in violation of s. 628.46 (1), the division may not also order an increased payment under s. 102.22 (1) or the payment of interest under s. 628.46 (1). The division may award an amount that the division considers just, not to exceed the lesser of 200 percent of total compensation due or $30,000 for each event or occurrence of malice or bad faith. The division may assess the penalty against the employer, the insurance carrier, or both. Neither the employer nor the insurance carrier is liable to reimburse the other for the penalty amount. The division may, by rule, define actions that demonstrate malice or bad faith.[126]

(bw) If an insurer, a self-insured employer, or, if applicable, the uninsured employers fund pays compensation to an employee in excess of its liability and another insurer or self-insured employer is liable for all or part of the excess payment, the department or the division may order the insurer or self-insured employer that is liable for that excess payment to reimburse the insurer or self-insured employer that made the excess payment or, if applicable, the uninsured employers fund.[127]

(c) If 2 or more examiners have conducted a formal hearing on a claim and are unable to agree on the order or award to be issued, the decision shall be the decision of the majority. If the examiners are equally divided on the decision, the division may appoint an additional examiner who shall review the record and consult with the other examiners concerning their impressions of the credibility of the evidence. Findings of fact and an order or award may then be issued by a majority of the examiners.[128]

(d) Any award which falls within a range of 5 percent of the highest or lowest estimate of permanent partial disability made by a practitioner which is in evidence is presumed to be a reasonable award, provided it is not higher than the highest or lower than the lowest estimate in evidence.[129]

(e) Except as provided in s. 102.21, if the department or the division orders a party to pay an award of compensation, the party shall pay the award no later than 21 days after the date on which the order is mailed to the last-known address of the party, unless the party files a petition for review under sub. (3). This paragraph applies to all awards of compensation ordered by the department or the division, whether the award results from a hearing, the default of a party, or a compromise or stipulation

[125] This amendment provides authority for administrative law judges to determine by finding of fact order after hearing or by compromise settlement whether prescription drug fees are reasonable in the same manner as authorized for reasonableness of fee and necessity of treatment disputes. 2007 Wis. Act 185, effective April 1, 2008.

[126] "Bad faith" actions for malicious failure to report injuries or pay compensation are made an administrative rather than a civil action remedy. The penalty is 200 percent of the benefits payable with a maximum of $30,000 for acts of bad faith on and after April 1, 2006. 2005 Wis. Act 172, effective April 1, 2006. Rule DWD 80.70 defines bad faith for purposes of worker's compensation.

[127] The department or division may order reimbursement from one employer or insurance carrier to another employer or insurance carrier if it finds the wrong party paid compensation.

[128] Section 102.18(1)(c) creates a tie-breaking procedure when administrative law judges are equally divided on a decision.

[129] Section 102.18(1)(d) gives administrative law judges the right to make an order within the range of the highest and lowest estimates of permanent disability within five percent of any estimate in evidence.

confirmed by the department or the division.[130]

(2) (a) The department shall have and maintain on its staff such examiners as are necessary to hear and decide claims for compensation described in s. 102.16 (1) (b) and to assist in the effective administration of this chapter.

(b) The division shall have and maintain on its staff such examiners as are necessary to decide claims for compensation described in s. 102.16 (1) (c) and to assist in the effective adjudication of claims under this chapter.

(c) Examiners under pars. (a) and (b) shall be attorneys and may be designated as administrative law judges. Those examiners may make findings and orders and may approve, review, set aside, modify, or confirm stipulations of settlement or compromises of claims for compensation.

(3) A party in interest may petition the commission for review of an examiner's decision awarding or denying compensation if the department, the division, or the commission receives the petition within 21 days after the department or the division mailed a copy of the examiner's findings and order to the last-known addresses of the parties in interest. The commission shall dismiss a petition that is not filed within those 21 days unless the petitioner shows that the petition was filed late for a reason that was beyond the petitioner's control.[131] If no petition is filed within those 21 days, the findings or order shall be considered final unless set aside, reversed, or modified by the examiner within that time. If the findings or order are set aside by the examiner, the status shall be the same as prior to the setting aside of the findings or order. If the findings or order are reversed or modified by the examiner, the time for filing a petition commences on the date on which notice of the reversal or modification is mailed to the last-known addresses of the parties in interest. The commission shall either affirm, reverse, set aside, or modify the findings or order, in whole or in part, or direct the taking of additional evidence. The commission's action shall be based on a review of the evidence submitted.[132]

(4) (a) Unless the liability under s. 102.35 (3), 102.43 (5), 102.49, 102.57, 102.58, 102.59, 102.60 or 102.61 is specifically mentioned, the order, findings or award are deemed not to affect such liability.

(b) Within 28 days after the date of a decision of the commission, the commission may, on its own motion, set aside the decision for further consideration.[133]

(c) On its own motion, for reasons it deems sufficient, the commission may set aside any final order or award of the commission or examiner within one year after the date of the order or award, upon grounds of mistake or newly discovered evidence, and, after further consideration, do any of the following:

1. Affirm, reverse or modify, in whole or in part, the order or award.

2. Reinstate the previous order or award.

3. Remand the case to the department or the division for further proceedings.

(d) While a petition for review by the commission is pending or after entry of an order or award by the commission but before commencement of an action for judicial review or expiration of the period in which to commence an action for judicial review, the commission shall remand any compromise presented to it to the department or the division for consideration and approval or rejection under s. 102.16 (1). Presentation of a compromise does not affect the period in which to commence an action for judicial review.

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[130] Section 102.18 (1)(e) creates a uniform 21 day payment standard for all orders awarding compensation, including awards resulting from hearings, defaults of parties and compromises and stipulations that are confirmed. 2003 Wis. Act 144, effective March 30, 2004, clarifies that where orders award benefits, the carrier or self-insured employer shall pay the undisputed amount within 21 days even if the employee files an appeal; and shall not wait to make payment until the appeal is resolved.

[131] The commission requested "petitioner" replace "petition" because, in practice, the commission allows petitioners to show probable good cause subsequent to filing the late petition. 1999 Wis. Act 14, effective January 1, 2000.

[132] In order that undue delay in decision may not result, simple and summary procedure under this provision becomes essential. This is especially true because the law provides for four appeals, one to the commission, one to the circuit court, one to the court of appeals, and one to the Supreme Court.

[133] The commission requested that the words "after the date" be inserted to clarify the time during which the commission may set aside an order for further consideration.

(5) If it appears to the division that a mistake may have been made as to cause of injury in the findings, order, or award upon an alleged injury based on accident, when in fact the employee was suffering from an occupational disease, within 3 years after the date of the findings, order, or award the division may, upon its own motion, with or without hearing, set aside the findings, order or award, or the division may take that action upon application made within those 3 years. After an opportunity for hearing, the division may, if in fact the employee is suffering from disease arising out of the employment, make new findings, and a new order or award, or the division may reinstate the previous findings, order, or award. [134]

(6) In case of disease arising out of employment, the division may from time to time review its findings, order, or award, and make new findings, or a new order or award, based on the facts regarding disability or otherwise as those facts may appear at the time of the review. This subsection shall not affect the application of the limitation in s. 102.17 (4).

History: 1971 c. 148; 1973 c. 150; 1975 c. 147; 1977 c. 29, 195; 1979 c. 89, 278, 355; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1987 a. 179; 1989 a. 64; 1997 a. 38; 1999 a. 14; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2007 a. 185; 2015 a. 55, 180.

Cross-reference: See also LIRC and s. HA 4.04, Wis. adm. code.

Committee Note, 1971: The intent is to authorize the commission within its absolute discretion to reopen final orders on the basis of mistake or newly discovered evidence within a period of one year from the date of such order where this is found to be just. It is intended that the commission have authority to grant or deny compensation, including the right to increase or to decrease benefits previously awarded. [Bill 371-A]

Interlocutory orders issued by the department in worker's compensation cases are not res judicata. Worsch v. DILHR, 46 Wis. 2d 504, 175 N.W.2d 201 (1970).

When the department reverses an examiner's findings and makes independent findings, the latter should be accompanied by a memorandum opinion indicating not only prior consultation with the examiner and review of the record, but a statement or statements of the reasons for reaching a different result or conclusion, particularly when the credibility of witnesses is involved. Transamerica Insurance Co. v. DILHR, 54 Wis. 2d 272, 195 N.W.2d 656 (1972). See also Mervosh v. LIRC, 2010 WI App 36, 324 Wis. 2d 134, 781 N.W.2d 236, 09-0271.

The department could properly find no permanent disability in the case of a successful fusion of vertebrae and still retain jurisdiction to determine future disability when doctors testified that there might be future effects. Vernon County v. DILHR, 60 Wis. 2d 736, 211 N.W.2d 441 (1973).

In a case involving conflicting testimony in which the department reverses an examiner's findings, fundamental fairness requires a separate statement by the department explaining why it reached its decision, as well as specifically setting forth in the record its consultation with the examiner with respect to impressions or conclusions in regard to the credibility of witnesses. Simonton v. DILHR, 62 Wis. 2d 112, 214 N.W.2d 302 (1974).

Sub. (5) is inapplicable if at the original hearing the examiner considered the possibility of both accidental injury and injury caused by occupational disease and denied the applicant benefits. Murphy v. DILHR, 63 Wis. 2d 248, 217 N.W.2d 370 (1974).

An award will be affirmed if it is supported by any credible evidence. When there are inconsistencies or conflicts in medical testimony, it is for the department and not the courts to reconcile inconsistencies. Theodore Fleisner, Inc. v. DILHR, 65 Wis. 2d 317, 222 N.W.2d 600 (1974).

The authority granted under sub. (3) to modify the findings of a hearing examiner does not extend to the making of findings and an order on an alternative basis of liability neither tried by the parties nor ruled on by the examiner. When another basis of liability is applicable, the examiner's findings must be set aside and an order directing the taking of additional testimony entered, directing the examiner to make new findings as to the substituted basis. Joseph Schlitz Brewing Co. v. DILHR, 67 Wis. 2d 185, 226 N.W.2d 492 (1975).

The dismissal of an application that was neither based upon a stipulation or compromise nor entered after a hearing was void. The original application was valid though made many years earlier. Kohler Co. v. DILHR, 81 Wis. 2d 11, 259 N.W.2d 695 (1977).

The department is not required to make specific findings as to a defense to a worker's claim, but it is better practice to either make findings or state why none were made. Universal Foundry Co. v. DILHR, 82 Wis. 2d 479, 263 N.W.2d 172 (1978).

Commission guidelines, formulated as internal standards of credibility in worker's compensation cases, are irrelevant to a court's review of the commission's findings. E. F. Brewer Co. v. DILHR, 82 Wis. 2d 634, 264 N.W.2d 222 (1978).

A general finding by the department implies all facts necessary to support it. A finding not explicitly made may be inferred from other properly made findings and from findings that were not made if there is evidence that would support those findings. Valadzic v. Briggs & Stratton Corp. 92 Wis. 2d 583, 286 N.W.2d 540 (1979).

Sub. (1) (bp) is constitutional. Messner v. Briggs & Stratton Corp. 120 Wis. 2d 127, 353 N.W.2d 363 (Ct. App. 1984).

[134] If the division finds that a mistake has been made as to the cause of injury, mistakenly determined to be on the basis of accident when in fact an employee was suffering from an occupational disease, the division may with or without hearing within three years from the date of the erroneous findings set aside the order. Likewise, the division may take such action upon application made within such three years.

An employer was penalized for denying a claim that was not "fairly debatable" under sub. (1) (bp). Kimberly-Clark Corp. v. LIRC, 138 Wis. 2d 58, 405 N.W.2d 684 (Ct. App. 1987).

Sub. (4) (c) grants the review commission exclusive authority to set aside findings due to newly discovered evidence. The trial court does not possess that authority. Hopp v. LIRC, 146 Wis. 2d 172, 430 N.W.2d 359 (Ct. App. 1988).

To show bad faith under sub. (1) (bp) a claimant must show that the employer acted without a reasonable basis for the delay and with knowledge or a reckless disregard of the lack of reasonable basis for the delay. North American Mechanical v. LIRC, 157 Wis. 2d 801, 460 N.W.2d 835 (Ct. App. 1990).

After the commission makes a final order and the review period has passed, the commission's decision is final for all purposes. Kwaterski v. LIRC, 158 Wis. 2d 112, 462 N.W.2d 534 (Ct. App. 1990).

Sub. (3) does not authorize LIRC to take administrative notice of any fact; review is limited to the record before the hearing examiner. Amsoil, Inc. v. LIRC, 173 Wis. 2d 154, 496 N.W.2d 150 (Ct. App. 1992).

The commission may not reject a medical opinion absent something in the record to support the rejection; countervailing expert testimony is not required in all cases. Leist v. LIRC, 183 Wis. 2d 450, 515 N.W.2d 268 (Ct. App. 1994).

Issuance of a default order under sub. (1) (a) is discretionary. Rules of civil procedure do not apply to administrative proceedings. Nothing in the law suggests a default order must be issued in the absence of excusable neglect. Verhaagh v. LIRC, 204 Wis. 2d 154, 554 N.W.2d 678 (Ct. App. 1996), 96-0470.

The commission may not rule on and consider issues on appeal that were not litigated and may not consider evidence not considered by the administrative law judge unless the parties are allowed to offer rebuttal evidence. Wright v. LIRC, 210 Wis. 2d 289, 565 N.W.2d 221 (Ct. App. 1997), 96-1024.

LIRC's authority under s. 102.17 (1) (a) to control its calendar and manage its internal affairs necessarily implies the power to deny an applicant's motion to withdraw an application for hearing. An appellant's failure to appear at a hearing after a motion to withdraw the application was denied was grounds for entry of a default judgment under sub. (1) (a). Baldwin v. LIRC, 228 Wis. 2d 601, 599 N.W.2d 8 (Ct. App. 1999), 98-3090.

LIRC's application of sub. (1) (bp) was entitled to great weight deference. Beverly Enterprises v. LIRC, 2002 WI App 23, 250 Wis. 2d 246, 640 N.W.2d 518, 01-0970.

Under s. 102.23 (1) (a), judicial review is available only from an order or award granting or denying compensation. Judicial review by common law certiorari was not available for a claim that LIRC failed to act within the statutory time limitations under sub. (4), which would be subject to judicial review of any subsequent order or award granting or denying compensation in that case. Vidal v. LIRC, 2002 WI 72, 253 Wis. 2d 426, 645 N.W.2d 870, 00-3548.

To demonstrate bad faith under sub. (1) (bp), a claimant must show the absence of a reasonable basis for denying benefits and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. Brown v. LIRC, 2003 WI 142, 267 Wis. 2d 31, 671 N.W.2d 279, 02-1429.

Because sub. (1) (bp) specifically allows for the imposition of bad faith penalties on an employer for failure to pay benefits, and because s. 102.23 (5) specifically directs the employer to pay benefits pending an appeal when the only issue is who will pay benefits, an employer may be subject to bad faith penalties under sub. (bp), independent from its insurer, when it fails to pay benefits in accordance with s. 102.23 (5). Bosco v. LIRC, 2004 WI 77, 272 Wis. 2d 586, 681 N.W.2d 157, 03-0662.

Sub. (1) (d) does not prohibit determinations in excess of the highest medical assessment in evidence, but rather creates a presumption of reasonableness for awards that fall within the prescribed range. The statute does not state that an award outside of the prescribed range is unreasonable and does not prohibit DWD from setting minimum loss of use percentages by administrative rule. Daimler Chrysler v. LIRC, 2007 WI 15, 299 Wis. 2d 1, 727 N.W.2d 311, 05-0544.

Sub. (1) (bp) does not govern the conduct of the department or its agent and does not impose any penalty on the department or its agent for bad faith conduct in administering the uninsured employers fund. Sub. (1) (bp) constitutes the exclusive remedy for the bad faith conduct of an employer or an insurance carrier. Because sub. (1) (bp) does not apply to the department's agent, it does not provide an exclusive remedy for the agent's bad faith. Moreover, s. 102.81 (1) (a) exempts the department and its agent from paying an employee the statutory penalties and interest imposed on an employer or an insurance carrier for their misdeeds, but nothing in s. 102.81 (1) (a) exempts the department or its agent from liability for its bad faith conduct in processing claims. Aslakson v. Gallagher Bassett Services, Inc. 2007 WI 39, 300 Wis. 2d 92, 729 N.W.2d 712, 04-2588.

Because the parties explicitly stated the only claim against the employer was for accidental injury, the employer could not "know the charges or claims" against it included an occupational disease claim. It never had an opportunity to be heard on "the probative force of the evidence adduced by both sides" as applied to the occupational disease claim, or on the law applicable to the occupational disease claim, either during the hearing or in its brief to the commission. As such, the employer was denied both due process and a "fair hearing" under sub. (1) (a). Waste Management Incorporated v. LIRC, 2008 WI App 50, 308 Wis. 2d 763, 747 N.W.2d 782, 07-2405.

Once a permanent partial disability award is made, the worker's compensation statutes provide only limited provision for reopening. The statutes do not provide for the reopening of a final award two years after it is rendered in the event the employer rehires the employee. Schreiber Foods, Inc. v. LIRC, 2009 WI App 40, 316 Wis. 2d 516, 765 N.W.2d 850, 08-1977.

Case law appears to define an order "awarding or denying compensation" in sub. (3) synonymously with an order reaching the merits of the applicant's claim. Although the administrative decisions in this case contemplated the possibility of future action by the claimant, the dismissal was not procedural or rooted in standing doctrines like

ripeness but based on a finding that the claimant presented insufficient evidence to substantiate it and did reach the merits. LaBeree v. Wausau Insurance Companies, 2010 WI App 148, 330 Wis. 2d 101, 793 N.W.2d 77, 09-1628.

The automatic-stay provisions of the federal bankruptcy code froze an employer's obligation to pay claims, including worker's compensation, that were not due at the time of the employer's bankruptcy filing. Accordingly, obligations that became due after filing were not in default and no late-payment penalty could be assessed under sub. (1) (bp). Grede Foundries, Inc. v. Labor and Industry Review Commission, 2012 WI App 86, 343 Wis. 2d 517, 819 N.W.2d 850, 11-2636.

102.19 Alien dependents; payments through consular officers. In case a deceased employee, for whose injury or death compensation is payable, leaves surviving alien dependents residing outside of the United States, the duly accredited consular officer of the country of which such dependents are citizens or such officer's designated representative residing within the state shall, except as otherwise determined by the department, be the sole representative of the deceased employee and dependents in all matters pertaining to their claims for compensation. The receipt by such officer or agent of compensation funds and the distribution thereof shall be made only upon order of the department, and payment to such officer or agent pursuant to any such order shall be a full discharge of the benefits or compensation. Such consular officer or such officer's representative shall furnish, if required by the department, a bond to be approved by it, conditioned upon the proper application of all moneys received by such person. Before such bond is discharged, such consular officer or representative shall file with the department a verified account of the items of his or her receipts and disbursements of such compensation. Such consular officer or representative shall make interim reports to the department as it may require.

History: 1977 c. 29.

102.195 Employees confined in institutions; payment of benefits. In case an employee is adjudged mentally ill or incompetent or convicted of a felony, and is confined in a public institution and has wholly dependent upon the employee for support a person whose dependency is determined as if the employee were deceased, compensation payable during the period of the employee's confinement may be paid to the employee and the employee's dependents in such manner, for such time, and in such amount as the department or division by order provides.

History: 1993 a. 492; 2015 a. 55.

102.20 Judgment on award. If any party presents a certified copy of the award to the circuit court for any county, the court shall, without notice, render judgment in accordance with the award. A judgment rendered under this section shall have the same effect as though rendered in an action tried and determined by the court, and shall, with like effect, be entered in the judgment and lien docket.

History: 1995 a. 224; 2001 a. 37.

"Award" under this section means an award that has become final under s. 102.18 (3). Warren v. Link Farms, Inc. 123 Wis. 2d 485, 368 N.W.2d 688 (Ct. App. 1985).

102.21 Payment of awards by local governmental units. When an award is made under this chapter or s. 66.191, 1981 stats., against any local governmental unit, the person in whose favor the award is made shall file a certified copy of the award with the clerk of the local governmental unit. Unless an appeal is taken, within 20 days after that filing, the clerk shall draw an order on the treasurer of the local governmental unit for the payment of the award. If upon appeal the award is affirmed in whole or in part, the clerk shall draw an order for payment of the award within 10 days after a certified copy of the judgment affirming the award is filed with that clerk. If the award or judgment provides for more than one payment, the clerk shall draw orders for payment as the payments become due. No statute relating to the filing of claims against, or the auditing, allowing, and payment of claims by, a local governmental unit applies to the payment of an award or judgment under this section.

History: 1983 a. 191 s. 6; 2015 a. 55, 180.

102.22 Penalty for delayed payments; interest.

(1) If the employer or his or her insurer inexcusably delays in making the first payment that is due an injured employee for more than 30 days after the date on which the employee leaves work as a result of an injury and if the amount

due is $500 or more, the payments as to which the delay is found shall be increased by 10 percent.[135] If the employer or his or her insurer inexcusably delays in making the first payment that is due an injured employee for more than 14 days after the date on which the employee leaves work as a result of an injury, the payments as to which the delay is found may be increased by 10 percent. If the employer or his or her insurer inexcusably delays for any length of time in making any other payment that is due an injured employee, the payments as to which the delay is found may be increased by 10 percent. If the delay is chargeable to the employer and not to the insurer, s. 102.62 applies and the relative liability of the parties shall be fixed and discharged as provided in that section. The department or the division may also order the employer or insurance carrier to reimburse the employee for any finance charges, collection charges, or interest that the employee paid as a result of the inexcusable delay by the employer or insurance carrier.[136] [137]

(2) If any sum that the department or the division orders to be paid is not paid when due, that sum shall bear interest at the rate of 10 percent per year. The state is liable for interest on awards issued against it under this chapter. The department or the division has jurisdiction to issue an award for payment of interest under this subsection at any time within one year after the date of its order or, if the order is appealed, within one year after final court determination. Interest awarded under this subsection becomes due from the date the examiner's order becomes final or from the date of a decision by the commission, whichever is later.

(3) If upon petition for review the commission affirms an examiner's order, interest at the rate of 7 percent per year on the amount ordered by the examiner shall be due for the period beginning on the 21st day after the date of the examiner's order and ending on the date paid under the commission's decision.[138] If upon petition for judicial review under s. 102.23 the court affirms the commission's decision, interest at the rate of 7 percent per year on the amount ordered by the examiner shall be due up to the date of the commission's decision, and thereafter interest shall be computed under sub. (2).

History: 1977 c. 195; 1979 c. 110 s. 60 (13); 1979 c. 278; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1993 a. 81; 2015 a. 55.

The department can assess the penalty for inexcusable delay in making payments prior to the entry of an order. The question of inexcusable delay is one of law and the courts are not bound by the department's finding as to it. Milwaukee County v. DILHR, 48 Wis. 2d 392, 180 N.W.2d 513 (1970).

The penalty under sub. (1) does not bar an action for bad faith for failure to pay a claim. Coleman v. American Universal Insurance Co. 86 Wis. 2d 615, 273 N.W.2d 220 (1979).

LIRC's application of sub. (1) was entitled to great weight deference. Beverly Enterprises v. LIRC, 2002 WI App 23, 250 Wis. 2d 246, 640 N.W.2d 518, 01-0970.

102.23 Judicial review.

(1) (a) 1. The findings of fact made by the commission acting within its powers shall, in the absence of fraud, be conclusive. The order or award granting or denying compensation, either interlocutory or final, whether judgment has been rendered on the order or award or not, is subject to review only as provided in this section and not under ch. 227 or s. 801.02. The commission shall identify in the order or award the persons that must be made parties to an action for review of the order or award.[139]

2. Within 30 days after the date of an order or award made by the commission, any party aggrieved by the order or award may commence an action in circuit court for review of the order

[135] The statute was amended to reflect the department's practices in enforcing this section.

[136] This gives the department and the division authority to order the employer or insurance carrier to reimburse the employee for finance charges, collection charges or interest which the employee paid as the result of inexcusable delay. This affects medical expenses only.

[137] Withholding amounts unquestionably due because the injured employee refuses to execute a release of his or her right to claim further benefits or for other reasons will be regarded as inexcusable delay in the making of compensation payments.

[138] Interest is due at the rate of 7 percent commencing 21 days after an administrative law judge's award until the date of a commission decision or date of payment on any part of the award which is affirmed.

[139] 2015 Wis. Act 180, effective March 2, 2016, provides that the party who files an appeal of a commission decision to the circuit court shall be named as the plaintiff and shall name as defendants the commission and those persons or entities identified by the commission in its decision as necessary to be named as a party for the appeal to court.

or award by serving a complaint as provided in par. (b) and filing the summons and complaint with the clerk of the circuit court. The summons and complaint shall name the party commencing the action as the plaintiff and shall name as defendants the commission and all persons identified by the commission under subd. 1. If the circuit court determines that any other person is necessary for the proper resolution of the action, the circuit court may join that person as a party to the action, unless joinder of the person would unduly delay the resolution of the action. If the circuit court is satisfied that a party in interest has been prejudiced because of an exceptional delay in the receipt of a copy of any finding or order, the circuit court may extend the time within which an action may be commenced by an additional 30 days.

3. The proceedings shall be in the circuit court of the county where the plaintiff resides, except that if the plaintiff is a state agency, the proceedings shall be in the circuit court of the county where the defendant resides. The proceedings may be brought in any circuit court if all parties stipulate and that court agrees.[140]

(b) In such an action a complaint shall be served with an authenticated copy of the summons. The complaint need not be verified, but shall state the grounds upon which a review is sought. Service upon a commissioner or agent authorized by the commission to accept service constitutes complete service on all parties, but there shall be left with the person so served as many copies of the summons and complaint as there are defendants, and the commission shall mail one copy to each other defendant.

(c) The commission shall serve its answer to the complaint within 20 days after the service of the complaint. Except as provided in par. (cm), any other defendant may serve an answer to the complaint within 20 days after the service of the complaint, which answer may, by way of counterclaim or cross complaint, ask for the review of the order or award referred to in the complaint, with the same effect as if the defendant had commenced a separate action for the review of the order or award.

(cm) If a defendant in an action brought under par. (a) is an insurance company, the insurance company may serve an answer to the complaint within 45 days after the service of the complaint.[141]

(d) The commission shall make return to the court of all documents and papers on file in the matter, all testimony that has been taken, and the commission's order, findings, and award. Such return of the commission when filed in the office of the clerk of the circuit court shall, with the papers specified in s. 809.15, constitute a judgment roll in the action; and it shall not be necessary to have a transcript approved. The action may thereupon be brought on for hearing before the court upon the record by any party on 10 days' notice to the other; subject, however, to the provisions of law for a change of the place of trial or the calling in of another judge.

(e) Upon such hearing, the court may confirm or set aside such order or award; and any judgment which may theretofore have been rendered thereon; but the same shall be set aside only upon the following grounds:

1. That the commission acted without or in excess of its powers.

2. That the order or award was procured by fraud.

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[140] The procedure for commencing an appeal of a commission decision is made the same as for commencing other circuit court actions.

[141] The time for serving the answer is decreased from 45 to 20 days except the time for serving the answer by insurance carriers remains 45 days. 2005 Wis. Act 442, effective November 1, 2006.

3. That the findings of fact by the commission do not support the order or award.[142] [143]

(2) Upon the trial of an action for review of an order or award the court shall disregard any irregularity or error of the commission, the department, or the division unless it is made to affirmatively appear that the plaintiff was damaged by that irregularity or error.

(3) The record in any case shall be transmitted to the department or the division within 5 days after expiration of the time for appeal from the order or judgment of the court, unless an appeal is taken from that order or judgment.

(4) Whenever an award is made against the state the attorney general may bring an action for review thereof in the same manner and upon the same grounds as are provided by sub. (1).

(5) When an action for review involves only the question of liability as between the employer and one or more insurance companies or as between several insurance companies, a party that has been ordered by the department, the division, the commission, or a court to pay compensation is not relieved from paying compensation as ordered.

(6) If the commission's order or award depends on any fact found by the commission, the court shall not substitute its judgment for that of the commission as to the weight or credibility of the evidence on any finding of fact. The court may, however, set aside the commission's order or award and remand the case to the commission if the commission's order or award depends on any material and controverted finding of fact that is not supported by credible and substantial evidence.

History: 1973 c. 150; 1975 c. 199; Sup. Ct. Order, 73 Wis. 2d xxxi (1976); 1977 c. 29; 1977 c. 187 ss. 59, 135; 1977 c. 195, 272, 447; Sup. Ct. Order, 83 Wis. 2d xiii (1978); 1979 c. 278; 1981 c. 390 s. 252; 1983 a. 98, 122, 538; 1985 a. 83; 1997 a. 187; 2001 a. 37; 2005 a. 172, 442; 2015 a. 55, 180.

Judicial Council Committee's Note, 1976: The procedure for initiating a petition for judicial review under ch. 102 is governed by the provisions of s. 102.23 rather than the provisions for initiating a civil action under s. 801.02. [Re Order effective Jan. 1, 1977]

The fact that a party appealing from a DILHR order as to unemployment compensation labeled his petition "under 227.15" [now 227.52], is immaterial since the circuit court had subject matter jurisdiction. An answer by the department that s. 227.15 [now 227.52] gave no jurisdiction amounted to an appearance, and the department could not later claim that the court had no personal jurisdiction because the appellant had not served a summons and complaint. Lees v. DILHR, 49 Wis. 2d 491, 182 N.W.2d 245 (1971).

A finding of fact, whether ultimate or evidentiary, is still in its essential nature a fact, whereas a conclusion of law accepts those facts, and by judicial reasoning results from the application of rules or concepts of law to those facts whether undisputed or not. Kress Packing Co. v. Kottwitz, 61 Wis. 2d 175, 212 N.W.2d 97 (1973).

A challenge to the constitutionality of sub. (1) was not sustained since it is manifest from the statute that the legislature intended to have the department be the real party in interest and not a mere nominal party. Hunter v. DILHR, 64 Wis. 2d 97, 218 N.W.2d 314 (1974).

When the claimant timely appealed an adverse worker's compensation decision in good faith, but erroneously captioned the appeal, the trial court abused its discretion by dismissing the action. Cruz v. DILHR, 81 Wis. 2d 442, 260 N.W.2d 692 (1978).

An employer whose unemployment compensation account is not affected by the commission's determination has no standing to seek judicial review. Cornwell Personnel Associates v. DILHR, 92 Wis. 2d 53, 284 N.W.2d 706 (Ct. App. 1979).

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[142] Comment by legislative committee of 1911: The finding of the board, in the absence of fraud, is made absolutely conclusive by this section. The award is reviewable only on three grounds: (1) That the board acted without or in excess of its power; (2) that the award was procured by fraud; (3) that the findings of fact by the board do not support the award. This review does not allow any retrial of the case as presented to the board. The facts found by the board are conclusive, and the review that is allowed in those cases where the findings of fact do not support the award, would occur only where the board had not given proper consideration to the act itself. In other words, the court will review only questions of law included in grounds 1 and 3 upon which an award may be reviewed. The fraud alluded to in the second ground will be only such as was perpetrated in procuring the award, and will not include false testimony of any party, because all such questions will be decided conclusively by the board. Buehler Bros. v. Industrial Comm., 220 Wis. 371 (1936). The object of having the action to review brought against the board is twofold: (1) If any error is made it will be an error made by the board. Consequently, the board should defend its own action, and this will be done at the expense of the state; (2) To relieve the party in whose favor the award was made of the expense of litigation in the circuit and supreme courts, the commission defends it own orders.

[143] A party must petition the commission for review of findings and order of an administrative law judge before appealing to the circuit court. Appeal to the court is always from an order of the commission.

An agency's mixed conclusions of law and findings of fact may be analyzed by using 2 methods: 1) the analytical method of separating law from fact; or 2) the practical or policy method that avoids law and fact labels and searches for a rational basis for the agency's decision. United Way of Greater Milwaukee v. DILHR, 105 Wis. 2d 447, 313 N.W.2d 858 (Ct. App. 1981).

A failure to properly serve the commission pursuant to sub. (1) (b) results in a jurisdictional defect rather than a mere technical error. Gomez v. Labor and Industry Review Commission, 153 Wis. 2d 686, 451 N.W.2d 475 (Ct. App. 1989).

Discretionary reversal is not applicable to judicial review of LIRC orders under ch. 102. There is no power to reopen a matter that has been fully determined under ch. 102. Kwaterski v. Labor and Industry Review Commission, 158 Wis. 2d 112, 462 N.W.2d 534 (Ct. App. 1990).

A LIRC decision is to be upheld unless it directly contravenes the words of the statute, is clearly contrary to legislative intent, or is otherwise without a rational basis. Wisconsin Electric Power Co. v. Labor and Industry Review Commission, 226 Wis. 2d 778, 595 N.W.2d 23 (1999), 97-2747.

An appeal under s. 102.16 (2m) (e) of a department determination may be served under sub. (1) (b) on the department or the commission. McDonough v. Department of Workforce Development, 227 Wis. 2d 271, 595 N.W.2d 686 (1999), 97-3711.

Under sub. (1) (a), judicial review is available only from an order or award granting or denying compensation. Judicial review by common law certiorari was not available for a claim that LIRC failed to act within the statutory time limitations under s. 102.18 (4), which would be subject to judicial review of any subsequent order or award granting or denying compensation in that case. Vidal v. Labor and Industry Review Commission, 2002 WI 72, 253 Wis. 2d 426, 645 N.W.2d 870, 00-3548.

The plaintiff complied with the requirement of sub. (1) that every adverse party be made a defendant by naming the defendant's insurer in the caption of the summons and complaint, which were timely filed and served even though the insurer was not mentioned in the complaint's body. Selaiden v. Columbia Hospital, 2002 WI App 99, 253 Wis. 2d 553, 644 N.W.2d 690, 01-2046.

Sub. (5) requires an employer to make payment to a disabled employee pending appeal of a date of injury defense in an occupational disease case when the employer's liability is not disputed on appeal and the only question is who will pay benefits. Bosco v. Labor and Industry Review Commission, 2004 WI 77, 272 Wis. 2d 586, 681 N.W.2d 157, 03-0662.

Because s. 102.18 (1) (bp) specifically allows for the imposition of bad faith penalties on an employer for failure to pay benefits and because sub. (5) specifically directs the employer to pay benefits pending an appeal when the only issue is who will pay benefits, an employer may be subject to bad faith penalties under s. 102.18 (1) (bp), independent from its insurer, when it fails to pay benefits in accordance with sub. (5). Bosco v. Labor and Industry Review Commission, 2004 WI 77, 272 Wis. 2d 586, 681 N.W.2d 157, 03-0662.

Under *Miller* an "adverse party" for worker's compensation actions in circuit court includes any party bound by the Commission's order or award granting or denying compensation to the claimant. The interests of an adverse party need not necessarily be adverse to the party filing a circuit court action. Xcel Energy Services, Inc. v. LIRC, 2012 WI App 19, 339 Wis. 2d 413, 810 N.W.2d 865, 11-0203.

Default judgment is unavailable to plaintiffs under this section when the employer has timely answered. Ellis v. Department of Administration, 2011 WI App 67, 333 Wis. 2d 228, 800 N.W.2d 6, 10-1374.

Failure to name an adverse party as a defendant under sub. (1) (a) deprives the circuit court of competency and requires dismissal of the complaint. "Adverse party" includes every party whose interest in relation to the judgment or decree appealed from is in conflict with the modification or reversal sought by the action for judicial review. Xcel Energy Services, Inc. v. Labor and Industry Review Commission, 2013 WI 64, 349 Wis. 2d 234, 833 N.W.2d 665, 11-0203.

The only reasonable reading of sub. (1) (c)'s plain language is that a stipulation is only required from active parties. To require the Department of Workforce Development to obtain stipulations to venue from parties who have not responded to the action and have not expressed any interest in participating is unreasonable and does not further the purpose of preventing inconvenience or hardship to parties involved in the action. The stipulation of the parties is not required prior to the filing of the action. Department of Workforce Development v. Labor and Industry Review Commission, 2015 WI App 56, 364 Wis. 2d 514, 869 N.W.2d 163, 14-2221.

The venue provision of sub. (1) (a) is central to the statutory scheme, and as such, failure to comply with its mandates deprived the circuit court of the competency to hear the cases. DWD v. LIRC, 2016 WI App 21, ___ Wis. 2d ___, ___ N.W.2d ___, 14-2928.

Judicial review of workmen's compensation cases. Haferman, 1973 WLR 576.

102.24 Remanding record.

(1) Upon the setting aside of any order or award, the court may recommit the controversy and remand the record in the case to the commission for further hearing or proceedings, or it may enter the proper judgment upon the findings of the commission, as the nature of the case shall demand. An abstract of the judgment entered by the trial court upon the review of any order or award shall be made by the clerk of circuit court upon the judgment and lien docket entry of any judgment which may have been rendered upon the order or award. Transcripts of the abstract may be obtained for like entry upon the judgment and lien dockets of the courts of other counties.

(2) After the commencement of an action to review any order or award of the commission, the parties may have the record remanded by the court for such time and under such condition as the parties may provide, for the purpose of having the department or the division act upon the question of approving or disapproving any settlement or compromise that the parties may desire to have so approved. If approved, the action shall be at an end and judgment may be entered upon the approval as upon an award. If not approved, the department or the division shall immediately return the record to the circuit court and the action shall proceed as if no remand had been made.

History: 1975 c. 147; 1977 c. 29; 1979 c. 278; 1995 a. 224; 2015 a. 55.

102.25 Appeal from judgment on award.

(1) Any party aggrieved by a judgment entered upon the review of any order or award may appeal the judgment within the period specified in s. 808.04 (1). A trial court may not require the commission or any party to the action to execute, serve, or file an undertaking under s. 808.07 or to serve, or secure approval of, a transcript of the notes of the stenographic reporter or the tape of the recording machine. The state is a party aggrieved under this subsection if a judgment is entered upon the review confirming any order or award against the state. At any time before the case is set down for hearing in the court of appeals or the supreme court, the parties may have the record remanded by the court to the department or the division in the same manner and for the same purposes as provided for remanding from the circuit court to the department or the division under s. 102.24 (2).

(2) It shall be the duty of the clerk of any court rendering a decision affecting an award of the commission to promptly furnish the commission with a copy of such decision without charge.

History: 1971 c. 148; Sup. Ct. Order, 67 Wis. 2d 585, 774 (1975); 1977 c. 29, 187, 195, 418; 1979 c. 278; 1983 a. 219; 2015 a. 55.

Judicial Council Note, 1983: Sub. (1) is amended to replace the appeal deadline of 30 days after service of notice of entry of judgment or award by the standard time specified in s. 808.04 (1), stats., for greater uniformity. The subsection is further amended to eliminate the superfluous provisions for calendaring and hearing the appeal. [Bill 151-S]

A court order setting aside an administrative order and remanding the case to the administrative agency disposed of the entire matter in litigation and was appealable as of right. Bearns v. DILHR, 102 Wis. 2d 70, 306 N.W.2d 22 (1981).

102.26 Fees and costs.

(1) No fees may be charged by the clerk of any circuit court for the performance of any service required by this chapter, except for the entry of judgments and certified transcripts of judgments. In proceedings to review an order or award, costs as between the parties shall be in the discretion of the court, but no costs may be taxed against the commission.

(2) Unless previously authorized by the department or the division, no fee may be charged or received for the enforcement or collection of any claim for compensation nor may any contract for that enforcement or collection be enforceable when that fee, inclusive of all taxable attorney fees paid or agreed to be paid for that enforcement or collection, exceeds 20 percent of the amount at which the claim is compromised or of the amount awarded, adjudged, or collected, except that in cases of admitted liability in which there is no dispute as to the amount of compensation due and in which no hearing or appeal is necessary, the fee charged may not exceed 10 percent, but not to exceed $250, of the amount at which the claim is compromised or of the amount awarded, adjudged, or collected.[144] The limitation as to fees shall apply to the combined charges of attorneys, solicitors, representatives, and adjusters who knowingly combine their efforts toward the enforcement or collection of any compensation claim.

(3) (a) Except as provided in par. (b), compensation exceeding $100 in favor of any claimant shall be made payable to and delivered directly to the claimant in person.[145]

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[144] 2007 Wis. Act 185, effective April 1, 2008, increases the maximum amount of attorney fees from $100 to $250 in cases of admitted liability where there is no dispute as to the compensation due.

[145] All compensation payments are to be made directly to the employee unless, by request of a party, the department or division has set the fee of an attorney or agent and provided for direct payment of the fee.

(b) 1. Subject to sub. (2), upon application of any interested party, the department or the division may fix the fee of the claimant's attorney or representative and provide in the award for that fee to be paid directly to the attorney or representative.

2. At the request of the claimant medical expense, witness fees and other charges associated with the claim may be ordered paid out of the amount awarded.

3. The claimant may request the insurer or self-insured employer to pay any compensation that is due the claimant by depositing the payment directly into an account maintained by the claimant at a financial institution. If the insurer or self-insured employer agrees to the request, the insurer or self-insured employer may deposit the payment by direct deposit, electronic funds transfer, or any other money transfer technique approved by the department or the division. The claimant may revoke a request under this subdivision at any time by providing appropriate written notice to the insurer or self-insured employer.[146]

(c) Payment according to the directions of the award shall protect the employer and the employer's insurer, or the uninsured employers fund if applicable, from any claim of attorney's lien.

(4) Any attorney or other person who charges or receives any fee in violation of this section may be required to forfeit double the amount retained by the attorney or other person, which forfeiture shall be collected by the state in an action in debt upon complaint of the department or the division. Out of the sum recovered the court shall direct payment to the injured party of the amount of the overcharge.

History: 1971 c. 148; 1975 c. 147 s. 54; 1975 c. 199; 1977 c. 29; 1979 c. 278; 1985 a. 83; 1989 a. 64; 1993 a. 490, 492; 1995 a. 224; 1999 a. 9; 2001 a. 37; 2007 a. 185; 2015 a. 55.

Cross-reference: See also s. DWD 80.43, Wis. adm. code.

The only fee authorized to be paid to any clerk of court under sub. (1) is the fee under s. 814.61 (5), when applicable. 76 Atty. Gen. 148.

102.27 Claims and awards protected; exceptions.

(1) Except as provided in sub. (2), no claim for compensation shall be assignable, but this provision shall not affect the survival thereof; nor shall any claim for compensation, or compensation awarded, or paid, be taken for the debts of the party entitled thereto.

(2) (a) A benefit under this chapter is assignable under s. 46.10 (14) (e), 49.345 (14) (e), 301.12 (14) (e), 767.225 (1) (L), 767.513 (3), or 767.75 (1) or (2m).[147]

(b) If a governmental unit provides public assistance under ch. 49 to pay medical costs or living expenses related to a claim under this chapter and if the governmental unit has given the parties to the claim written notice stating that the governmental unit provided the assistance and the cost of that assistance, the department or the division shall order the employer or insurance carrier owing compensation to reimburse that governmental unit for the amount of assistance the governmental unit provided or two-thirds of the amount of the award or payment remaining after deduction of attorney fees and any other fees or costs chargeable under ch. 102, whichever is less. The department shall comply with this paragraph when making payments under s. 102.81.[148]

History: 1981 c. 20, 391; 1983 a. 27, 192; 1985 a. 83; 1989 a. 64; 1993 a. 481; 1997 a. 191, 237; 1999 a. 9; 2005 a. 443 s. 265; 2007 a. 20; 2015 a. 55.

102.28 Preference of claims; worker's compensation insurance.

(1) PREFERENCE. The whole claim for compensation for the injury or death of any

[146] The department and the division can authorize insureds and self-insureds to pay compensation directly into employees' accounts at financial institutions by direct deposit or electronic fund transfers if requested by employees. This section was created by 2001 Wis. Act 37, effective January 1, 2002.

[147] Effective July 31, 1981, benefits can be assigned for support. Upon receipt of executed copies of order from the circuit court or family court commissioner and the assignment by the employee, the employer or carrier shall make payments to the court as ordered.

[148] Effective July 2, 1983, government units can also be reimbursed for public assistance benefits paid to worker's compensation claimants.

employee or any award or judgment thereon, and any claim for unpaid compensation insurance premiums are entitled to preference in bankruptcy or insolvency proceedings as is given creditors' actions except as denied or limited by any law of this state or by the federal bankruptcy act, but this section shall not impair the lien of any judgment entered upon any award.

(2) REQUIRED INSURANCE; EXCEPTIONS.

(a) *Duty to insure payment for compensation.* Unless exempted under par. (b) or (bm) or sub. (3), every employer, as described in s. 102.04 (1),[149] shall insure payment for compensation under this chapter in an insurer authorized to do business in this state. A joint venture may elect to be an employer under this chapter and obtain insurance for payment of compensation.[150] If a joint venture that is subject to this chapter only because the joint venture elected to be an employer under this chapter is dissolved and cancels or terminates its contract for the insurance of compensation under this chapter, that joint venture is deemed to have effected withdrawal, which shall be effective on the day after the contract is canceled or terminated.[151]

(b) *Exemption from duty to insure; employers generally.* The department may grant a written order of exemption to an employer who shows its financial ability to pay the amount of compensation, agrees to report faithfully all compensable injuries and agrees to comply with this chapter and the rules of the department. The department may condition the granting of an exemption upon the employer's furnishing of satisfactory security to guarantee payment of all claims under compensation. The department may require that bonds or other personal guarantees be enforceable against sureties in the same manner as an award may be enforced. The department may from time to time require proof of financial ability of the employer to pay compensation. Any exemption shall be void if the application for it contains a financial statement which is false in any material respect. An employer who files an application containing a false financial statement remains subject to par. (a).[152] The department may promulgate rules establishing an amount to be charged to an initial applicant for exemption under this paragraph and an annual amount to be charged to employers that have been exempted under this paragraph.[153]

(bm) *Exemption from duty to insure; governmental employers.* [154]

1. Subject to subds. 2. to 4., if the state or a local governmental unit that has independent taxing authority is not partially insured or fully insured for its liability for the payment of compensation under this chapter, or to the extent that the state or a local governmental unit that has independent taxing authority is not partially insured for that liability under one or more contracts issued with the consent of the department under s. 102.31 (1) (b), and if the state or local governmental unit agrees to report faithfully all compensable injuries and to comply with this chapter and all rules of the department, the state or local governmental unit may elect to self-insure that liability without further order of the department.

2. Notwithstanding the absence of an order of exemption from the duty to insure under par. (a),

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[149] The language which was deleted "which is liable to pay compensation under this chapter" had been interpreted to mean that an employer was not required to insure for payment of compensation until after an event occurred. The purpose of this amendment was to state clearly that when an employer attains the status of an employer as defined by s. 102.04, that employer must then insure the liability for compensation and not delay obtaining such insurance until after a compensable injury.

[150] A joint venture may elect to be insured by itself. Under previous court decisions it could not be insured and the coverage was only through the individual policies issued to each party to the joint venture.

[151] This simplified the withdrawal procedure for joint ventures when they are dissolved.

[152] An employer who has fraudulently obtained exemption from insuring liability under the worker's compensation act is in the same position as an employer who fails to carry worker's compensation insurance without securing exemption. The effect is to take away all the exemptions of such an employer in case of an injury to an employee and to render him or her liable to the penalties provided for failure to insure.

[153] The department has the authority to adopt administrative rules establishing fees from applicants for self-insurance or for the renewal of self-insurance and use those funds in the administration of the self-insurance program.

[154] 2015 Wis. Act 180, effective March 2, 2016, codified the process for political subdivisions of the state to become self-insured for purposes of worker's compensation and clarified the Self-Insurers Council is not involved with the self-insured status of political subdivisions.

the state or a local governmental unit that elects to self-insure as provided in subd. 1. is exempt from that duty. Notwithstanding that exemption, if the state or a local governmental unit that elects to self-insure as provided in subd. 1. desires partial insurance or divided insurance, the state or local governmental unit shall obtain the consent of the department under s. 102.31 (1) (b) to the issuance of a contract providing such insurance.

3. a. A local governmental unit that elects to self-insure its liability for the payment of compensation under this chapter shall notify the department of that election in writing before commencing to self-insure that liability and shall notify the department of its intent to continue to self-insure that liability every 3 years after that initial notice. A local government unit that wishes to withdraw that election shall notify the department of that withdrawal not less than 30 days before the effective date of that withdrawal.

b. A notice under subd. 3. a. shall be accompanied by a resolution adopted by the governing body of the local governmental unit and signed by the elected or appointed chief executive of the local governmental unit stating that the governing body intends and agrees to self-insure the liability of the local governmental unit for the payment of compensation under this chapter and that the local government unit agrees to report faithfully all compensable injuries and to comply with this chapter and all rules of the department.

4. An election to self-insure under subd. 1. is subject to revocation under par. (c) 2. Once such an election is revoked, the employer whose election is revoked may not elect to self-insure its liability for the payment of compensation under this chapter unless at least 3 calendar years have elapsed since the revocation and the department finds that the employer's financial condition is adequate to pay its employees' claims for compensation, that the employer has not received an excessive number of claims for compensation, and that the employer has faithfully discharged its obligations under this chapter and the rules of the department.

(c) *Revocation of exemption or election.*

1. The department, after seeking the advice of the self-insurers council, may revoke an exemption granted to an employer under par. (b), upon giving the employer 10 days' written notice, if the department finds that the employer's financial condition is inadequate to pay its employees' claims for compensation, that the employer has received an excessive number of claims for compensation, or that the employer has failed to discharge faithfully its obligations according to the agreement contained in the application for exemption.

2. The department may revoke an election made by an employer under par. (bm), upon giving the employer 10 days' written notice, if the department finds that the employer's financial condition is inadequate to pay its employees' claims for compensation, that the employer has received an excessive number of claims for compensation, or that the employer has failed to discharge faithfully its obligations under this chapter and the rules of the department.

3. Within 10 days after receipt of a notice of revocation under subd. 1. or 2., the employer may request in writing a review of the revocation by the secretary or the secretary's designee and the secretary or the secretary's designee shall review the revocation within 30 days after receipt of the request for review. If the employer is aggrieved by the determination of the secretary or the secretary's designee, the employer may, within 10 days after receipt of notice of that determination, request a hearing under s. 102.17. If the secretary or the secretary's designee determines that the employer's exemption or election should be revoked, the employer shall obtain insurance coverage as required under par. (a) immediately upon receipt of notice of that determination and, notwithstanding the pendency of proceedings under ss. 102.17 to 102.25, shall keep that coverage in force until another exemption under par. (b) is granted or another election under par. (bm) is made.

(d) *Effect of insuring with unauthorized insurer.* If an employer that is exempted under par. (b) or (bm) from the duty to insure under par. (a) enters into any agreement for excess insurance coverage with an insurer not authorized to do business in this state, the employer shall report that agreement to the department immediately. The placing of such coverage shall not by itself be grounds for revocation of the exemption.

(e) *Rules*. The department shall promulgate rules to implement this subsection.

(3) PROVISION OF ALTERNATIVE BENEFITS.[155]

(a) An employer may file with the department an application for exemption from the duty to pay compensation under this chapter with respect to any employee who signs the waiver described in subd. 1. and the affidavit described in subd. 2. if an authorized representative of the religious sect to which the employee belongs signs the affidavit specified in subd. 3. and the agreement described in subd. 4. An application for exemption under this paragraph shall include all of the following:

1. A written waiver by the employee or, if the employee is a minor, by the employee and his or her parent or guardian of all compensation under this chapter other than the alternative benefits provided under par. (c).

2. An affidavit by the employee or, if the employee is a minor, by the employee and his or her parent or guardian stating that the employee is a member of a recognized religious sect and that, as a result of the employee's adherence to the established tenets or teachings of the religious sect, the employee is conscientiously opposed to accepting the benefits of any public or private insurance that makes payments in the event of death, disability, old age or retirement, or that makes payments toward the cost of or provides medical care, including any benefits provided under the federal social security act, 42 USC 301 to 1397f.

3. An affidavit by an authorized representative of the religious sect to which the employee belongs stating that the religious sect has a long-standing history of providing its members who become dependent on the support of the religious sect as a result of work-related injuries, and the dependents of those members, with a standard of living and medical treatment that are reasonable when compared to the general standard of living and medical treatment for members of the religious sect.

4. An agreement signed by an authorized representative of the religious sect to which the employee belongs to provide the financial and medical assistance described in subd. 3. to the employee and to the employee's dependents if the employee sustains an injury which, but for the waiver under subd. 1., the employer would be liable for under s. 102.03.

(b) The department shall approve an application under par. (a) if the department determines that all of the following conditions are satisfied:

1. The employee has waived all compensation under this chapter other than the alternative benefits provided under par. (c).

2. The employee is a member of a religious sect whose established tenets or teachings oppose accepting the benefits of insurance as described in par. (a) 2. and that, as a result of adherence to those tenets or teachings, the employee conscientiously opposes accepting those benefits.

3. The religious sect to which the employee belongs has a long-established history of providing its members who become dependent on the religious sect as a result of work-related injuries, and the dependents of those members, with a standard of living and medical treatment that are reasonable when compared to the general standard of living and medical treatment for members of the religious sect. In determining whether the religious sect has a long-standing history of providing the financial and medical assistance described in this subdivision, the department shall presume that a 25-year history of providing that financial and medical assistance is long-standing for purposes of this subdivision.

4. The religious sect to which the employee belongs has agreed to provide the financial and medical assistance described in subd. 3. to the employee and to the dependents of the employee if the employee sustains an injury that, but for the waiver under par. (a) 1., the employer would be liable for under s. 102.03.

(c) An employee who has signed a waiver under par. (a) 1. and an affidavit under par. (a) 2., who sustains an injury that, but for that waiver, the employer would be liable for under s. 102.03,

[155] This section exempts employers from the duty to insure employees whose religion is opposed to accepting the benefits of any public or private insurance payments for death, disability, old age, retirement or medical bills (including federal social security benefits) if: (1) the worker requests it; and (2) the religious sect agrees to pay benefits at a reasonable standard of living and medical treatment when compared to the general standards for members of the sect. The sect is no longer required to prove financial ability.

who at the time of the injury was a member of a religious sect whose authorized representative has filed an affidavit under par. (a) 3. and an agreement under par. (a) 4., and who as a result of the injury becomes dependent on the religious sect for financial and medical assistance, or the employee's dependent, may request a hearing under s. 102.17 (1) to determine if the religious sect has provided the employee and his or her dependents with a standard of living and medical treatment that are reasonable when compared to the general standard of living and medical treatment for members of the religious sect. If, after hearing, the division determines that the religious sect has not provided that standard of living or medical treatment, or both, the division may order the religious sect to provide alternative benefits to that employee or his or her dependent, or both, in an amount that is reasonable under the circumstances, but not in excess of the benefits that the employee or dependent could have received under this chapter but for the waiver under par. (a) 1.

(d) The department shall provide a form for the application for exemption of an employer under par. (a) (intro.), the waiver and affidavit of an employee under par. (a) 1. and 2., the affidavit of a religious sect under par. (a) 3. and the agreement of a religious sect under par. (a) 4. A properly completed form is prima facie evidence of satisfaction of the conditions under par. (b) as to the matter contained in the form.

(4) CLOSURE ORDER.

(a) When the department discovers an uninsured employer, the department may order the employer to cease operations until the employer complies with sub. (2).

(b) If the department believes that an employer may be an uninsured employer, the department shall notify the employer of the alleged violation of sub. (2) and the possibility of closure under this subsection. The employer may request and shall receive a hearing under s. 102.17 on the matter if the employer applies for a hearing within 10 days after the notice of the alleged violation is served.

(c) After a hearing under par. (b), or without a hearing if one is not requested, the division may issue an order to an employer to cease operations on a finding that the employer is an uninsured employer. If no hearing is requested, the department may issue such an order.

(d) The department of justice may bring an action in any court of competent jurisdiction for an injunction or other remedy to enforce an order to cease operations under par. (c).

(5) EMPLOYER'S LIABILITY. If compensation is awarded under this chapter, against any employer who at the time of the accident has not complied with sub. (2), such employer shall not be entitled as to such award or any judgment entered thereon, to any of the exemptions of property from seizure and sale on execution allowed in ss. 815.18 to 815.21. If such employer is a corporation, the officers and directors thereof shall be individually and jointly and severally liable for any portion of any such judgment as is returned unsatisfied after execution against the corporation.

(6) REPORTS BY EMPLOYER. Every employer shall upon request of the department report to it the number of employees and the nature of their work and also the name of the insurance company with whom the employer has insured liability under this chapter and the number and date of expiration of such policy. Failure to furnish such report within 10 days from the making of a request by certified mail shall constitute presumptive evidence that the delinquent employer is violating sub. (2).

(7) INSOLVENT EMPLOYERS; ASSESSMENTS.

(a) If an employer who is currently or was formerly exempted by written order of the department under sub. (2) (b) is unable to pay an award, judgment is rendered in accordance with s. 102.20 against that employer, and execution is levied and returned unsatisfied in whole or in part, payments for the employer's liability shall be made from the fund established under sub. (8). If a currently or formerly exempted employer files for bankruptcy and not less than 60 days after that filing the department has reason to believe that compensation payments due are not being paid, the department in its discretion may make payment for the employer's liability from the fund established under sub. (8). The secretary of administration shall proceed to recover those payments from the employer or the employer's receiver or trustee in bankruptcy, and may commence an action or proceeding or file a claim for those payments. The attorney

general shall appear on behalf of the secretary of administration in any such action or proceeding. All moneys recovered in any such action or proceeding shall be paid into the fund established under sub. (8).[156]

(b) 1. Each employer exempted by written order of the department under sub. (2) (b) shall pay into the fund established by sub. (8) an initial assessment based on orders of the department as provided in subd. 2. An order of the department requiring exempt employers to pay into that fund shall provide for an amount that is sufficient to secure estimated payments of an insolvent exempt employer due for the period up to the date of the order and for one year following the date of the order and to pay the estimated cost of insurance carrier or insurance service organization services under par. (c). Payments ordered to be made to the fund shall be paid to the department within 30 days after the date of the order. If additional moneys are required, further assessments shall be made based on orders of the department as provided under subd. 2.

2. An initial or further assessment under subd. 1. shall be prorated on the basis of the gross payroll for this state of the exempt employer as reported to the department for the previous calendar year for unemployment insurance purposes under ch. 108 or, if an exempt employer is not covered under ch. 108, on the basis of the comparable gross payroll for the exempt employer as determined by the department. If payment of any assessment made under subd. 1. is not made within 30 days after the date of the order of the department, the attorney general may appear on behalf of the state to collect the assessment.[157]

(bm) The department may not do any of the following:[158]

1. Require an employer that elects under sub. (2) (bm) to self-insure its liability for the payment of compensation under this chapter to pay into the fund established under sub. (8).

2. Make any payments from the fund established under sub. (8) for the liability under this chapter of an employer that elects under sub. (2) (bm) to self-insure its liability for the payment of compensation under this chapter, whether currently or formerly exempt from the duty to insure under sub. (2) (a).

(c) The department may retain an insurance carrier or insurance service organization to process, investigate and pay valid claims. The charge for such service shall be paid from the fund as provided under par. (b).

(d) The department shall promulgate rules to implement this subsection.

(8) SELF-INSURED EMPLOYERS LIABILITY FUND. The moneys paid into the state treasury under sub. (7), together with all accrued interest, shall constitute a separate nonlapsible fund designated as the self-insured employers liability fund. Moneys in the fund may be expended only as provided in s. 20.445 (1) (s) and may not be used for an other purpose of the state.[159]

History: 1973 c. 150; Sup. Ct. Order, 67 Wis. 2d 585, 774 (1975); 1975 c. 147 ss. 23, 54; 1975 c. 199; 1977 c. 195; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1987 a. 179; 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 1997 a. 38, 39; 2003 a. 33; 2005 a. 172; 2015 a. 55, 180.

Cross-reference: See also ss. DWD 80.40 and 80.60, Wis. adm. code.

The "insure payment" requirement of sub. (2) (a) requires an employer to provide coverage for every employee in all possible employment situations. Substantial compliance with sub. (2) (a) is not sufficient. This provision does not violate due process. State v. Koch, 195 Wis. 2d 801, 537 N.W.2d 39 (Ct. App. 1995), 94-1230.

102.29 Third party liability.

(1) (a) The making of a claim for compensation against an employer or compensation insurer for the injury or death of an employee shall not affect the right of the employee, the employee's personal representative, or other person entitled to bring action to make claim or maintain an action in tort against any other party for such

[156] This provides for commencement of payments from the Self-Insured Employers Liability Fund 60 days after a self-insured employer files for bankruptcy.

[157] Section 102.28(7) shall apply to employers who are exempt on or after December 30, 1975, for injuries occurring after December 30, 1975. 2015 Wis. Act 180, effective March 2, 2016, provides that all assessments under this subsection will be made against private sector self-insured employers on a pro rata basis according to payroll.

[158] 2015 Wis. Act 180, effective March 2, 2016, created this paragraph to provide that political subdivisions will not be assessed by and are not entitled to receive any payments from the Self-Insured Employers Liability Fund.

[159] The Self-Insured Employers Liability Fund is made nonlapsible with this amendment and the money in the fund may only be used for statutory purposes and no other state purposes. 2005 Wis. Act 172, effective April 1, 2006.

injury or death, hereinafter referred to as a 3rd party; nor shall the making of a claim by any such person against a 3rd party for damages by reason of an injury to which ss. 102.03 to 102.66 are applicable, or the adjustment of any such claim, affect the right of the injured employee or the employee's dependents to recover compensation.[160] An employer or compensation insurer that has paid or is obligated to pay a lawful claim under this chapter shall have the same right to make claim or maintain an action in tort against any other party for such injury or death. If the department pays or is obligated to pay a claim under s. 102.66 (1)[161] or 102.81 (1), the department shall also have the right to maintain an action in tort against any other party for the employee's injury or death. However, each shall give to the other reasonable notice and opportunity to join in the making of such claim or the instituting of an action and to be represented by counsel.

(b) If a party entitled to notice cannot be found, the department shall become the agent of that party for the giving of a notice as required in par. (a) and the notice, when given to the department, shall include an affidavit setting forth the facts, including the steps taken to locate that party. Each party shall have an equal voice in the prosecution of the claim, and any disputes arising shall be passed upon by the court before whom the case is pending, and if no action is pending, then by a court of record or by the department or the division. If notice is given as provided in par. (a), the liability of the tort-feasor shall be determined as to all parties having a right to make claim and, irrespective of whether or not all parties join in prosecuting the claim, the proceeds of the claim shall be divided as follows:

1. After deducting the reasonable cost of collection, one-third of the remainder shall in any event be paid to the injured employee or the employee's personal representative or other person entitled to bring action.

2. Out of the balance remaining after the deduction and payment specified in subd. 1., the employer, the insurance carrier, or, if applicable, the uninsured employers fund or the work injury supplemental benefit fund shall be reimbursed for all payments made by the employer, insurance carrier, or department, or which the employer, insurance carrier, or department may be obligated to make in the future, under this chapter, except that the employer, insurance carrier, or department shall not be reimbursed for any payments made or to be made under s. 102.18 (1) (b) 3. or (bp), 102.22, 102.35 (3), 102.57, or 102.60.[162]

3. Any balance remaining after the reimbursement described in subd. 2. shall be paid to the employee or the employee's personal representative or other person entitled to bring action.

(c) If both the employee or the employee's personal representative or other person entitled to bring action, and the employer, compensation insurer, or department, join in the pressing of said claim and are represented by counsel, the attorney fees allowed as a part of the costs of collection shall be, unless otherwise agreed upon, divided between the attorneys for those parties as directed by the court or by the department or the division.

(d) A settlement of a 3rd-party claim shall be void unless the settlement and the distribution of the proceeds of the settlement are approved by the court before whom the action is pending or, if no action is pending, then by a court of record or by the department or the division.

(2) In the case of liability of the employer or insurer to make payment into the state treasury under s. 102.49 or 102.59, if the injury or death

[160] Acceptance of compensation does not operate as an assignment of claim against a third party, nor does settlement with a third party operate as a waiver of claim for compensation.

[161] The Work Injury Supplemental Benefit Fund will be authorized to share in the distribution of proceeds from third party settlements. 2011 Wis. Act 183, effective April 17, 2012.

[162] This provides that the employer or worker's compensation insurance carrier shall not be reimbursed out of third party settlements for payments of increased compensation made or to be made under the provisions of ss. 102.18(1)(b)3 or (bp), 102.22, 102.35(3), 102.57 or 102.60. These respectively are penalties for bad faith; for delayed payments; for unreasonable refusal to rehire; increased compensation for violation of a safety order or double or treble compensation paid because of employment of a minor without required permit or at prohibited employment.

was due to the actionable act, neglect or default of a 3rd party, the employer or insurer shall have a right of action against the 3rd party to recover the sum so paid into the state treasury, which right may be enforced either by joining in the action mentioned in sub. (1), or by independent action. Contributory negligence of the employee because of whose injury or death such payment was made shall bar recovery if such negligence was greater than the negligence of the person against whom recovery is sought, and the recovery allowed the employer or insurer shall be diminished in proportion to the amount of negligence attributable to such injured or deceased employee. Any action brought under this subsection may, upon order of the court, be consolidated and tried together with any action brought under sub. (1).

(3) Nothing in this chapter shall prevent an employee from taking the compensation that the employee may be entitled to under this chapter and also maintaining a civil action against any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist for malpractice.[163] [164]

(4) If the employer and the 3rd party are insured by the same insurer, or by the insurers who are under common control, the employer's insurer shall promptly notify the parties in interest and the department. If the employer has assumed the liability of the 3rd party, it shall give similar notice, in default of which any settlement with an injured employee or beneficiary is void. This subsection does not prevent the employer or compensation insurer from sharing in the proceeds of any 3rd-party claim or action, as set forth in sub. (1).

(5) An insurer subject to sub. (4) which fails to comply with the notice provision of that subsection and which fails to commence a 3rd-party action, within the 3 years allowed by s. 893.54, may not plead that s. 893.54 is a bar in any action commenced by the injured employee under this section against any such 3rd party subsequent to 3 years from the date of injury, but prior to 6 years from such date of injury. Any recovery in such an action is limited to the insured liability of the 3rd party. In any such action commenced by the injured employee subsequent to the 3-year period, the insurer of the employer shall forfeit all right to participate in such action as a complainant and to recover any payments made under this chapter.[165]

(6) (a) In this subsection, "temporary help agency" means a temporary help agency that is primarily engaged in the business of placing its employees with or leasing its employees to another employer as provided in s. 102.01 (2) (f).

(b) No employee of a temporary help agency who has the right to make a claim for compensation may make a claim or maintain an action in tort against any of the following:[166]

1. Any employer that compensates the temporary help agency for the employee's services.

2. Any other temporary help agency that is compensated by that employer for another employee's services.

3. Any employee of that compensating employer or of that other temporary help agency, unless

[163] The sentence in this section which was deleted prevented the employer or insurance carrier from sharing in the distribution of proceeds obtained by an employee when that employee was successful in a malpractice action against any physician, chiropractor or podiatrist for improper treatment of a compensable injury. The court of appeals in a published decision held that this provision was unconstitutional. Therefore, the statute was amended to comply with this ruling. Subsequently, the Supreme Court reversed the court of appeals and found the prior statute constitutional. Racine Steel Castings v. Hardy, 139 Wis.2d 232 (Ct. of App. 1987); 144 Wis.2d 553 (1988). This amendment was effected by Chapter 179, Laws of 1987, effective April 1, 1988.

[164] 2003 Wis. Act 144, effective March 30, 2004, adds physician assistants and advance practice nurse prescribers as practitioners employees may maintain actions against for malpractice.

[165] The purpose of the provision is to give incentive to the common insurance carrier of the employer and third party to act in the interests of the employee in proceeding against the third party. There is not the same keen interest for the insurer to proceed where it is a common carrier as there is in the case where different carriers are involved. The penalty for failure to take prompt action is against the carrier that fails to initiate necessary steps to bring third party action. The carrier has already lost its right to proceed except as notice of injury has been served or action commenced within the three-year period. It, therefore, loses nothing under this provision but also fails to gain that which is gained by the employee who, under this provision, will be permitted to commence his or her action after the three-year period.

[166] Employees of a temporary help agency may not make a claim for negligence against the employer with whom they are placed.

the employee who has the right to make a claim for compensation would have a right under s. 102.03 (2) to bring an action against the employee of the compensating employer or the employee of the other temporary help agency if the employees were coemployees.

(c) No employee of an employer that compensates a temporary help agency for another employee's services who has the right to make a claim for compensation may make a claim or maintain an action in tort against any of the following:

1. The temporary help agency.

2. Any employee of the temporary help agency, unless the employee who has the right to make a claim for compensation would have a right under s. 102.03 (2) to bring an action against the employee of the temporary help agency if the employees were coemployees.

(6m) (a) No leased employee, as defined in s. 102.315 (1) (g), who has the right to make a claim for compensation may make a claim or maintain an action in tort against any of the following:

1. The client, as defined in s. 102.315 (1) (b), that accepted the services of the leased employee.

2. Any other employee leasing company, as defined in s. 102.315 (1) (f), that provides the services of another leased employee to the client.

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

(b) No employee of a client who has the right to make a claim for compensation may make a claim or maintain an action in tort against any of the following:

1. An employee leasing company that provides the services of a leased employee to the client.

2. Any leased employee of the employee leasing company, unless the employee who has the right to make a claim for compensation would have a right under s. 102.03 (2) to bring an action against the leased employee if the employee and the leased employee were coemployees.[167]

(7) No employee who is loaned by his or her employer to another employer and who has the right to make a claim for compensation under this chapter may make a claim or maintain an action in tort against the employer who accepted the loaned employee's services.[168]

(8) No student of a public school, a private school, or an institution of higher education who is named under s. 102.077 as an employee of the school district, private school, or institution of higher education for purposes of this chapter and who has the right to make a claim for compensation under this chapter may make a claim or maintain an action in tort against the employer that provided the work training or work experience from which the claim arose.

(8m) No participant in a community service job under s. 49.147 (4) or a transitional placement under s. 49.147 (5) who, under s. 49.147 (4) (c) or (5) (c), is provided worker's compensation coverage by a Wisconsin works agency, as defined under s. 49.001 (9), and who has the right to make a claim for compensation under this chapter may make a claim or maintain an action in tort against the employer who provided the community service job or transitional placement from which the claim arose.

(8r) No participant in a food stamp employment and training program under s. 49.79 (9) who, under s. 49.79 (9) (a) 5., is provided worker's compensation coverage by the department of health services or by a Wisconsin Works agency, as defined in s. 49.001 (9), or other provider under contract with the department of health services or a county department under s. 46.215, 46.22, or 46.23 or tribal governing body to administer the food stamp employment and training program and who has the right to make a claim for compensation under this chapter may make a claim or maintain an action in tort

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[167] The amendments to s. 102.29(6) and (6m), Stats., extend the exclusive remedy to cover more than one temporary help agency, employee leasing company or professional employer organization and all the employees that they provide to a client employer. 2007 Wis. Act 185, effective April 1, 2008.

[168] The employer accepting a loaned employee's service has the same protection against negligence claims as the original employer.

against the employer who provided the employment and training from which the claim arose.

(9) No participant in a work experience component of a job opportunities and basic skills program who, under s. 49.193 (6) (a), 1997 stats., was considered to be an employee of the agency administering that program, or who, under s. 49.193 (6) (a), 1997 stats., was provided worker's compensation coverage by the person administering the work experience component, and who makes a claim for compensation under this chapter may make a claim or maintain an action in tort against the employer who provided the work experience from which the claim arose. This subsection does not apply to injuries occurring after February 28, 1998.

(10) A practitioner who, under s. 257.03, is considered an employee of the state for purposes of worker's compensation coverage while providing services on behalf of a health care facility, the department of health services, or a local health department during a state of emergency and who has the right to make a claim for compensation under this chapter may not make a claim or maintain an action in tort against the health care facility, department, or local health department that accepted those services.

(11) No security officer employed by the department of military affairs who is deputed under s. 59.26 (4m), who remains an employee of the state for purposes of worker's compensation coverage while conducting routine external security checks around military installations in this state, and who has the right to make a claim for compensation under this chapter may make a claim or bring an action in tort against the county in which the security officer is conducting routine external security checks or against the sheriff or undersheriff who deputed the security officer.

(12) No individual who is an employee of an entity described in s. 102.07 (20) for purposes of this chapter and who has the right to make a claim for compensation under this chapter may make a claim or maintain an action in tort against the person described in s. 102.07 (20) who received the services from which the claim arose.[169]

History: 1975 c. 147 ss. 24, 54; 1977 c. 195; 1979 c. 323 s. 33; 1981 c. 92; 1985 a. 83 s. 44; 1985 a. 332 s. 253; 1987 a. 179; 1989 a. 64; 1995 a. 117, 289; 1997 a. 38; 1999 a. 9, 14; 2001 a. 16, 37; 2003 a. 144; 2005 a. 96, 172, 253; 2007 a. 20 ss. 2645, 9121 (6) (a); 2007 a. 97, 185; 2009 a. 42, 154; 2011 a. 183; s. 2013 a. 165 s. 114; 2015 a. 55, 180; 2017 a. 139.

Note: See cases annotated under 102.03 as to the right to bring a 3rd-party action against a coemployee.

In a 3rd-party action under s. 102.29, safe place liability under s. 101.11 cannot be imposed on officers or employees of the employer. Their liability must be based on common law negligence. Pitrowski v. Taylor, 55 Wis. 2d 615, 201 N.W.2d 52 (1972).

Members of a partnership are employers of the employees of the partnership. An employee cannot bring a 3rd-party action against a member of the employing partnership. Candler v. Hardware Dealers Mutual Insurance Co. 57 Wis. 2d 85, 203 N.W.2d 659 (1973).

Liability of a corporate officer in a 3rd-party action must derive from acts done in the capacity of coemployee, not as a corporate officer and supervisor. Kruse v. Schieve, 61 Wis. 2d 421, 213 N.W.2d 65 (1973).

Sub. (1) provides attorney fees are to be allowed as "costs of collection" and, unless otherwise agreed upon, are to be divided between the attorneys for both the employee and the compensation carrier pursuant to court direction. Diedrick v. Hartford Accident & Indemnity Co. 62 Wis. 2d 759, 216 N.W.2d 193 (1974).

The words "action commenced by the injured employee" in sub. (5) also encompass the bringing of wrongful death and survival actions. Ortman v. Jensen & Johnson, Inc. 66 Wis. 2d 508, 225 N.W.2d 635 (1975).

The 6-year limitation on 3rd-party actions for wrongful death provided in sub. (5) does not deny 3rd-party defendants equal protection although other wrongful death defendants are subject to the s. 893.205 (2) 3-year limitation. Ortman v. Jenson & Johnson, Inc. 66 Wis. 2d 508, 225 N.W.2d 635 (1975).

The extra-hazardous activity exception did not apply to an employee of a general contractor who was injured while doing routine work in a nuclear power plant. Snider v. Northern States Power Co. 81 Wis. 2d 224, 260 N.W.2d 260 (1975).

A "business pursuit" exclusion in a defendant coemployee's homeowner's policy did not offend public policy. Bertler v. Employers Insurance of Wausau, 86 Wis. 2d 13, 271 N.W.2d 603 (1978).

That sub. (2) denies 3rd-party tort-feasors the right to a contribution action against a negligent employer who was

[169] Employees of fiscal agents covered by worker's compensation insurance under s. 102.07 (20) who provide long term care services to elderly and disabled people will be prohibited from bringing an action in tort against the elderly or disabled persons who received the long term care services. 2015 Wis. Act 180, effective March 2, 2016. See also footnote 44.

substantially more at fault does not render the statute unconstitutional. Mulder v. Acme-Cleveland Corp. 95 Wis. 2d 173, 290 N.W.2d 276 (1980).

The right to share in a jury award was not dependent on participation in the prosecution of the underlying action. Guyette v. West Bend Mutual Insurance Co. 102 Wis. 2d 496, 307 N.W.2d 311 (Ct. App. 1981).

The provision by an employer of alleged negligent medical care to an employee injured on the job by persons employed for that purpose did not subject the employer to tort liability for malpractice. Jenkins v. Sabourin, 104 Wis. 2d 309, 311 N.W.2d 600 (1981).

An award for loss of consortium is not subject to the distribution formula under sub. (1). DeMeulenaere v. Transport Insurance Co. 116 Wis. 2d 322, 342 N.W.2d 56 (Ct. App. 1983).

The trial court exceeded its authority under sub. (1) by applying an alternative allocation formula without the consent of all the parties. An award for pain and suffering is subject to allocation under sub. (1), but an award to a spouse for loss of consortium prior to the employee's death is not. Kottka v. PPG Industries, Inc. 130 Wis. 2d 499, 388 N.W.2d 160 (1986).

The distribution scheme under sub. (1) renders common-law subrogation principles inapplicable. Martinez v. Ashland Oil, Inc. 132 Wis. 2d 11, 390 N.W.2d 72 (Ct. App. 1986).

When there are competing claims for insufficient insurance proceeds and one claim is subject to sub. (1) allocation, while the other is not, the formula set forth in this case is to be followed. Brewer v. Auto-Owners Ins. Co. 142 Wis. 2d 864, 418 N.W.2d 841 (Ct. App. 1987). The "dual persona" doctrine is adopted, replacing the "dual capacity" doctrine. A 3rd-party may recover from an employer only when the employer has operated in a distinct persona as to the employee. Henning v. General Motors Assembly, 143 Wis. 2d 1, 419 N.W.2d 551 (1988).

Unless he or she is affirmatively negligent with respect to the claimant, a person who employs an independent contractor may not be held vicariously liable to the independent contractor's employees. Wagner v. Continental Casualty Co. 143 Wis. 2d 379, 421 N.W.2d 835 (1988).

The legal distinction between a corporation/employer and a partnership/landlord that leased the factory to the corporation, although both entities were composed of the same individuals, eliminated the partners' immunity as individuals under the exclusivity doctrine for negligence in maintaining the leased premises. Couillard v. Van Ess, 152 Wis. 2d 62, 447 N.W.2d 391 (Ct. App. 1989).

In structured settlement situations, the "remainder" under sub. (1) from which an employee must receive the first one-third is the remainder of the front payment after deduction of collection costs. Skirowski v. Employers Mutual Casualty Co. 158 Wis. 2d 242, 462 N.W.2d 245 (Ct. App. 1990).

Sub. (6) does not require a temporary employer to control or have the right to control the details of the work being performed. The temporary employer need only control the work activities of the temporary employee; it need not have exclusive control over the employee's work. Gansch v. Nekoosa Papers, Inc., 158 Wis. 2d 743, 463 N.W.2d 682 (1990).

An employee's cause of action created by a 3rd-party's negligence does not relate back to the initial work injury, but creates a separate cause of action; the cause of action and the employer's rights of subrogation accrue at the time of the 3rd-party negligence. Sutton v. Kaarakka, 159 Wis. 2d 83, 464 N.W.2d 29 (Ct. App. 1990).

A parent corporation can be liable to an employee of a subsidiary as a 3rd-party tort-feasor when the parent negligently undertakes to render services to the subsidiary that the parent should have recognized were necessary for the protection of the subsidiary's employees. Miller v. Bristol-Myers, 168 Wis. 2d 863, 485 N.W.2d 31 (1992).

Rights under sub. (1) are not a type of subrogation, but provide a direct cause of action. Campion v. Montgomery Elevator Co. 172 Wis. 2d 405, 493 N.W.2d 244 (Ct. App. 1992).

An insurer must be paid under sub. (1) in a 3rd-party settlement for an injury that it concluded was noncompensable but was consequential to the original injury. Nelson v. Rothering, 174 Wis. 2d 296, 496 N.W.2d 87 (1993).

A worker's compensation insurer cannot bring a 3rd-party action against an insurer who paid a claimant under uninsured motorist coverage; uninsured motorist coverage is contractual and this section only applies to tort actions. Berna-Mork v. Jones, 174 Wis. 2d 645, 498 N.W.2d 221 (1993).

Sub. (1) does not require an interested party receiving notice of another's 3rd-party claim to give a reciprocal notice to the party making the claim in order to share in the settlement proceeds. Elliot v. Employers Mut. Cas. Co. 176 Wis. 2d 410, 500 N.W.2d 397 (Ct. App. 1993).

The "dual persona doctrine" that allows an employee to sue an employer in tort when the employer was acting in a persona distinct from its employer persona is available to a temporary employee subject to sub. (6). Melzer v. Cooper Industries, Inc. 177 Wis. 2d 609, 503 N.W.2d 291 (Ct. App. 1993).

Third-party claims under sub. (1) include wrongful death actions; settlement proceeds are subject to allocation under sub. (1). Stolper v. Owens-Corning Fiberglass Corp. 178 Wis. 2d 747, 505 N.W.2d 157 (Ct. App. 1993).

An insurer had no right to reimbursement from legal malpractice settlement proceeds arising from a failure to file an action for a work related injury. The employee's injury from the malpractice was the loss of a legal right not a physical injury. Smith v. Long, 178 Wis. 2d 797, 505 N.W.2d 429 (Ct. App. 1993).

Damages for a child's loss of a parent's society and financial support are not subject to allocation under sub. (1). Cummings v. Klawitter, 179 Wis. 2d 408, 506 N.W.2d 750 (Ct. App. 1993).

The traditional 4-prong *Seaman* test for determining whether a person was a "loaned employee" subject to the exclusive remedy provisions of this chapter applies to temporary employees not covered by sub. (6). Bauernfeind v. Zell, 190 Wis. 2d 701, 528 N.W.2d 1 (1995).

Pecuniary damages recovered in a 3rd-party wrongful death action are subject to distribution under this section. Johnson v. ABC Insurance Co. 193 Wis. 2d 35, 532 N.W.2d 130 (1995).

An insurer is entitled to reimbursement under sub. (1) from an employee's settlement with his or her employer when the employer's basis for liability is an indemnification agreement with a 3rd-party tort-feasor. Houlihan v. ABC Insurance Co. 198 Wis. 2d 133, 542 N.W.2d 178 (Ct. App. 1995), 95-0662.

Sub. (5) extends the statute of limitations only when s. 893.54 is the applicable statute; it does not extend the statute of another state when it is applicable under s. 893.07. That sub. (5) only applies to cases subject to the Wisconsin statute is not unconstitutional. Bell v. Employers Casualty Co. 198 Wis. 2d 347, 541 N.W.2d 824 (Ct. App. 1995), 95-0301.

The *Seaman* loaned employee test has 3 elements but is often miscast because the *Seaman* court indicated that there are four "vital questions" that must be answered. The 3 elements are: 1) consent by the employee; 2) entry by the employee upon work for the special employer; and 3) power in the special employer to control details of the work. When an employee of one employer assists the employees of another employer as a true volunteer, a loaned employee relationship does not result. Borneman v. Corwyn Transport, Ltd. 212 Wis. 2d 25, 567 N.W.2d 887 (Ct. App. 1997), 96-2511.

The allocation of a settlement to various plaintiffs cannot be contested by an insurer who defaults at the hearing to approve the settlement. An insurer does not lose its right to share in the proceeds by defaulting, but it does forfeit its right to object to the application of settlement proceeds to specific claims. Herlache v. Blackhawk Collision Repair, Inc. 215 Wis. 2d 99, 572 N.W.2d 121 (Ct. App. 1997), 97-0760.

In a 3rd-party action filed by an insurer under sub. (1), the insurer has the right to maintain an action for payments it has made or will make to the employee by making a claim for all of the employees' damages, including pain and suffering. Threshermens Mutual Insurance Co. v. Page, 217 Wis. 2d 451, 577 N.W.2d 335 (1998), 95-2942.

A variety of factors indicated that a party's participation in an action constituted "pressing" a claim under this section. Zentgraf v. The Hanover Insurance Co. 2002 WI App 13, 250 Wis. 2d 281, 640 N.W.2d 171, 01-0323.

Under the "dual persona" doctrine, the employer's second role must be so unrelated to its role as an employer that it constitutes a separate legal person. St. Paul Fire & Marine Insurance Co. v. Keltgen, 2003 WI App 53, 260 Wis. 2d 523, 659 N.W.2d 906, 02-1249.

A "temporary help agency" requires: 1) an employer who places its employee with a 2nd employer, 2) the 2nd employer controls the employee's work activities, and 3) the 2nd employer compensates the first employer for the employee's services. Placement turns not on the physical proximity of the employee to an employer, but upon the purpose of the employee's work. It is a matter of whose work the employee is performing, not where the work is being performed. Control requires some evidence of compulsion or specific direction concerning the employee's daily activities. Peronto v. Case Corporation, 2005 WI App 32, 278 Wis. 2d 800; 693 N.W.2d 133, 04-0846.

Any activities that the attorney takes to bring the claim to court on behalf of his or her client, as enumerated in *Zentgraf*, constitute a cost of collection amenable to recovery under sub. (1). Sub. (1) does not require a worker's compensation attorney to demonstrate that his or her activities substantially contributed to obtaining recovery from the third party, or that the activities were taken on behalf of the employee, in order to join in the pressing of a claim. Anderson v. MSI Preferred Insurance Company, 2005 WI 62, 281 Wis. 2d 66, 697 N.W.2d 73, 03-1880.

The deduction for costs of collection under sub. (1) must be reasonable. The circuit court must consider all of the circumstances to determine whether a contingency fee figure is reasonable and look to the factors in SCR 20:1.5(a) that help determine the reasonableness of an attorney's fee. For hourly attorney fees the court must follow the lodestar approach under which the circuit court must first multiply the reasonable hours expended by a reasonable rate then make adjustments using the SCR 20:1.5(a) factors. The sum of all the attorneys' reasonable fees and costs may, but need not, equal a reasonable cost of collection. The court must evaluate the total cost of collection and determine whether that sum is reasonable, in light of, among other things, the recovery. Anderson v. MSI Preferred Insurance Company, 2005 WI 62, 281 Wis. 2d 66, 697 N.W.2d 73, 03-1880.

The pro rata distribution formula under *Brewer*, 142 Wis. 2d 864, applies whenever the insurance proceeds are insufficient to satisfy all claims regardless of the reason for that insufficiency, including a settlement by the parties. Allocating a disproportionate amount of the total settlement to claims that are exempt from sub. (1) circumvents legislative intent. The *Brewer* formula prevents the parties from using settlement as an end-run around the purposes of the worker's compensation scheme. Green v. Advance Finishing Technology, Inc. 2005 WI App 70, 280 Wis. 2d 743, 695 N.W.2d 856, 04-0877.

Sub. (1) transforms a worker's compensation insurer's right of subrogation into a right to bring direct claims against 3rd-party tortfeasors. The insurer is entitled to prosecute the action along with the employee by virtue of sub. (1). Sub. (1) gives the trial court the right to settle a dispute between the two plaintiffs, as to whether or not a compromise settlement offered by the defendant should be accepted and does not differentiate between the employee and the worker's compensation insurer. Dalka v. American Family Mutual Insurance Co. 2011 WI App 90, 334 Wis. 2d 686, 799 N.W.2d 923, 10-1428.

A circuit court may compel an employee to accept settlement of a claim against a 3rd party under sub. (1). This result does not violate the employee's right to a jury trial because the claim sub. (1) creates is not the counterpart of a cause of action at law recognized at the time of the adoption of the Wisconsin Constitution. The circuit court's authority to compel an employee to accept settlement does not violate procedural due process because judicial resolution of disputes is part of the statutory claim. Adams v. Northland Equipment Company, Inc. 2014 WI 79, 356 Wis. 2d 529, 850 N.W.2d 272, 12-0580.

This section preserves an existing common law right. It does not create a new right to tort claims against a third party and it does not permit a party to bypass a statute of repose. Crisanto v. Heritage Relocation Services, Inc. 2014 WI App 75, 356 Wis. 2d 529, 850 N.W.2d 272, 13-1369.

Problems in 3rd-party action procedure under the Wisconsin worker's compensation act. Piper. 60 MLR 91.

Impleading a negligent employer in a third-party action when the employer has provided workman's compensation benefits. 1976 WLR 1201.

Product liability in the workplace: The effect of workers' compensation on the rights and liabilities of 3rd parties. Weisgall. 1977 WLR 1035.

Preoccupation with Work Defense to Contributory Negligence. Parlee. Wis. Law. May 1995.

Worker's Compensation Act No Longer Protects Against Employment Discrimination Claims. Skinner. Wis. Law. March 1998.

"Equal Voice" Confirmed: Worker's Comp Carriers Can Compel Settlement. Weiss. Wis. Law. May 2012.

102.30 Other insurance not affected; liability of insured employer.

(1) This chapter does not affect the organization of any mutual or other insurance company or the right of the employer to insure in mutual or other companies against such liability or against the liability for the compensation provided for by this chapter.

(2) An employer may provide by mutual or other insurance, by arrangement with employees or otherwise, for the payment to those employees, their families, their dependents or their representatives, of sick, accident or death benefits in addition to the compensation provided under this chapter. Liability for compensation is not affected by any insurance, contribution or other benefit due to or received by the person entitled to that compensation.[170]

(3) Unless an employee elects to receive sick leave benefits in lieu of compensation under this chapter, if sick leave benefits are paid during the period that temporary disability benefits are payable, the employer shall restore sick leave benefits to the employee in an amount equal in value to the amount payable under this chapter. The combination of temporary disability benefits and sick leave benefits paid to the employee may not exceed the employee's weekly wage.

(4) Regardless of any insurance or other contract, an employee or dependent entitled to compensation under this chapter may recover compensation directly from the employer and may enforce in the person's own name, in the manner provided in this chapter, the liability of any insurance company which insured the liability for that compensation. The appearance, whether general or special, of any such insurance carrier by agent or attorney constitutes waiver of the service of copy of application and of notice of hearing required by s. 102.17.

(5) Payment of compensation under this chapter by either the employer or the insurance company shall, to the extent thereof, bar recovery against the other of the amount so paid. As between the employer and the insurance company, payment by either the employer or the insurance company directly to the employee or the person entitled to compensation is subject to the conditions of the policy.

(6) The failure of the assured to do or refrain from doing any act required by the policy is not available to the insurance carrier as a defense against the claim of the injured employee or the injured employee's dependents.

(7) (a) The department or the division may order direct reimbursement out of the proceeds payable under this chapter for payments made under a nonindustrial insurance policy covering the same disability and expenses compensable under s. 102.42 when the claimant consents or when it is established that the payments under the nonindustrial insurance policy were improper. No attorney fee is due with respect to that reimbursement.

(b) An insurer who issues a nonindustrial insurance policy described in par. (a) may not intervene as a party in any proceeding under this chapter for reimbursement under par. (a).[171]

History: 1973 c. 150; 1975 c. 147 ss. 25, 54; 1975 c. 199; 1985 a. 83; 1987 a. 179; 2015 a. 55.

The prohibition of intervention by nonindustrial insurers under sub. (7) (b) is constitutional. An insurer is not denied a remedy for amounts wrongfully paid to its insured. It may bring a direct action the insured. Employers Health Insurance Co. v Tesmer, 161 Wis. 2d 733, 469 N.W.2d 203 (Ct. App. 1991).

Although sub. (7) (a), read in isolation, authorizes the reimbursement of a subrogated insurer, when an insurer becomes subrogated by paying medical expenses arising

[170] Liability for compensation is not reduced because the employee carries insurance, and no part of the wages of the employee may be taken to pay insurance premiums against liability under this act.

[171] This amendment allows reimbursement to a non-industrial insurance carrier of all covered benefits provided rather than the previously specifically defined benefits. It also provides that the non-industrial carrier cannot be a party to proceedings under the Wisconsin worker's compensation act.

from injuries that are compensable under this chapter, and the employer's worker's compensation insurance carrier is in liquidation, s. 646.31 (11) precludes the commission from ordering the employer to reimburse the subrogated insurer for those expenses. Wisconsin Insurance Security Fund v. Labor and Industry Review Commission, 2005 WI App 242, 288 Wis. 2d 206, 707 N.W.2d 293, 04-2157.

102.31 Worker's compensation insurance; policy regulations.

(1) (a) Every contract for the insurance of compensation provided under this chapter or against liability therefor is subject to this chapter and provisions inconsistent with this chapter are void.

(b) Except as provided in par. (c), a contract under par. (a) shall be construed to grant full coverage of all liability of the assured under this chapter unless the department specifically consents by written order to the issuance of a contract providing divided insurance or partial insurance.

(c) 1. Liability under s. 102.35 (3) is the sole liability of the employer, notwithstanding any agreement of the parties to the contrary.

2. An intermediate agency or publisher of a newspaper or magazine may, under its own contract of insurance, cover liability of persons selling or distributing the newspaper or magazine on the street or from house to house for an intermediate or independent news agency, if the contract of insurance of the publisher or intermediate agency is endorsed to cover those persons. If the publisher so covers, the intermediate or independent news agency need not cover liability for those persons.[172]

(d) A contract procured to insure a partnership may not be construed to cover the individual liability of the members of the partnership in the course of a trade, business, profession or occupation conducted by them as individuals. A contract procured to insure an individual may not be construed to cover the liability of a partnership of which the individual is a member or to cover the liability of the individual arising as a member of any partnership.[173]

(dL) A contract procured to insure a limited liability company may not be construed to cover the individual liability of the members of the limited liability company in the course of a trade, business, profession or occupation conducted by them as individuals. A contract procured to insure an individual may not be construed to cover the liability of a limited liability company of which the individual is a member or to cover the liability of the individual arising as a member of any limited liability company.[174]

(e) An insurer who provides a contract under par. (a) shall file the contract as provided in s. 626.35.[175]

(2) (a) No party to a contract of insurance may cancel the contract within the contract period or terminate or not renew the contract upon the expiration date until a notice in writing is given to the other party fixing the proposed date of cancellation or declaring that the party intends to terminate or does not intend to renew the policy upon expiration. Except as provided in par. (b), when an insurance company does not renew a policy upon expiration, the nonrenewal is not effective until 60 days after the insurance company has given written notice of the nonrenewal to the insured employer and the department.[176] Cancellation or termination of a policy by an insurance company for any reason other than nonrenewal is not effective until 30 days after the insurance company has given written notice of the cancellation or termination to the insured employer and the department. Notice to the department may be given by personal service of the notice upon the

[172] The law establishes no direct liability against the publisher for the employees of the intermediate or independent agency except as the agency may be a contractor under this publisher, in which case liability would exist under s. 102.06. The publisher is permitted to assume, under its insurance policy, the liability that exists directly against the intermediate or independent news agency, and to relieve those agencies from covering liability of carriers.

[173] This language operates to treat a partnership for insurance purposes as an entity. If A, an individual, has insurance and joins a partnership his or her individual insurance will not cover the partnership. Conversely, the partnership insurance will not cover A as an individual.

[174] This treats the limited liability companies in the same manner as partnerships under s. 102.31 (1)(d).

[175] Insurers must file copies of policies within 60 days of the date of coverage. The penalty adopted by the rating bureau for failure to file was raised to $150 effective January 1, 1998.

[176] An insurer is now required to give an employer 60 days notice of nonrenewal of a policy unless nonrenewal is based on a failure to pay premiums. This is to allow the employer ample time to purchase a replacement policy.

department at its office in Madison or by sending the notice to the department in a medium approved by the department.[177]

The department may provide by rule that the notice of cancellation or termination be given to the Wisconsin compensation rating bureau rather than to the department in a medium approved by the department after consultation with the Wisconsin compensation rating bureau. Whenever the Wisconsin compensation rating bureau receives such a notice of cancellation or termination it shall immediately notify the department of the notice of cancellation or termination.[178]

(b) 1. In the event of a court-ordered liquidation of an insurance company, a contract of insurance issued by that company terminates on the date specified in the court order.

2. Regardless of whether the notices required under par. (a) have been given, a cancellation or termination is effective upon the effective date of replacement insurance coverage obtained by the employer, the effective date of an order under s. 102.28 (2) (b) exempting the employer from the duty to carry insurance under s. 102.28 (2) (a), or the effective date of an election by an employer under s. 102.28 (2) (bm) to self-insure its liability for the payment of compensation under this chapter.

(3) The department may examine from time to time the books and records of any insurer insuring liability or compensation for an employer in this state. The department may require an insurer to designate one mailing address for use by the department and to respond to correspondence from the department within 30 days. Any insurer that refuses or fails to answer correspondence from the department or to allow the department to examine its books and records is subject to enforcement proceedings under s. 601.64.

(4) If any insurer authorized to transact worker's compensation insurance in this state fails to promptly pay claims for compensation for which it is liable or fails to make reports to the department required by s. 102.38, the department may recommend to the commissioner of insurance, with detailed reasons, that enforcement proceedings under s. 601.64 be invoked. The commissioner shall furnish a copy of the recommendation to the insurer and shall set a date for a hearing, at which both the insurer and the department shall be afforded an opportunity to present evidence. If after the hearing the commissioner finds that the insurer has failed to carry out its obligations under this chapter, the commissioner shall institute enforcement proceedings under s. 601.64. If the commissioner does not so find, the commissioner shall dismiss the complaint.

(5) If any employer whom the department exempted from carrying compensation insurance arbitrarily or unreasonably refuses employment to or discharges employees because of a nondisabling physical condition, the department shall revoke the exemption of that employer.

(6) The department has standing to appear as a complainant and present evidence in any administrative hearing or court proceeding instituted for alleged violation of s. 628.34 (7).

(7) If the department by one or more written orders specifically consents to the issuance of one or more contracts covering only the liability incurred on a construction project and if the construction project owner designates the insurance carrier and pays for each such contract, the construction project owner shall reimburse the department for all costs incurred by the department in issuing the written orders and in ensuring minimum confusion and maximum safety on the construction project. All moneys received under this subsection shall be deposited in the worker's compensation operations fund and credited to the appropriation account under s. 20.445 (1) (rb).

(8) The Wisconsin compensation rating bureau shall provide the department with any information that the department may request relating to worker's compensation insurance coverage, including the names of employers insured and any insured employer's address, business status, type and date of coverage,

[177] 2009 Wis. Act 206, effective May 1, 2010, permits insurance carriers to give notice of cancellation, nonrenewal or termination of a policy to the Wisconsin Compensation Rating Bureau by a medium approved by the department.

[178] Section 102.31(2)(a) provides that the department may provide by rule for notice of cancellation or termination of an insurance policy to be made directly to the Wisconsin compensation rating bureau. See Rule DWD 80.65.

manual premium code, and policy information including numbers, cancellations, terminations, endorsements, and reinstatement dates. The department may enter into contracts with the Wisconsin compensation rating bureau to share the costs of data processing and other services. No information obtained by the department under this subsection may be made public by the department except as authorized by the Wisconsin compensation rating bureau.[179]

History: 1971 c. 260, 307; 1975 c. 39; 1975 c. 147 ss. 26, 54; 1975 c. 199, 371; 1977 c. 29, 195; 1979 c. 278; 1981 c. 92; 1983 a. 189 s. 329 (25); 1985 a. 29, 83; 1987 a. 179; 1989 a. 64, 332; 1993 a. 81, 112; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2007 a. 185; 2009 a. 206; 2015 a. 180.

Cross-reference: See also ss. DWD 80.61 and 80.65, Wis. adm. code.

Sub. (1) (b) [now (1) (d)] does not apply to a joint venture, and insurance written in the name of one venturer is sufficient to cover his or her joint liability. Insurance Company of North America v. DILHR, 45 Wis. 2d 361, 173 N.W.2d 192 (1970).

102.315 Worker's compensation insurance; employee leasing companies.[180]

(1) DEFINITIONS. In this section:

(a) "Bureau" means the Wisconsin compensation rating bureau under s. 626.06.

(b) "Client" means a person that obtains all or part of its nontemporary, ongoing employee workforce through an employee leasing agreement with an employee leasing company.

(c) "Divided workforce" means a workforce in which some of the employees of a client are leased employees and some of the employees of the client are not leased employees.

(d) "Divided workforce plan" means a plan under which 2 worker's compensation insurance policies are issued to cover the employees of a client that has a divided workforce, one policy covering the leased employees of the client and one policy covering the employees of the client who are not leased employees.

(e) "Employee leasing agreement" means a written contract between an employee leasing company and a client under which the employee leasing company provides all or part of the nontemporary, ongoing employee workforce of the client.

(f) "Employee leasing company" means a person that contracts to provide the nontemporary, ongoing employee workforce of a client under a written agreement, regardless of whether the person uses the term "professional employer organization," "PEO," "staff leasing company," "registered staff leasing company," or "employee leasing company," or uses any other, similar name, as part of the person's business name or to describe the person's business. "Employee leasing company" does not include a cooperative educational service agency. This definition applies only for the purposes of this chapter and does not apply to the use of the term in any other chapter.

(g) "Leased employee" means a nontemporary, ongoing employee whose services are obtained by a client under an employee leasing agreement.

(h) "Master policy" means a single worker's compensation insurance policy issued by an insurer authorized to do business in this state to an employee leasing company in the name of the employee leasing company that covers more than one client of the employee leasing company.

(i) "Multiple coordinated policy" means a contract of insurance for worker's compensation under which an insurer authorized to do business in this state issues separate worker's compensation insurance policies to an employee leasing company for each client of the employee leasing company that is insured under the contract.

(j) "Small client" means a client that has an unmodified annual premium assignable to its

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[179] The department cannot make public any of the information specified in s. 102.31(8) except as authorized by the Wisconsin Compensation Rating Bureau. This section was created by 2001 Wis. Act 37, effective January 1, 2002.

[180] 2007 Wis. Act 185, effective April 1, 2008 establishes requirements for worker's compensation insurance coverage for professional employer organizations and employee leasing companies. This amendment requires insurance carriers to insure professional employer organizations and employee leasing companies through multiple coordinated policies. Small client employers whose premiums are not large enough for experience rating may continue to be insured under master policies. Insurance carriers may be permitted to cover all employee leasing companies and professional employer organizations under master policies in the future when unit statistical data and other claims data can be tracked for each client employer and the filing is approved by the Office of the Commissioner of Insurance and the Wisconsin Compensation Rating Bureau. This amendment repealed the previous s. 102.31(2m).

business, including the business of all entities or organizations that are under common control or ownership with the client, that is equal to or less than the threshold below which employers are not experience rated under the standards and criteria under ss. 626.11 and 626.12, without regard to whether the client has a divided workforce.

(2) EMPLOYEE LEASING COMPANY LIABLE. An employee leasing company is liable under s. 102.03 for all compensation payable under this chapter to a leased employee, including any payments required under s. 102.16 (3), 102.18 (1) (b) 3. or (bp), 102.22 (1), 102.35 (3), 102.57, or 102.60. Except as permitted under s. 102.29, an employee leasing company may not seek or receive reimbursement from another employer for any payments made as a result of that liability. An employee leasing company is not liable under s. 102.03 for any compensation payable under this chapter to an employee of a client who is not a leased employee.

(3) MULTIPLE COORDINATED POLICY REQUIRED. Except as provided in subs. (4) and (5) (a), an employee leasing company shall insure its liability under sub. (2) by obtaining a separate worker's compensation insurance policy for each client of the employee leasing company under a multiple coordinated policy. The policy shall name both the employee leasing company and the client as named insureds, shall indicate which named insured is the employee leasing company and which is the client, shall designate either the employee leasing company or the client, but not both, as the first named insured, and shall provide the mailing address of each named insured. Except as permitted under sub. (6), an insurer may issue a policy for a client under this subsection only if all of the employees of the client are leased employees and are covered under the policy.

(4) MASTER POLICY; APPROVAL REQUIRED. An employee leasing company may insure its liability under sub. (2) by obtaining a master policy that has been approved by the commissioner of insurance as provided in this subsection. The commissioner of insurance may approve the issuance of a master policy if the insurer proposing to issue the master policy submits a filing to the bureau showing that the insurer has the technological capacity and operation capability to provide to the bureau information, including unit statistical data, information concerning proof of coverage and cancellation, termination, and nonrenewal of coverage, and any other information that the bureau may require, at the client level and in a format required by the bureau and the bureau submits the filing to the commissioner of insurance for approval under s. 626.13. A master policy filing under this subsection shall also establish basic manual rules governing the issuance of an insurance policy covering the leased employees of a divided workforce that are consistent with sub. (6) and the cancellation, termination, and nonrenewal of policies that are consistent with sub. (10). On approval by the commissioner of insurance of a master policy filing, an insurer may issue a master policy to an employee leasing company insuring the liability of the employee leasing company under sub. (2).

(5) MASTER POLICY; SMALL CLIENTS.

(a) Regardless of whether a master policy has been approved under sub. (4), an employee leasing company may insure its liability under sub. (2) with respect to a group of small clients of the employee leasing company by obtaining a master policy in the voluntary market insuring that liability. The fact that an employee leasing company has a client that is covered under a mandatory risk-sharing plan under s. 619.01 does not preclude the employee leasing company from obtaining a master policy under this paragraph so long as that client is not covered under the master policy. An insurer may issue a master policy under this paragraph insuring in the voluntary market the liability under sub. (2) of an employee leasing company with respect to a group of small clients of the employee leasing company regardless of whether any of those small clients has a divided workforce.

(b) Within 30 days after the effective date of an employee leasing agreement with a small client that is covered under a master policy under par. (a), the employee leasing company shall report to the department all of the following information:

1. The name and address of the small client and of each entity or organization that is under common control or ownership with the small client.

2. The number of employees initially covered under the master policy.

3. The estimated unmodified annual premium assignable to the small client's business, including the business of all entities or organizations that are under common control or ownership with the small client, without regard to whether the small client has a divided workforce, which information the small client shall report to the employee leasing company.

4. The effective date of the employee leasing agreement.

(c) Within 30 days after the effective date of coverage of a small client under a master policy under par. (a), the insurer or, if authorized by the insurer, the employee leasing company shall file proof of that coverage with the department. Coverage of a small client under a master policy becomes binding when the insurer or employee leasing company files proof of that coverage under this paragraph or provides notice of coverage to the small client, whichever occurs first. Nothing in this paragraph requires an employee leasing company or an employee of an employee leasing company to be licensed as an insurance intermediary under ch. 628.

(d) If at any time the unmodified annual premium assignable to the business of a small client that is covered under a master policy under par. (a), including the business of all entities or organizations that are under common control or ownership with the small client, without regard to whether the small client has a divided workforce, exceeds the threshold below which employers are not experience rated under the standards and criteria under ss. 626.11 and 626.12, the employee leasing company shall notify the insurer and obtain coverage for the small client under sub. (3) or (4).

(6) DIVIDED WORKFORCE.

(a) If a client notifies the department as provided under par. (b) of its intent to have a divided workforce, an insurer may issue a worker's compensation insurance policy covering only the leased employees of the client. An insurer that issues a policy covering only the leased employees of a client is not liable under s. 102.03 for any compensation payable under this chapter to an employee of the client who is not a leased employee unless the insurer also issues a policy covering that employee. A client that has a divided workforce shall insure its employees who are not leased employees in the voluntary market and may not insure those employees under the mandatory risk-sharing plan under s. 619.01 unless the leased employees of the client are covered under that plan.

(b) A client that intends to have a divided workforce shall notify the department of that intent on a form prescribed by the department that includes all of the following:

1. The names and mailing addresses of the client and the employee leasing company, the effective date of the employee leasing agreement, a description of the employees of the client who are not leased employees, and such other information as the department may require.

2. Except as provided in par. (c), evidence that the employees of the client who are not leased employees are covered in the voluntary market. That evidence shall be in the form of a copy of the information page or declaration page of a worker's compensation insurance policy or binder evidencing placement of coverage in the voluntary market covering those employees.

3. An agreement by the client to assume full responsibility to immediately pay all compensation and other payments payable under this chapter as may be required by the department should a dispute arise between 2 or more insurers as to liability under this chapter for an injury sustained while a divided workforce plan is in effect, pending final resolution of that dispute. This subdivision does not preclude a client from insuring that responsibility in an insurer authorized to do business in this state.

(c) If the leased employees of a client are covered under a mandatory risk-sharing plan under s. 619.01, the client may, instead of providing the evidence required under par. (b) 2., provide evidence in its notification under par. (b) that both the leased employees of the client and the employees of the client who are not leased employees are covered under that mandatory risk-sharing plan. That evidence shall be in the form of a copy of the information page or declaration page of a worker's compensation insurance policy or binder evidencing placement of coverage under the mandatory risk-sharing plan covering both those leased employees and employees who are not leased employees.

(d) When the department receives a notification under par. (b), the department shall immediately provide a copy of the notification to the bureau.

(e) 1. If a client intends to terminate a divided workforce plan, the client shall notify the department of that intent on a form prescribed by the department. Termination of a divided workforce plan by a client is not effective until 10 days after notice of the termination is received by the department.

2. If an insurer cancels, terminates, or does not renew a worker's compensation insurance policy issued under a divided workforce plan that covers in the voluntary market the employees of a client who are not leased employees, the divided workforce plan is terminated on the effective date of the cancellation, termination, or nonrenewal of the policy, unless the client submits evidence under par. (c) that both the leased employees of the client and the employees of the client who are not leased employees are covered under a mandatory risk-sharing plan.

3. If an insurer cancels, terminates, or does not renew a worker's compensation insurance policy issued under a divided workforce plan that covers under the mandatory risk-sharing plan under s. 619.01 the employees of a client who are not leased employees, the divided workforce plan is terminated on the effective date of the cancellation, termination, or nonrenewal of the policy.

(7) FILING OF CONTRACTS. An insurer that provides a policy under sub. (3), (4), or (5) (a) shall file the policy as provided in s. 626.35.

(8) COVERAGE OF CERTAIN EMPLOYEES.

(a) A sole proprietor, a partner, or a member of a limited liability company is not eligible for worker's compensation benefits under a policy issued under sub. (3), (4), or (5) (a) unless the sole proprietor, partner, or member elects coverage under s. 102.075 by an endorsement on the policy naming the sole proprietor, partner, or member who has so elected.

(b) An officer of a corporation is covered for worker's compensation benefits under a policy issued under sub. (3), (4), or (5) (a), unless the officer elects under s. 102.076 not to be covered under the policy by an endorsement on the policy naming the officer who has so elected.

(c) An employee leasing company shall obtain a worker's compensation insurance policy that is separate from a policy covering the employees whom it leases to its clients to cover the employees of the employee leasing company who are not leased employees.

(9) PREMIUMS.

(a) An insurer that issues a policy under sub. (3), (4), or (5) (a) may charge a premium for coverage under that policy that complies with the applicable classifications, rules, rates, and rating plans filed with and approved by the commissioner of insurance under s. 626.13.

(b) For a policy issued under sub. (3) in which an employee leasing company is the first named insured or for a master policy issued under sub. (4) or (5) (a), an insurer may obligate only the employee leasing company to pay premiums due for a client's coverage under the policy and may not recover any unpaid premiums due for that coverage from the client.

(c) This subsection does not prohibit an insurer from doing any of the following:

1. Collecting premiums or other charges due with respect to a client by means of list billing through an employee leasing company.

2. Requiring an employee leasing company to maintain a letter of credit or other form of security to ensure payment of a premium.

3. Issuing policies that have a common renewal date to all, or a class of all, clients of an employee leasing company.

4. Grouping together the clients of an employee leasing company for the purpose of offering dividend eligibility and paying dividends to those clients in compliance with s. 631.51.

5. Applying a discount to the premium charged with respect to a client as permitted by the bureau.

6. Applying a retrospective rating option for determining the premium charged with respect to a client. No insurer or employee leasing company may impose on, allocate to, or collect from a client a penalty under a retrospective rating option arrangement. This subdivision does not prohibit an insurer from requiring an employee leasing company to pay a penalty under a retrospective rating option arrangement with respect to a client of the employee leasing company.

(10) CANCELLATION, TERMINATION, AND NONRENEWAL OF POLICIES.

(a) 1. A policy issued under sub. (3) in which the employee leasing company is the first named insured and a policy issued under sub. (4) or (5) (a) may be cancelled, terminated, or nonrenewed as provided in subds. 2. to 4.

2. The insureds under a policy described in subd. 1. may cancel the policy during the policy period if both the employee leasing company and the client agree to the cancellation, the cancellation is confirmed by the employee leasing company promptly providing written confirmation of the cancellation to the client or by the client agreeing to the cancellation in writing, and the insurer provides written notice of the cancellation to the department as required under s. 102.31 (2) (a).

3. Subject to subd. 4., an insurer may cancel, terminate, or nonrenew a policy described in subd. 1. by providing written notice of the cancellation, termination, or nonrenewal to the insured employee leasing company and to the department as required under s. 102.31 (2) (a) and by providing that notice to the insured client. The insurer is not required to state in the notice to the insured client the facts on which the decision to cancel, terminate, or nonrenew the policy is based. Except as provided in s. 102.31 (2) (b), cancellation or termination of a policy under this subdivision for any reason other than nonrenewal is not effective until 30 days after the insurer has provided written notice of the cancellation or termination to the insured employee leasing company, the insured client, and the department. Except as provided in s. 102.31 (2) (b), nonrenewal of a policy under this subdivision is not effective until 60 days after the insurer has provided written notice of the cancellation or termination to the insured employee leasing company, the insured client, and the department.

4. If an employee leasing company terminates an employee leasing agreement with a client in its entirety, an insurer may cancel or terminate a policy described in subd. 1. covering that client during the policy period by providing written notice of the cancellation or termination to the insured employee leasing company and the department as required under s. 102.31 (2) (a) and by providing that notice to the insured client. The insurer shall state in the notice to the insured client that the policy is being cancelled or terminated due to the termination of the employee leasing agreement. Except as provided in s. 102.31 (2) (b), cancellation or termination of a policy under this subdivision is not effective until 30 days after the insurer has provided written notice of the cancellation or termination to the insured employee leasing company, the insured client, and the department.

(b) 1. A policy issued under sub. (3) in which the client is the first named insured may be cancelled, terminated, or nonrenewed as provided in subds. 2. to 4.

2. The insureds under a policy described in subd. 1. may cancel the policy during the policy period if both the employee leasing company and the client agree to the cancellation, the cancellation is confirmed by the employee leasing company promptly providing written confirmation of the cancellation to the client or by the client agreeing to the cancellation in writing, and the insurer provides written notice of the cancellation to the department as required under s. 102.31 (2) (a).

3. An insurer may cancel, terminate, or nonrenew a policy described in subd. 1., including cancellation or termination of a policy providing continued coverage under subd. 4., by providing written notice of the cancellation, termination, or nonrenewal to the insured employee leasing company and to the department as required under s. 102.31 (2) (a) and by providing that notice to the insured client. Except as provided in s. 102.31 (2) (b), cancellation or termination of a policy under this subdivision for any reason other than nonrenewal is not effective until 30 days after the insurer has provided written notice of the cancellation or termination to the insured employee leasing company, the insured client, and the department. Except as provided in s. 102.31 (2) (b), nonrenewal of a policy under this subdivision is not effective until 60 days after the insurer has provided written notice of the cancellation or termination to the insured employee leasing company, the insured client, and the department.

4. If an employee leasing agreement is terminated during the policy period of a policy described in subd. 1., an insurer shall cancel the

employee leasing company's coverage under the policy by an endorsement to the policy and coverage of the client under the policy shall continue as to all employees of the client unless the policy is cancelled or terminated as permitted under subd. 3.

History: 2007 a. 185; 2015 a. 180.

102.32 Continuing liability; guarantee settlement, gross payment.

(1m) In any case in which compensation payments for an injury have extended or will extend over 6 months or more after the date of the injury or in any case in which death benefits are payable, any party in interest may, in the discretion of the department or the division, be discharged from, or compelled to guarantee, future compensation payments by doing any of the following:

(a) Depositing the present value of the total unpaid compensation upon a 5 percent interest discount basis with a credit union, savings bank, savings and loan association, bank, or trust company designated by the department or the division.

(b) Purchasing an annuity, within the limitations provided by law, from an insurance company licensed in this state that is designated by the department.

(c) Making payment in gross upon a 5 percent interest discount basis to be approved by the department or the division.

(d) In cases in which the time for making payments or the amounts of payments cannot be definitely determined, furnishing a bond, or other security, satisfactory to the department or the division for the payment of compensation as may be due or become due. The acceptance of the bond, or other security, and the form and sufficiency of the bond or other security, shall be subject to the approval of the department or the division. If the employer or insurer is unable or fails to immediately procure the bond, the employer or insurer, in lieu of procuring the bond, shall deposit with a credit union, savings bank, savings and loan association, bank, or trust company designated by the department or the division the maximum amount that may reasonably become payable in those cases, to be determined by the department or the division at amounts consistent with the extent of the injuries and the law. The bonds and deposits may be reduced only to satisfy claims and may be withdrawn only after the claims which they are to guarantee are fully satisfied or liquidated under par. (a), (b), or (c).

(5) Any insured employer may, in the discretion of the department or the division, compel the insurer to discharge, or to guarantee payment of, the employer's liabilities in any case described in sub. (1m) and by that discharge or guarantee release the employer from liability for compensation in that case, except that if for any reason a bond furnished or deposit made under sub. (1m) (d) does not fully protect the beneficiary of the bond or deposit, the compensation insurer or insured employer, as the case may be, shall still be liable to that beneficiary.

(6) (a) If compensation is due for permanent disability following an injury or if death benefits are payable, payments shall be made to the employee or dependent on a monthly basis as provided in pars. (b) to (e).[181]

[181] This gives the department authority for its longstanding policy to have permanent disability and death benefits paid monthly.

(b) Subject to par. (d), if the employer or the employer's insurer concedes liability for an injury that results in permanent disability and if the extent of the permanent disability can be determined based on a minimum permanent disability rating promulgated by the department by rule, compensation for permanent disability shall begin within 30 days after the end of the employee's healing period or the date on which compensation for temporary disability ends due to the employee's return to work, whichever is earlier.[182]

(c) Subject to par. (d), if the employer or the employer's insurer concedes liability for an injury that results in permanent disability, but the extent of the permanent disability cannot be determined without a medical report that provides the basis for a minimum permanent disability rating, compensation for permanent disability shall begin within 30 days after the employer or the employer's insurer receives a medical report that provides a basis for a permanent disability rating.

(d) The department shall promulgate rules for determining when compensation for permanent disability shall begin in cases in which the employer or the employer's insurer concedes liability, but disputes the extent of permanent disability.

(e) Payments for permanent disability, including payments based on minimum permanent disability ratings promulgated by the department by rule, shall continue on a monthly basis and shall accrue and be payable between intermittent periods of temporary disability so long as the employer or insurer knows the nature of the permanent disability.

(6m) The department or the division may direct an advance on a payment of unaccrued compensation for permanent disability or death benefits if the department or the division determines that the advance payment is in the best interest of the injured employee or the employee's dependents. In directing the advance, the department or the division shall give the employer or the employer's insurer an interest credit against its liability. The credit shall be computed at 5 percent. An injured employee or dependent may receive no more than 3 advance payments per calendar year.[183] [184]

(7) No lump sum settlement shall be allowed in any case of permanent total disability upon an estimated life expectancy, except upon consent of all parties, after hearing and finding by the division that the interests of the injured employee will be conserved by the lump sum settlement.

History: 1977 c. 195; 1979 c. 278; 1983 a. 98, 368, 538; 1991 a. 221; 1993 a. 492; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2007 a. 185; 2015 a. 55.

Cross-reference: See also ss. DWD 80.32, 80.33, 80.39, and 80.50, Wis. adm. code.

The interest credit under sub. (6) [now sub. (6m)] was properly calculated on a per annum basis rather than a one-time simple interest basis. Hamm v. LIRC, 223 Wis. 2d 183, 588 N.W.2d 358 (Ct. App. 1998), 98-0051.

102.33 Forms and records; public access.

(1) The department and the division shall print and furnish free to any employer or employee any blank forms that are necessary to facilitate efficient administration of this chapter. The department and the division shall keep any record books or records that are necessary for the proper and efficient administration of this chapter.

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[182] Payment of compensation for permanent partial disability must begin within 30 days after the end of the healing period and accrues and becomes payable between intermittent periods of temporary disability. 2003 Wis. Act 144, effective March 30, 2004, clarifies the requirements for the payment of permanent partial disability benefits. When a minimum disability rating is set by department rule, the carrier or self-insured employer shall begin paying compensation for permanent disability within 30 days of the end of the healing period. When the extent of disability is not set by department rule, and the insurer or self-insured employer admits liability for the injury, the carrier or employer shall begin paying compensation for permanent disability within 30 days after receiving a medical report providing the disability rating. Rule DWD 80.52 provides when compensation for permanent disability shall be paid when the insurer or employer disputes the extent of permanent disability but admits liability for the injury. With the amendment created by 2005 Wis. Act 172, effective April 1, 2006, an employee who is still in the healing period and has returned to work is eligible to receive payments based on minimum ratings established by Rule DWD 80.32.

[183] With this amendment employees and dependents are limited to 3 advancements per calendar year. 2005 Wis. Act 172, effective April 1, 2006.

[184] Under this amendment the interest credit for advancement and lump sum payments is reduced from 7% to 5%. 2007 Wis. Act 185, effective April 1, 2008.

(2) (a) Except as provided in pars. (b) and (c), the records of the department, the division, and the commission, related to the administration of this chapter are subject to inspection and copying under s. 19.35 (1).[185]

(b) Except as provided in this paragraph and par. (d), a record maintained by the department, the division, or the commission that reveals the identity of an employee who claims worker's compensation benefits, the nature of the employee's claimed injury, the employee's past or present medical condition, the extent of the employee's disability, or the amount, type, or duration of benefits paid to the employee and a record maintained by the department that reveals any financial information provided to the department by a self-insured employer or by an applicant for exemption under s. 102.28 (2) (b) are confidential and not open to public inspection or copying under s. 19.35 (1). The department, the division, or the commission may deny a request made under s. 19.35 (1) or, subject to s. 102.17 (2m) and (2s), refuse to honor a subpoena issued by an attorney of record in a civil or criminal action or special proceeding to inspect and copy a record that is confidential under this paragraph, unless one of the following applies:[186]

1. The requester is the employee who is the subject of the record or an attorney or authorized agent of that employee. An attorney or authorized agent of an employee who is the subject of a record shall provide a written authorization for inspection and copying from the employee if requested by the department, the division, or the commission.

2. The record that is requested contains confidential information concerning a worker's compensation claim and the requester is an insurance carrier or employer that is a party to any worker's compensation claim involving the same employee or an attorney or authorized agent of that insurance carrier or employer, except that the department, the division, or the commission is not required to do a random search of its records and may require the requester to provide the approximate date of the injury and any other relevant information that would assist the department, the division, or the commission in finding the record requested. An attorney or authorized agent of an insurance carrier or employer that is a party to an employee's worker's compensation claim shall provide a written authorization for inspection and copying from the insurance carrier or employer if requested by the department, the division, or the commission.[187]

3. The record that is requested contains financial information provided by a self-insured employer or by an applicant for exemption under s. 102.28 (2) (b) and the requester is the self-insured employer or applicant for exemption or an attorney or authorized agent of the self-insured employer or applicant for exemption. An attorney or authorized agent of the self-insured employer or of the applicant for exemption shall provide a written authorization for inspection and copying from the self-insured employer or applicant for exemption if requested by the department.

4. A court of competent jurisdiction in this state orders the department, the division, or the commission to release the record.[188]

5. The requester is the department of children and families or a county child support agency under s. 59.53 (5), the request is made under s. 49.22 (2m), and the request is limited to the name and address of the employee who is the subject of the record, the name and address of the employee's employer, and any financial

[185] This provides that worker's compensation records are subject to Wisconsin public records law except for records identifying an employee's name, injury, medical condition, disability or benefits or financial records of applicants for self-insurance, which are confidential. Confidential records are generally available only to the parties to a worker's compensation claim or their representatives. Restrictions on access apply to confidential worker's compensation records at the Labor and Industry Review Commission under the amendment created by 2005 Wis. Act 172, effective April 1, 2006. Restrictions on access apply to confidential worker's compensation records at the Division of Hearings and Appeals with the amendment created by 2015 Wis. Act 183, effective March 2, 2016.

[186] This codifies the department's policy of not honoring subpoenas for claim records from parties to another legal proceeding.

[187] This provides access to records of prior claims in order to facilitate settlements and prevent fraud. It also codifies the department's long-standing prohibition of random searches.

[188] The department will only honor court orders for release of records from Wisconsin courts.

information about that employee contained in the record.[189]

6. The department of revenue requests the record for the purpose of locating a person, or the assets of a person, who has failed to file tax returns, who has underreported taxable income or who is a delinquent taxpayer; identifying fraudulent tax returns; or providing information for tax-related prosecutions.[190]

(c) A record maintained by the department, the division, or the commission that contains employer or insurer information obtained from the Wisconsin compensation rating bureau under s. 102.31 (8) or 626.32 (1) (a) is confidential and not open to public inspection or copying under s. 19.35 (1) unless the Wisconsin compensation rating bureau authorizes public inspection or copying of that information.[191]

(d) 1. In this paragraph:

a. "Government unit" has the meaning given in s. 108.02 (17) and also includes a corresponding unit in the government of another state or a unit of the federal government.

b. "Institution of higher education" has the meaning given in s. 108.02 (18).

c. "Nonprofit research organization" means an organization that is exempt from federal income tax under section 501 (a) of the Internal Revenue Code and whose mission is to engage in research.

2. The department, the division, or the commission may release information that is confidential under par. (b) to a government unit, an institution of higher education, or a nonprofit research organization for purposes of research and may release information that is confidential under par. (c) to those persons for that purpose if the Wisconsin compensation rating bureau authorizes that release. A government unit, institution of higher education, or nonprofit research organization may not permit inspection or disclosure of any information released to it under this subdivision that is confidential under par. (b) unless the department, the division, or the commission authorizes that inspection or disclosure and may not permit inspection or disclosure of any information released to it under this subdivision that is confidential under par. (c) unless the department, the division, or the commission, and the Wisconsin compensation rating bureau, authorize the inspection or disclosure. A government unit, institution of higher education, or nonprofit research organization that obtains any confidential information under this subdivision for purposes of research shall provide the results of that research free of charge to the person that released or authorized the release of that information.[192]

History: 1975 c. 147 s. 54; 1989 a. 64; 1991 a. 85; 1995 a. 117; 1997 a. 191, 237; 2001 a. 37, 107; 2005 a. 172; 2009 a. 180; 2015 a. 55.

[189] This was created by 1997 Wis. Act 191 relating to support enforcement.

[190] This was created by 1997 Wis. Act 237 concerning tax delinquencies.

[191] This section was created by 2001 Wis. Act 37, effective January 1, 2002 relating to records maintained by the department containing employer or insurer information obtained from the Wisconsin Compensation Rating Bureau.

[192] This paragraph was created by 2005 Wis. Act 172, effective April 1, 2006, that authorizes the release of confidential information to government agencies, educational institutions and non-profit research organizations with the assurance that information will not be re-released without authorization from the department.

102.35 Penalties.

(1) Every employer and every insurance company that fails to keep the records or to make the reports required by this chapter or that knowingly falsifies such records or makes false reports shall pay a work injury supplemental benefit surcharge to the state of not less than $10 nor more than $100 for each offense. The department may waive or reduce a surcharge imposed under this subsection if the employer or insurance company that violated this subsection requests a waiver or reduction of the surcharge within 45 days after the date on which notice of the surcharge is mailed to the employer or insurance company and shows that the violation was due to mistake or an absence of information. A surcharge imposed under this subsection is due within 30 days after the date on which notice of the surcharge is mailed to the employer or insurance company. Interest shall accrue on amounts that are not paid when due at the rate of 1 percent per month. All surcharges and interest payments received under this subsection shall be deposited in the fund established under s. 102.65.[193] [194]

(2) Any employer, or duly authorized agent thereof, who, without reasonable cause, refuses to rehire an employee injured in the course of employment, or who, because of a claim or attempt to claim compensation benefits from such employer, discriminates or threatens to discriminate against an employee as to the employee's employment, shall forfeit to the state not less than $50 nor more than $500 for each offense. No action under this subsection may be commenced except upon request of the department.

(3) Any employer who without reasonable cause refuses to rehire an employee who is injured in the course of employment, when suitable employment is available within the employee's physical and mental limitations, upon order of the department or the division, has exclusive liability to pay to the employee, in addition to other benefits, the wages lost during the period of such refusal, not exceeding one year's wages. In determining the availability of suitable employment the continuance in business of the employer shall be considered and any written rules promulgated by the employer with respect to seniority or the provisions of any collective bargaining agreement with respect to seniority shall govern.

History: 1975 c. 147; 1977 c. 29, 195; 2003 a. 144; 2005 a. 172; 2011 a. 183; 2015 a. 55.

An employer cannot satisfy sub. (3) by rehiring with an intent to fire at a later date. Dielectric Corporation v. LIRC, 111 Wis. 2d 270, 330 N.W.2d 606 (Ct. App. 1983).

An employer has the burden to prove that rehiring was in good faith. West Allis School Dist. v. DILHR, 116 Wis. 2d 410, 342 N.W.2d 415 (1984).

A one-day absence from work due to an injury triggered the rehire provision under sub. (3). Link Industries, Inc. v. LIRC, 141 Wis. 2d 551, 415 N.W.2d 574 (Ct. App. 1987).

For liability under sub. (3), the employee must show that he or she: 1) was an employee; 2) sustained a compensable injury;. 3) applied for rehire; 4) had the application for rehire refused due to the injury. Universal Foods Corporation v. LIRC, 161 Wis. 2d 1, 467 N.W.2d 793 (Ct. App. 1991).

Sub. (3) does not bar an employee from seeking arbitration under a collective bargaining agreement to determine whether termination following an injury violated the agreement. Sub. (3) relates to harm other than worker injuries and is not subject to the exclusive remedy provision of s. 102.03 (2); the "exclusive liability" language in sub. (3) does not bar lawsuits but imposes a penalty on the employer for refusal to hire. County of LaCrosse v. WERC, 182 Wis. 2d 15, 513 N.W.2d 708 (1994).

A LIRC interpretation of sub. (3), that a violation requires an employee who is unable to return to a prior employment to express an interest in reemployment in a different capacity, was reasonable. Hill v. LIRC, 184 Wis. 2d 110, 516 N.W.2d 441 (Ct. App. 1994).

If an employer shows that it refused to rehire an injured employee because the employee's position was eliminated to reduce costs and increase efficiency, reasonable cause has been shown under sub. (3). Ray Hutson Chevrolet, Inc. v. LIRC, 186 Wis. 2d 118, 519 N.W.2d 649 (Ct. App. 1994).

An attendance policy that includes absences due to work-related injuries as part of the total of absences allowed before termination violates sub. (3). Great Northern Corp. v. LIRC, 189 Wis. 2d 313, 525 N.W.2d 361 (Ct. App. 1994).

Sub. (3) does not contemplate requiring employers to either deviate from a facially reasonable and uniformly applied policy, or explain why it would be burdensome to do so, when a returning employee requests the deviation to accommodate a non-work and non-injury-related personal

[193] 2003 Wis. Act 144, effective March 30, 2004, provides that the department may waive or reduce a surcharge on the grounds that it was imposed due to a mistake or an absence of information. The insurer or employer must request a waiver or reduction within 45 days after the department mails the notice of the surcharge.

[194] This amendment provides that forfeitures will be changed to surcharges and interest on unpaid surcharges will be deposited in the Work Injury Supplemental Benefit Fund. 2005 Wis. Act 172, effective April 1, 2006.

need. Sub. (3) does not contain "accommodation" requirements and does not require an employer to change its legitimate and long-standing safety policies in order to assist an employee in meeting personal obligations. DeBoer Transportation, Inc. v. Swenson, 2011 WI 64, 335 Wis. 2d 599, 804 N.W.2d 658, 09-0564.

Neither sub. (2) nor case law authorizes employees who are terminated for filing worker's compensation claims to bring wrongful discharge claims against their employers. Brown v. Pick 'n Save Food Stores, 138 F. Supp. 2d 1133 (2001).

102.37 Employers' records. Every employer of 3 or more persons and every employer who is subject to this chapter shall keep a record of all accidents causing death or disability of any employee while performing services growing out of and incidental to the employment. This record shall give the name, address, age, and wages of the deceased or injured employee, the time and causes of the accident, the nature and extent of the injury, and any other information the department may require by rule or general order. Reports based upon this record shall be furnished to the department at such times and in such manner as the department may require by rule or general order, in a format approved by the department.

History: 1975 c. 147 s. 54; 1985 a. 83; 2001 a. 37.

102.38 Records and reports of payments. Every insurance company that transacts the business of compensation insurance, and every employer who is subject to this chapter, but whose liability is not insured, shall keep a record of all payments made under this chapter and of the time and manner of making the payments and shall furnish reports based upon these records and any other information to the department as the department may require by rule or general order, in a format approved by the department.

History: 1975 c. 147 s. 54; 1975 c. 199; 1979 c. 89; 1985 a. 83; 2001 a. 37.

102.39 Rules and general orders; application of statutes. The provisions of s. 103.005 relating to the adoption, publication, modification, and court review of rules or general orders of the department shall apply to all rules promulgated or general orders adopted under this chapter.

History: 1995 a. 27; 2001 a. 37.

102.40 Reports not evidence in actions. Reports furnished to the department pursuant to ss. 102.37 and 102.38 shall not be admissible as evidence in any action or proceeding arising out of the death or accident reported.

102.42 Incidental compensation.

(1) TREATMENT OF EMPLOYEE. The employer shall supply such medical, surgical, chiropractic, psychological, podiatric, dental, and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances, and training in the use of artificial members and appliances, or, at the option of the employee, Christian Science treatment in lieu of medical treatment, medicines, and medical supplies, as may be reasonably required to cure and relieve from the effects of the injury, and to attain efficient use of artificial members and appliances, and in case of the employer's neglect or refusal seasonably to do so, or in emergency until it is practicable for the employee to give notice of injury, the employer shall be liable for the reasonable expense incurred by or on behalf of the employee in providing such treatment, medicines, supplies, and training. When the employer has knowledge of the injury and the necessity for treatment, the employer's failure to tender the necessary treatment, medicines, supplies, and training constitutes such neglect or refusal. The employer shall also be liable for reasonable expense incurred by the employee for necessary treatment to cure and relieve the employee from the effects of occupational disease prior to the time that the employee knew or should have known the nature of his or her disability and its relation to employment, and as to such treatment subs. (2) and (3) shall not apply. The obligation to furnish such treatment and appliances shall continue as required to prevent further deterioration in the condition of the employee or to maintain the existing status of such condition whether or not healing is completed.[195]

(1m) LIABILITY FOR UNNECESSARY TREATMENT. If an employee who has sustained a compensable injury undertakes in good faith invasive treatment that is generally medically acceptable, but that is unnecessary, the employer shall pay disability indemnity for all disability incurred as a result of that treatment. An employer is not liable for disability indemnity for any disability incurred as a result of any unnecessary treatment undertaken in good faith that is noninvasive or not medically acceptable.[196] This subsection applies to all findings that an employee has sustained a compensable injury, whether the finding results from a hearing, the default of a party, or a compromise or stipulation confirmed by the department or the division.

(2) CHOICE OF PRACTITIONER.

(a) When the employer has notice of an injury and its relationship to the employment, the employer shall offer to the injured employee his or her choice of any physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber,[197] or podiatrist licensed to practice and practicing in this state for treatment of the injury. By mutual agreement, the employee may have the choice of any qualified practitioner not licensed in this state. In case of emergency, the employer may arrange for treatment without tendering a choice. After the emergency has passed the employee shall be given his or her choice of attending practitioner at the earliest opportunity. The employee has the right to a 2nd choice of attending practitioner on notice to the employer or its insurance carrier. Any further choice shall

[195] Medical treatment when necessary is to be provided regardless of whether or not indemnity is payable or whether indemnity disability has ceased. There is provision for payment of expense for treatment procured by an employee who does not learn until later of the nature of his or her disability, or its relation to employment. Formerly, no liability would have existed unless and until notice of injury had been given. In such cases as tuberculosis following silicosis, this worked hardship on an employee who, although reasonably diligent, could not give notice of necessity for treatment because the employee had not yet learned the nature of his or her disability and its relation to employment. The obligation to provide treatment continues even after a final order has been issued. See Lisney v. LIRC, 171 Wis.2d 499 (1992).

[196] This subsection was created by 2001 Wis. Act 37, effective January 1, 2002. The intent is to modify the holding in Spencer v. DILHR, 55 Wis.2d 525 (1972), in response to the decision in Honthaners Restaurants Inc. v. LIRC, 240 Wis.2d 234 (Ct. App. 2000). The intent is to permit insurance carriers and self-insured employers to use examining practitioner's opinions to defeat liability for compensation for indemnity in an otherwise conceded case that is a consequence of non-invasive unnecessary treatment even if the employee underwent the unnecessary treatment in good faith. It was not intended that this subsection modify the holding in City of Wauwatosa v. LIRC, 110 Wis.2d 298 (1982).

[197] 2003 Wis. Act 144, effective March 30, 2004, provides that physician assistants and advanced practice nurse prescribers are included as practitioners employees may select for treatment.

be by mutual agreement. Partners and clinics are considered to be one practitioner. Treatment by a practitioner on referral from another practitioner is considered to be treatment by one practitioner.[198]

(b) The employer is liable for the expense of reasonable travel to obtain treatment at the same rate as is provided for state officers and employees under s. 20.916 (8). The employer is not liable for the expense of unreasonable travel to obtain treatment.[199]

(3) PRACTITIONER CHOICE UNRESTRICTED. If the employer fails to tender treatment as provided in sub. (1) or choice of an attending practitioner as provided in sub. (2), the employee's right to choose the attending practitioner is not restricted and the employer is liable for the reasonable and necessary expense thereof.[200]

(4) CHRISTIAN SCIENCE. The liability of an employer for the cost of Christian Science treatment provided to an injured employee is limited to the usual and customary charge for that treatment.[201]

(5) ARTIFICIAL MEMBERS. Liability for repair and replacement of prosthetic devices is limited to the effects of normal wear and tear. Artificial members furnished at the end of the healing period for cosmetic purposes only need not be duplicated.

(6) TREATMENT REJECTED BY EMPLOYEE. Unless the employee has elected Christian Science treatment in lieu of medical, surgical, dental, or hospital treatment, no compensation shall be payable for the death or disability of an employee, if the death is caused, or insofar as the disability may be aggravated, caused, or continued by an unreasonable refusal or neglect to submit to or follow any competent and reasonable medical, surgical, or dental treatment or, in the case of tuberculosis, by refusal or neglect to submit to or follow hospital or medical treatment when found by the department or the division to be necessary. The right to compensation accruing during a period of refusal or neglect to submit to or follow hospital or medical treatment when found by the department or the division to be necessary in the case of tuberculosis shall be barred, irrespective of whether disability was aggravated, caused, or continued by that refusal or neglect.

(8) AWARD TO STATE EMPLOYEE. Whenever the department or the division makes an award on behalf of a state employee, the department or the division shall file duplicate copies of the award with the subunit of the department of administration responsible for risk management. Upon receipt of the copies of the award, the department of administration shall promptly issue a voucher in payment of the award from the proper appropriation under s. 20.865 (1) (fm), (kr) or (ur), and shall transmit one copy of the voucher and the award to the officer, department, or agency by whom the affected employee is employed.

(9) REHABILITATION; PHYSICAL AND VOCATIONAL.

(a) One of the primary purposes of this chapter is restoration of an injured employee to gainful employment. To this end, the department shall employ a specialist in physical, medical and vocational rehabilitation.

(b) Such specialist shall study the problems of rehabilitation, both physical and vocational and shall refer suitable cases to the department for vocational evaluation and training. The specialist shall investigate and maintain a directory of such rehabilitation facilities, private and public, as are capable of rendering competent rehabilitation service to seriously injured employees.

(c) The specialist shall review and evaluate reported injuries for potential cases in which seriously injured employees may be in need of

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[198] Effective January 1, 2000, an employee's right to out-of-state treatment when referred by an in-state practitioner is not limited by a requirement for prior approval by the employer or carrier. See UFE Inc. v. LIRC, 201 Wis.2d 274 (1996). A restrictive amendment enacted in Chapter 38, Laws of 1997, effective January 1, 1998, expired January 1, 2000.

[199] This amendment codifies the department's policy of setting the mileage reimbursement rate that employees receive for travel to obtain treatment at the same rate state employees receive for business travel. 2005 Wis. Act 172, effective April 1, 2006. A listing of applicable mileage rates is set forth at the back of this publication.

[200] The intent is to allow complete free choice of practitioner rather than using restrictive panels, which had been allowed in the past.

[201] With this amendment employers are no longer permitted to elect not to have their employees covered by Christian Science treatment and fees for Christian Science treatment are limited to usual and customary charges. 2007 Wis. Act 185, effective April 1, 2008.

physical and medical rehabilitation and may confer with the injured employee, employer, insurance carrier or attending practitioner regarding treatment and rehabilitation.

History: 1971 c. 61; 1973 c. 150, 282; 1975 c. 147; 1977 c. 195 ss. 24 to 28, 45; 1977 c. 273; 1979 c. 278; 1981 c. 20; 1987 a. 179; 1989 a. 64; 1995 a. 27 ss. 3743m, 3744, 9130 (4); 1997 a. 3, 38; 1999 a. 9; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2007 a. 185; 2015 a. 55.

The requirement that medical treatment be supplied during the healing period, defined as prior to the time the condition becomes stationary, is not determined by reference to the percentage of disability, but by a determination that the injury has stabilized. Custodial care, as distinguished from nursing services, is not compensable. Mednicoff v. DILHR, 54 Wis. 2d 7, 194 N.W.2d 670 (1972).

In appropriate cases, the department may postpone a determination of permanent disability for a reasonable period until after a claimant completes a competent and reasonable course of physical therapy or vocational rehabilitation as an essential part of the treatment required for full recovery and minimization of damages. Transamerica Insurance Co. v. DILHR, 54 Wis. 2d 272, 195 N.W.2d 656 (1972).

An employee who wishes to consult a second doctor on the panel after the first says no further treatment is needed may do so without notice or consent. If the second doctor prescribes an operation that increases the amount of disability, the employer is liable. Spencer v. DILHR, 55 Wis. 2d 525, 200 N.W.2d 611 (1972).

Sub. (7) [now sub. (6)] relieves an employer of liability when the employee refuses treatment provided by the employer, as required under sub. (1). An employee is not required to seek treatment from someone other than the employer. Klein Industrial Salvage v. DILHR, 80 Wis. 2d 457, 259 N.W.2d 124 (1972).

Under ss. 102.42 (9) (a), 102.43 (5), and 102.61, the department may extend temporary disability, travel expense, and maintenance costs beyond 40 weeks if additional training is warranted. Beloit Corporation v. State, 152 Wis. 2d 579, 449 N.W.2d 299 (Ct. App. 1989).

Sub. (1) requires an employer to pay medical expenses even after a final order has been issued. Lisney v. LIRC, 171 Wis. 2d 499, 493 N.W.2d 14 (1992).

Sub. (2) (a) does not require an employer to consent to out-of-state health care expenses that result from a referral by an in-state practitioner selected in accordance with the statute. UFE Inc. v. LIRC, 201 Wis. 2d 274, 548 N.W.2d 57 (1996), 94-2794.

The continuing obligation to compensate an employee for work related medical expenses under s. 102.42 does not allow agency review of compromise agreements after the one-year statute of limitations in s. 102.16 (1) has run if the employee incurs medical expenses after that time. Schenkoski v. LIRC, 203 Wis. 2d 109, 552 N.W.2d 120 (Ct. App. 1996), 96-0051.

Under sub. (2), an employee can seek reimbursement for expenses related to 2 practitioners regardless of whether they are the first 2 practitioners whom the employee has seen. Hermax Carpet Marts v. LIRC, 220 Wis. 2d 611, 583 N.W.2d 662 (Ct. App. 1998), 97-1119.

Section 102.01 (2) (g) sets the date of injury of an occupational disease and s. 102.01 (1) provides that medical expenses incurred before an employee knows of the work-related injury are compensable. Read together, medical expenses in occupational disease cases are not compensable until the date of injury, but once the date is established all expenses associated with the disease, even if incurred before the date of injury, are compensable. United Wisconsin Insurance Co. v. LIRC, 229 Wis. 2d 416, 600 N.W.2d 186 (Ct. App. 1999), 97-3776.

Spencer creates an exception to the general rule that compensation is permitted only if medical expenses are reasonably required and necessary. As long as a claimant engages in unnecessary and unreasonable treatment in good faith, the employer is responsible for payment. Honthaners Restaurants, Inc. v. LIRC, 2000 WI App 273, 240 Wis. 2d 234, 621 N.W.2d 660, 99-3002.

Continuing Payments for Medical Expenses in Worker's Compensation Proceedings. Carnell & Woog. Wis. Law. Nov. 1993.

102.425 Prescription and nonprescription drug treatment.[202]

(1) DEFINITIONS. In this section:

(a) "Dispense" has the meaning given in s. 450.01 (7).

(b) "Drug" has the meaning given in s. 450.01 (10).

(c) "Drug product equivalent" has the meaning given in s. 450.13 (1).

(cm) "Licensed pharmacy" means a pharmacy licensed under s. 450.06 or 450.065.[203]

(d) "Nonprescription drug product" has the meaning given in s. 450.01 (13m).

(e) "Pharmacist" has the meaning given in s. 450.01 (15).

(f) "Practitioner" has the meaning given in s. 450.01 (17).

(g) "Prescription" has the meaning given in s. 450.01 (19).

(h) "Prescription drug" has the meaning given in s. 450.01 (20).

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[202] 2005 Wis. Act 172, effective April 1, 2006, creates a pharmacy fee schedule that limits charges to the average wholesale price, plus a $3 dispensing fee and applicable state and federal taxes. This amendment encourages the use of generic drugs and prohibits balance billing employees for charges over fee schedule amounts.

[203] Reimbursement for medications dispensed outside of a licensed pharmacy shall be limited to the pharmacy fee schedule and the existing dispensing fee, ss. 102.425 (1) (cm) & (3) (a). This definition was created by 2015 Wis. Act 180, effective March 2, 2016.

(i) "Prescription order" has the meaning given in s. 450.01 (21).

(2) SUBSTITUTION OF DRUG PRODUCT EQUIVALENTS.

(a) Except as provided in pars. (b) and (c), when a drug is prescribed to treat an injury for which an employer or insurer is liable under this chapter, the pharmacist or practitioner dispensing the drug shall substitute a drug product equivalent in place of the prescribed drug if all of the following apply:

1. In the professional judgment of the dispensing pharmacist or practitioner, the drug product equivalent is therapeutically equivalent to the prescribed drug.

2. The charge for the drug product equivalent is less than the charge for the prescribed drug.

(b) A pharmacist or practitioner may not substitute a drug product equivalent under par. (a) in place of a prescribed drug if any of the following apply:

1. The prescribed drug is a single-source patented drug for which there is no drug product equivalent.

2. The prescriber determines that the prescribed drug is medically necessary and indicates that no substitution may be made for that prescribed drug by writing on the face of the prescription order or, in the case of a prescription order that is transmitted electronically, by designating in electronic format the phrase "No substitutions" or "Dispense as written" or words of similar meaning or the initials "N.S." or "D.A.W."

(c) Unless par. (b) applies, if an injured employee requests that a specific brand name drug be used to treat the employee's injury, the pharmacist or practitioner dispensing the prescription shall dispense the specific brand name drug as requested. If a specific brand name drug is dispensed under this paragraph, the employer or insurer and the employee shall share the cost of the prescription as follows:

1. The employer or insurer shall be liable in an amount equal to the average wholesale price, as determined under sub. (3) (a) 1., of the lowest-priced drug product equivalent that the pharmacist or practitioner has in stock on the day on which the brand name drug is dispensed, plus the dispensing fee under sub. (3) (a) 2. and any applicable taxes under sub. (3) (a) 3. that would be payable for that drug product equivalent.

2. The employee shall be liable in an amount equal to the difference between the amount for which the employer or insurer is liable under subd. 1. and an amount equal to the average wholesale price, as determined under sub. (3) (a) 1., of the brand name drug on the day on which the brand name drug is dispensed, plus any applicable taxes under sub. (3) (a) 3. that are payable for that brand name drug.

(3) LIABILITY OF EMPLOYER OR INSURER.

(a) The liability of an employer or insurer for the cost of a prescription drug dispensed under sub. (2) for outpatient use by an injured employee, including a prescription drug dispensed outside of a licensed pharmacy, is limited to the sum of all of the following:

1. The average wholesale price of the prescription drug as of the date on which the prescription drug is dispensed, as quoted in the Drug Topics Red Book, published by Medical Economics Company, Inc., or its successor, or, if that book is discontinued and becomes unavailable, as quoted in another nationally recognized pricing source determined by the department.[204]

2. A dispensing fee of $3 per prescription order, which shall be payable for all prescription drugs dispensed under sub. (2) regardless of the location from which the prescription drug is dispensed, but which shall be payable only to a pharmacist who dispenses the prescription drug.

3. Any state or federal taxes that may be applicable to the prescription drug dispensed.

(b) In addition to the liability under par. (a), an employer or insurer is also liable for reimbursement to an injured employee for all out-of-pocket expenses incurred by the injured employee in obtaining the prescription drug dispensed.

(c) A billing statement submitted to an employer or insurer for a prescription drug dispensed under sub. (2) shall include the national drug code number of the prescription as listed in the national drug code directory maintained by the

[204] 2015 Wis. Act 180, effective March 2, 2016, gives the department the authority to locate and utilize a successor to the Drug Topics Red Book if necessary as a reference for determining average wholesale price of prescription drugs.

federal food and drug administration and shall state separately the price of the prescription drug and the dispensing fee.

(4) LIABILITY OF EMPLOYEE.

(a) Except as provided in par. (b), a pharmacist or practitioner who dispenses a prescription drug under sub. (2) to an injured employee may not collect, or bring an action to collect, from the injured employee any charge that is in excess of the liability of the injured employee under sub. (2) (c) 2. or the liability of the employer or insurer under sub. (3) (a).

(b) If an employer or insurer denies or disputes liability for the cost of a drug prescribed to an injured employee under sub. (2), the pharmacist or practitioner who dispensed the drug may collect, or bring an action to collect, from the injured employee the cost of the prescription drug dispensed, subject to the limitations specified in sub. (3) (a). If an employer or insurer concedes liability for the cost of a drug prescribed to an injured employee under sub. (2), but disputes the reasonableness of the amount charged for the prescription drug, the employer or insurer shall provide notice under sub. (4m) (b) to the pharmacist or practitioner that the reasonableness of the amount charged is in dispute and the pharmacist or practitioner who dispensed the drug may not collect, or bring an action to collect, from the injured employee the cost of the prescription drug dispensed after receiving that notice.

(4m) RESOLUTION OF PRESCRIPTION DRUG CHARGE DISPUTES.[205]

(a) The department has jurisdiction under this subsection, the department and the division have jurisdiction under s. 102.16 (1m) (c), and the division has jurisdiction under s. 102.17 to resolve a dispute between a pharmacist or practitioner and an employer or insurer over the reasonableness of the amount charged for a prescription drug dispensed under sub. (2) for outpatient use by an injured employee who claims benefits under this chapter.

(b) An employer or insurer that disputes the reasonableness of the amount charged for a prescription drug dispensed under sub. (2) for outpatient use by an injured employee or the department or division under sub. (4) (b) or s. 102.16 (1m) (c) or 102.18 (1) (bg) 3. shall provide, within 30 days after receiving a completed bill for the prescription drug, reasonable written notice to the pharmacist or practitioner that the charge is being disputed.[206] After receiving reasonable written notice under this paragraph or under sub. (4) (b) or s. 102.16 (1m) (c) or 102.18 (1) (bg) 3. that a prescription drug charge is being disputed, a pharmacist or practitioner may not collect the disputed charge from, or bring an action for collection of the disputed charge against, the employee who received the prescription drug.

(c) A pharmacist or practitioner that receives notice under par. (b) that the reasonableness of the amount charged for a prescription drug dispensed under sub. (2) for outpatient use by an injured employee is in dispute shall file the dispute with the department within 6 months after receiving that notice.

(d) The department shall deny payment of a prescription drug charge that the department determines under this subsection to be unreasonable. A pharmacist or practitioner and an employer or insurer that are parties to a dispute under this subsection over the reasonableness of a prescription drug charge are bound by the department's determination under this subsection on the reasonableness of the disputed charge, unless that determination is set aside on judicial review as provided in par. (e).

(e) Within 30 days after a determination under this subsection, the department may set aside, reverse, or modify the determination for any reason that the department considers sufficient. Within 60 days after a determination under this subsection, the department may set aside, reverse, or modify the determination on grounds of mistake. A pharmacist, practitioner, employer, or insurer that is aggrieved by a determination of the department under this subsection may seek judicial review of that

[205] 2007 Wis. Act 185, effective April 1, 2008 creates a dispute resolution process for resolving disputes involving the pharmacy fee schedule that is similar to the process used for reasonableness of fee disputes.

[206] This amendment provides the requirement for written notice by an insurance carrier or self-insured employer to a health care provider that the reasonableness of the amount charged for a prescription drug is being disputed. 2009 Wis. Act 206, effective May 1, 2010.

determination in the same manner that compensation claims are reviewed under s. 102.23.

(5) NONPRESCRIPTION DRUG PRODUCTS. The liability of an employer or insurer for the cost of a nonprescription drug product used to treat an injured employee is limited to the usual and customary charge to the general public for the nonprescription drug product.

History: 2005 a. 172; 2007 a. 185; 2009 a. 206; 2015 a. 55, 180.

102.43 Weekly compensation schedule. If the injury causes disability, an indemnity shall be due as wages commencing the 4th calendar day from the commencement of the day the scheduled work shift began, exclusive of Sundays only, excepting where the employee works on Sunday, after the employee leaves work as the result of the injury, and shall be payable weekly thereafter, during such disability. If the disability exists after 7 calendar days from the date the employee leaves work as a result of the injury and only if it so exists, indemnity shall also be due and payable for the first 3 calendar days, exclusive of Sundays only, excepting where the employee works on Sunday. Said weekly indemnity shall be as follows:

(1) If the injury causes total disability, two-thirds of the average weekly earnings during such disability.

(2) If the injury causes partial disability, during the partial disability, such proportion of the weekly indemnity rate for total disability as the actual wage loss of the injured employee bears to the injured employee's average weekly wage at the time of the injury.[207]

(3) If the disability caused by the injury is at times total and at times partial, the weekly indemnity during each total or partial disability shall be in accordance with subs. (1) and (2), respectively.

(4) If the disability period involves a fractional week, indemnity shall be paid for each day of such week, except Sundays only, at the rate of one-sixth of the weekly indemnity.[208]

(5) (a) Temporary disability, during which compensation shall be payable for loss of earnings, shall include such period as may be reasonably required for training in the use of artificial members and appliances.

(b) Except as provided in s. 102.61 (1g), temporary disability shall also include such period as the employee may be receiving instruction under s. 102.61 (1) or (1m). Temporary disability on account of receiving instruction under s. 102.61 (1) or (1m), and not otherwise resulting from the injury, shall not be in excess of 80 weeks. That 80-week limitation does not apply to temporary disability benefits under this section, the cost of tuition, fees, books, travel, or maintenance under s. 102.61 (1), or the cost of private rehabilitation counseling or rehabilitative training under s. 102.61 (1m) if the department or the division determines that additional training is warranted. The necessity for additional training as authorized by the department or the division for any employee shall be subject to periodic review and reevaluation.

(c) Compensation for temporary disability on account of receiving instruction under s. 102.61 (1) or (1m) shall not be reduced under sub. (2) on account of any wages earned for the first 24 hours worked by an employee during a week in which the employee is receiving that instruction. If an employee performs more than 24 hours of work during a week in which the employee is receiving that instruction, all wages earned for hours worked in excess of 24 during that week shall be offset against the employee's average weekly wage in calculating compensation for temporary disability under sub. (2). An employee who is receiving compensation for temporary disability on account of receiving instruction under s. 102.61 (1) or (1m) shall report any wages earned during the period in which the employee is receiving that instruction

[207] In case of partial disability occasioning a wage loss, proportionate compensation is paid. For example: If an employee earns 50 percent of his or her wage, the employee would also be entitled to 50 percent of the compensation due for temporary total disability.

[208] Compensation is to be paid for each day of disability except Sunday, regardless of whether or not the day of disability is a working day. Payment for each day is to be made uniformly at the rate of 1/6 of the weekly indemnity regardless of the number of days per week, which the employee works.

to the insurance carrier or self-insured employer paying that compensation.[209]

(6) (a) Except as provided in par. (b), no sick leave benefits provided in connection with other employment or wages received from other employment held by the employee when the injury occurred may be considered in computing actual wage loss from the employer in whose employ the employee sustained injury.[210]

(b) In the case of an employee whose average weekly earnings are calculated under s. 102.11 (1) (a), wages received from other employment held by the employee when the injury occurred shall be considered in computing actual wage loss from the employer in whose employ the employee sustained the injury as provided in this paragraph. If an employee's average weekly earnings are calculated under s. 102.11 (1) (a), wages received from other employment held by the employee when the injury occurred shall be offset against those average weekly earnings and not against the employee's actual earnings in the employment in which the employee was engaged at the time of the injury.

(c) Wages received from the employer in whose employ the employee sustained injury or from other employment obtained after the injury occurred shall be considered in computing benefits for temporary disability.

(7) (a) If an employee has a renewed period of temporary disability commencing more than 2 years after the date of injury and, except as provided in par. (b), the employee returned to work for at least 10 days preceding the renewed period of disability, payment of compensation for the new period of disability shall be made as provided in par. (c).

(b) An employee need not return to work at least 10 days preceding a renewed period of temporary disability to obtain benefits under sub. (5) (b) for rehabilitative training commenced more than 2 years after the date of injury. Benefits for rehabilitative training shall be made as provided in par. (c).

(c) 1. If the employee was entitled to maximum weekly benefits at the time of injury, payment for the renewed temporary disability or the rehabilitative training shall be at the maximum rate in effect at the commencement of the new period.[211]

2. If the employee was entitled to less than the maximum rate, the employee shall receive the same proportion of the maximum which is in effect at the time of the commencement of the renewed period or the rehabilitative training as the employee's actual rate at the time of injury bore to the maximum rate in effect at that time.[212]

3. For an employee who is receiving rehabilitative training, a holiday break, semester break or other, similar scheduled interruption in a course of instruction does not commence a

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[209] 2015 Wis. Act 180, effective March 2, 2016, provides that a person receiving compensation for vocational rehabilitation training will not have a reduction in the temporary disability rate for wages earned in the first 24 hours of part-time employment. Employees will be required to report all wages earned to the WC carriers and self-insured employers for each week they are receiving compensation for training under this provision. The previous sunset on this provision is eliminated.

[210] With the enactment of Chapter 83, Laws of 1985, effective November 27, 1985 earnings from a second job in which the employee was also engaged at the time of injury are not considered in determining the temporary disability benefits due. However, a part-time employee who does not restrict his or her availability on the labor market does have his or her wage expanded for purposes of computing the weekly temporary total disability rate per s. 102.11(1)(a) to the wage of a full-time employee. The amendment in Chapter 79, Laws of 1987, effective April 1, 1988, provides that if this part-time employee with the expanded compensation wage is employed and returns to work for another employer while unable to work for the employer for whom he or she was working at the time of the injury, the wages earned from that second employer will be used to reduce the employee's compensation from temporary total disability to temporary partial disability. The wages paid by the second employer can again be factored into the computation made to determine the amount of compensation due for temporary partial disability. The amendment in 2001 Wis. Act 37, effective January 1, 2002, provides that the compensation for temporary disability will be offset by the expanded wage against the second employer rather than the actual wage.

[211] This clarifies that the escalated temporary total disability rate for renewed periods of temporary disability more than two years after the date of injury applies to temporary partial as well as temporary total disability.

[212] This is intended to correct the situation where the employee has one or more additional periods of disability more than two years after the date of injury. In such cases the new rate in effect at the time of the later disability will apply. Before the new rates apply, the employee must actually have returned to work for ten days.

new period of rehabilitative training under this paragraph.[213]

(8) During a compulsory vacation period scheduled in accordance with a collective bargaining agreement:

(a) Regardless of whether the employee's healing period has ended, no employee at work immediately before the compulsory vacation period may receive a temporary total disability benefit for injury sustained while engaged in employment for that employer.[214]

(b) An employee receiving temporary partial disability benefits immediately before the compulsory vacation period for injury sustained while engaged in employment for that employer shall continue to receive those benefits.[215]

(9) Temporary disability, during which compensation shall be payable for loss of earnings, shall include the period during which an employee could return to a restricted type of work during the healing period, unless any of the following apply:

(a) Suitable employment that is within the physical and mental limitations of the employee is furnished to the employee by the employer or some other employer. For purposes of this paragraph, if the employer or some other employer makes a good faith offer of suitable employment that is within the physical and mental limitations of the employee and if the employee refuses without reasonable cause to accept that offer, the employee is considered to have returned to work as of the date of the offer at the earnings that the employee would have received but for the refusal. In case of a dispute as to the extent of an employee's physical or mental limitations or as to what employment is suitable within those limitations, the employee may file an application under s. 102.17 and ss. 102.17 to 102.26 shall apply.

(b) The employee's employment with the employer has been suspended or terminated due to the employee's alleged commission of a crime, the circumstances of which are substantially related to that employment, and the employee has been charged with the commission of that crime. If the employee is not found guilty of the crime, compensation for temporary disability shall be payable in full.

(c) The employee's employment with the employer has been suspended or terminated due to the employee's violation of the employer's policy concerning employee drug use during the period when the employee could return to a restricted type of work during the healing period. Compensation for temporary disability may be denied under this paragraph only if prior to the date of injury the employer's policy concerning employee drug use was established in writing and regularly enforced by the employer.

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[213] For example, the TTD rate established at the commencement of a multi-year course of instruction would not increase due to a semester or holiday break in the school calendar.

[214] This amendment clarifies that the employee must actually be working rather than just in employment status to be barred from receiving temporary total disability benefits during the defined compulsory vacation period.

[215] If the collective bargaining agreement provides a compulsory vacation shutdown an injured employee working within the healing period at the time of the shutdown is not entitled to temporary total disability benefits, but may be entitled to temporary partial disability benefits. For purposes of temporary partial disability compensation, wage loss will be based on the earnings in the week prior to the shutdown.

(d) The employee has been convicted of a crime, is incarcerated, and is not available to return to a restricted type of work during the healing period.[216]

(e) The employee's employment with the employer has been suspended or terminated due to misconduct, as defined in s. 108.04 (5), or substantial fault, as defined in s. 108.04 (5g) (a), by the employee connected with the employee's work.

History: 1971 c. 148; 1973 c. 150; 1975 c. 147; 1977 c. 195; 1979 c. 278; 1983 a. 98; 1985 a. 83; 1987 a. 179; 1993 a. 370, 492; 1995 a. 225, 413; 2001 a. 37; 2005 a. 172; 2009 a. 206; 2011 a. 183; 2015 a. 55, 180.

Committee Note, 1971: Employees who have two jobs who have been injured at one of them have in some cases been made totally disabled for work at either job. Sick leave benefits from the other employer has suspended eligibility for compensation or has reduced compensation even though the employee suffered a wage loss. This is considered to be inequitable. Sick leave benefits from the employer where injury occurred are to be considered, however, in determining eligibility for compensation from such employer. [Bill 371-A]

Under ss. 102.42 (9) (a), 102.43 (5), and 102.61, the department may extend temporary disability, travel expense, and maintenance costs beyond 40 weeks if additional training is warranted. Beloit Corp. v. State, 152 Wis. 2d 579, 449 N.W.2d 299 (Ct. App. 1989).

The phrase "if the injury causes disability" is interpreted in light of the "as is" rule that an employee's susceptibility to injury due to a pre-existing condition does not relieve the employer from liability. ITW Deltar v. LIRC, 226 Wis. 2d 11, 593 N.W.2d 908 (Ct. App. 1999), 98-2912.

The "as is" rule applies to delays in treatment of a work-related injury caused by a pre-existing condition. It was reasonable to find that a woman was entitled to benefits for the period she was unable to undergo surgery to repair a work-related injury due to the threat that anesthesia would cause harm to her pre-existing pregnancy. ITW Deltar v. LIRC, 226 Wis. 2d 11, 593 N.W.2d 908 (Ct. App. 1999), 98-2912.

102.44 Maximum limitations. Section 102.43 shall be subject to the following limitations:

(1) (ag) Notwithstanding any other provision of this chapter, every employee who is receiving compensation under this chapter for permanent total disability or continuous temporary total disability more than 24 months after the date of injury resulting from an injury that occurred prior to January 1, 2003, shall receive supplemental benefits that shall be payable by the employer or the employer's insurance carrier, or in the case of benefits payable to an employee under s. 102.66, shall be paid by the department out of the fund created under s. 102.65. Those supplemental benefits shall be paid only for weeks of disability occurring after January 1, 2005, and shall continue during the period of such total disability subsequent to that date.

(am) If the employee is receiving the maximum weekly benefits in effect at the time of the injury, the supplemental benefit for a week of disability occurring after March 2, 2016, shall be an amount that, when added to the regular benefit established for the case, shall equal $669.[217]

[216] This subsection was created by 2005 Wis. Act 172, effective April 1, 2006 and codifies an employer's liability for benefits to an employee when the employee is released by his or her doctor to return to restricted work during the healing period, as formerly found in Rule DWD 80.47 and as interpreted in Brakebush Brothers, Inc. v. LIRC, 210 Wis. 2d 623 (1997). In general, terminations of employment are not a defense to liability for temporary disability benefits. There are 5 exceptions to that general rule: (1) the employee refused suitable restricted duty employment without reasonable cause; (2) the employee committed a crime connected to the employment; (3) the employee violated the employer's previously established and enforced written drug policy; (4) the employee was unavailable for restricted work due to incarceration following the conviction of a crime; and (5) the employee's employment was suspended or terminated due to misconduct as defined in s. 108.04(5) or substantial fault as defined in s. 108.04(5g)(a) connected with the employee's employment. On the question of whether there is an offer of suitable restricted duty employment based on competing medical limitations applicable to the employee under par. (a), a hearing should be conducted to determine the appropriate restrictions and liability for benefits resulting from the application of such restrictions. The amendment pertaining to unavailability for restrictive work because of incarceration due to conviction of a crime was created by 2009 Wis. Act 206, effective May 1, 2010. The amendment pertaining to suspension or termination of an employee's employment due to misconduct or substantial fault was created by 2015 Wis. Act 180, effective March 2, 2016. DWD 80.47 applies to injuries occurring before the effective dates of the amendments.

[217] 2015 Wis. Act 180, effective March 2, 2016, amended s. 102.44(1) to extend supplemental benefits to employees with injuries that occurred prior to January 1, 2003, who are permanently disabled or receiving continuous temporary disability for more than 24 months after the date of injury. The maximum weekly benefit rate for supplemental benefits is increased from $582 to $669. Persons receiving less than the maximum rate for dates of injury prior to January 1, 2003, receive the same percent of $669 that their compensation rate bears to the maximum rate in effect at the time of their injury.

(b) If the employee is receiving a weekly benefit that is less than the maximum benefit that was in effect on the date of the injury, the supplemental benefit for a week of disability occurring after March 2, 2016, shall be an amount sufficient to bring the total weekly benefits to the same proportion of $669 as the employee's weekly benefit bears to the maximum in effect on the date of injury.

(c) 1. An insurance carrier paying the supplemental benefits required under this subsection shall be entitled to reimbursement for each such case from the worker's compensation operations fund, commencing one year after the date of the first payment of those benefits and annually thereafter while those payments continue. To receive reimbursement under this paragraph, an insurance carrier must file a claim for that reimbursement with the department by no later than 12 months after the end of the year in which the supplemental benefits were paid and the claim must be approved by the department.[218]

2. After the expiration of the deadline for filing a claim under subd. 1., the department shall determine the total amount of all claims filed by that deadline and shall use that total to determine the amount to be collected under s. 102.75 (1g) from each licensed worker's compensation insurance carrier, deposited in the worker's compensation operations fund, and used to provide reimbursement to insurance carriers paying supplemental benefits under this subsection. Subject to subd. 3., the department shall pay a claim for reimbursement approved by the department by no later than 16 months after the end of the year in which the claim was received by the department.[219]

3. The maximum amount that the department may pay under subd. 2. in a calendar year is $5,000,000. If the amount determined payable under subd. 2. in a calendar year is $5,000,000 or less, the department shall pay that amount. If the amount determined payable under subd. 2. in a calendar year exceeds $5,000,000, the department shall pay $5,000,000 in the year in which the determination is made and, subject to the maximum amount payable of $5,000,000 per calendar year, shall pay the excess in the next calendar year or in subsequent calendar years until that excess is paid in full. The department shall pay claims for reimbursement under subd. 2. in the chronological order in which those claims are received.[220]

4. This paragraph does not apply to supplemental benefits paid for an injury that occurs on or after January 1, 2016.[221]

(2) In case of permanent total disability, aggregate indemnity shall be weekly indemnity for the period that the employee may live. Total impairment for industrial use of both eyes, the loss of both arms at or near the shoulder, the loss of both legs at or near the hip, or the loss of one arm at the shoulder and one leg at the hip constitutes permanent total disability. This enumeration is not exclusive, but in other cases the division shall find the facts.

(3) For permanent partial disability not covered by ss. 102.52 to 102.56, the aggregate number of weeks of indemnity shall bear such relation to 1,000 weeks as the nature of the injury bears to one causing permanent total disability and shall be payable at the rate of two-thirds of the

[218] An insurance carrier that has paid supplemental benefits can seek reimbursement of those payments if the request is made no later than 12 months after the end of the year in which the benefits were paid.

[219] When an insurance carrier makes a timely claim for reimbursement of supplemental benefits payments, the department will make the reimbursement within 16 months of the end of the year in which the claim for reimbursement was received by the department. 2015 Wis. Act 180, effective March 2, 2016.

[220] 2015 Wis. Act 55, effective January 1, 2016, terminates reimbursement from the Work Injury Supplemental Benefit Fund for supplemental benefits paid by employers and insurance carriers effective January 1, 2016. Reimbursement for supplemental benefits for injuries occurring before that date will be made to the insurance carriers from the worker's compensation operations fund under s. 102.75(1g). The maximum amount the department may pay for reimbursement in a calendar year is $5,000,000. If the amount payable in a calendar year exceeds $5,000,000 the department will pay that amount in the year in which the determination is made and subject to the $5,000,000 maximum amount per calendar year, shall pay the excess in the next calendar year or in subsequent calendar years until the excess is paid in full. The department will pay claims for reimbursement in the chronological order in which the claims were received.

[221] Supplemental benefit reimbursement payments will not be made for injuries occurring on and after January 1, 2016, and worker's compensation insurance carriers and self-insured employers will be responsible to make supplemental benefit payments without receiving reimbursement. 2015 Wis. Act 55, effective January 1, 2016.

average weekly earnings of the employee, the earnings to be computed as provided in s. 102.11.[222] The weekly indemnity shall be in addition to compensation for the healing period and shall be for the period that the employee may live, not to exceed 1,000 weeks.

(4) Where the permanent disability is covered by ss. 102.52, 102.53, and 102.55,[223] such sections shall govern; provided, that in no case shall the percentage of permanent total disability be taken as more than 100 percent.

(4m)[224] (a) The department shall promulgate rules establishing minimum permanent disability ratings for amputation levels, losses of motion, sensory losses, and surgical procedures resulting from injuries for which permanent partial disability is claimed under sub. (3) or (4). At least once every 8 years the department shall review and revise those minimum permanent disability ratings as necessary to reflect advances in the science of medicine. Before the department may revise those ratings, the department shall appoint a medical advisory committee under s. 227.13, composed of physicians practicing in one or more areas of specialization or treating disciplines within the medical profession, to review and recommend revision of those ratings, based on typical loss of function, to the department and the council on worker's compensation.

(b) In considering an individual for appointment to the medical advisory committee under par. (a), the department shall consider the individual's training and experience, the number of years the individual has been practicing in the individual's area of specialization or treating discipline, any certifications by a recognized medical specialty board or other agency held by the individual, any recommendations made by organizations that regulate or promote profession standards in the area of specialization or treating discipline in which the individual practices, and any other factors that the department determines are relevant to the individual's knowledge and ability to serve as a member of the medical advisory committee.

(5) In cases where it is determined that periodic benefits granted by the federal social security act are paid to the employee because of disability, the benefits payable under this chapter shall be reduced as follows:[225]

(a) For each dollar that the total monthly benefits payable under this chapter, excluding attorney fees and costs, plus the monthly benefits payable under the social security act for disability exceed 80 percent of the employee's average current earnings as determined by the social security administration, the benefits payable under this chapter shall be reduced by the same amount so that the total benefits payable shall not exceed 80 percent of the employee's average current earnings. However, no total benefit payable under this chapter and under the federal social security act may be reduced to an amount less than the benefit payable under this chapter.

(b) No reduction under this section shall be made because of an increase granted by the social security administration as a cost of living adjustment.

(c) Failure of the employee, except for excusable neglect, to report social security disability payments within 30 days after written request shall allow the employer or insurance carrier to reduce weekly compensation benefits payable under this chapter by 75 percent. Compensation benefits otherwise payable shall be reimbursed to the employee after reporting.

(d) The employer or insurance carrier making such reduction shall report to the department the

[222] Compensation is to be paid at the full weekly rate but is to be proportioned to the total number of weeks provided for permanent partial disability. For example, 10 percent permanent partial disability because of a back injury entitles the injured employee to 100 weeks of compensation. The basis of weekly payment for all compensation cases is uniform.

[223] This provides for applications for the "multiple injury" feature of the law as between scheduled and non-scheduled injuries as well as merely between scheduled injuries.

[224] 2015 Wis. Act 180, effective March 2, 2016, requires the department to create a medical advisory committee to review the minimum permanent disability ratings in s. DWD 80.32, and to review these minimum ratings every 8 years.

[225] This provides that any offset is taken on the compensation benefits rather than on the social security benefits. The injured worker is to receive the same total amount from the combined benefits that he or she would have received before the offset was figured on the worker's compensation benefits but not less than the benefits payable under this chapter. Attorney fees and costs are not offset.

reduction and as requested by the department, furnish to the department satisfactory proof of the basis for the reduction.

(e) The reduction prescribed by this section shall be allowed only as to payments made on or after July 1, 1980, and shall be computed on the basis of payments made for temporary total, temporary partial, permanent total and permanent partial disability.

(f) No reduction shall take into account payments made under the social security act to dependents of an employee.

(g) No reduction under this subsection shall be made on temporary disability benefits payable during a period in which an injured employee is receiving vocational rehabilitation services under s. 102.61 (1) or (1m).[226]

(6) (a) Where an injured employee claiming compensation for disability under sub. (2) or (3) has returned to work for the employer for whom he or she worked at the time of the injury, the permanent disability award shall be based upon the physical limitations resulting from the injury without regard to loss of earning capacity unless the actual wage loss in comparison with earnings at the time of injury equals or exceeds 15 percent.[227]

(b) If during the period set forth in s. 102.17 (4) the employment relationship is terminated by the employer at the time of the injury or by the employee because his or her physical or mental limitations prevent his or her continuing in such employment, or if during that period a wage loss of 15 percent or more occurs, the division may reopen any award and make a redetermination taking into account loss of earning capacity.

(c) The determination of wage loss shall not take into account any period during which benefits are payable for temporary disability.

(d) The determination of wage loss shall not take into account any period during which benefits are paid under ch. 108.

(e) For the purpose of determining wage loss, payment of benefits for permanent partial disability shall not be considered payment of wages.

(f) Wage loss shall be determined on wages, as defined in s. 102.11. Percentage of wage loss shall be calculated on the basis of actual average wages over a period of at least 13 weeks.

(g) For purposes of this subsection, if the employer in good faith makes an offer of employment which is refused by the employee without reasonable cause, the employee is considered to have returned to work with the earnings the employee would have received had it not been for the refusal.

(h) In all cases of permanent partial disability not covered by ss. 102.52 to 102.56, whether or not the employee has returned to work, the permanent partial disability shall not be less than that imposed by the physical limitations.

History: 1971 c. 148; 1973 c. 150; 1975 c. 147 ss. 33, 54, 57; 1975 c. 199; 1977 c. 195; 1979 c. 278; 1981 c. 92; 1983 a. 98; 1991 a. 85; 1995 a. 117; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2007 a. 185; 2009 a. 177, 206; 2011 a. 183, 257; 2015 a. 55, 180.

Cross-reference: See also ss. DWD 80.32, 80.34, and 80.50, Wis. adm. code.

Committee Note, 1971: Employees who are totally disabled receive compensation at the wage level and the compensation rate in effect as of the date of their injury. This is an average of approximately $45.90 per week for the employees who are injured previous to February 1, 1970. The intent is to provide for payment of supplemental benefits; for example, an employee who was injured in October 1951 and earning wages in excess of the maximum of $52.86 is receiving $37 a week for total disability. This employee will receive supplemental benefits of $42 a week to bring the total up to $79, which was the maximum February 1, 1970. An employee injured in October 1951 with a wage of $26.43 has been receiving $18.50 per week for total disability. This is 50 percent of the maximum in effect in October 1951. Such employee will receive supplemental benefits of $21 a week to bring the total up to $39.50, which is 50 percent of the maximum in effect February 1, 1970. It is not intended that any death benefit payment be affected by this section. [Bill 371-A]

The department must disregard total loss of earning capacity in the case of a relative scheduled injury. Mednicoff v. DILHR, 54 Wis. 2d 7, 194 N.W.2d 670 (1972).

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[226] This amendment provides that the social security reverse offset does not apply to compensation payable for vocational rehabilitation training. 2009 Wis. Act 206, effective May 1, 2010.

[227] Section 102.44(6) provides that in cases of non-scheduled injury, permanent partial disability is to be determined on the basis of the physical limitations without regard to loss of earning capacity where the employee has returned to work for the same employer as at the time of injury at a wage loss of less than 15 percent. A good faith offer of employment refused by the employee without reasonable basis has the same effect as actual reemployment. The claims subject to this section including those upon which an award is issued remain open for the period of the statute of limitations in the event that there is a termination of the employment or a wage loss of 15% or more occurs.

The "odd-lot" doctrine is a part of Wisconsin law. It provides that if a claimant makes a prima facie case that he or she was injured in an industrial accident and, because of injury, age, education, and capacity, is unable to secure continuing gainful employment, the burden of showing that the claimant is employable shifts to the employer. Balczewski v. DILHR, 76 Wis. 2d 487, 251 N.W.2d 794 (1977).

Sub. (6) (a) includes only wage loss suffered at the employment where the injury occurred and does not include wage loss from a second job. Ruff v. LIRC, 159 Wis. 2d 239, 464 N.W.2d 56 (Ct. App. 1990).

LIRC exceeded its authority when it ordered temporary total disability payments for an indefinite future period. Such payments are not authorized for the period after a medical condition has stabilized and before the employee undergoes surgery. GTC Auto Parts v. LIRC, 184 Wis. 2d 450, 516 N.W.2d 313 (Ct. App. 1993).

Sub. (4) requires apportionment between scheduled and unscheduled injuries when both contribute to permanent total disability. Loss of earning capacity may not be awarded for scheduled injuries. Langhus v. LIRC, 206 Wis. 2d 494, 557 N.W.2d 450 (Ct. App. 1996), 96-0622.

In order for sub. (6) (b) to apply, the physical limitations must be from an unscheduled injury. Mireles v. LIRC, 226 Wis. 2d 53, 593 N.W.2d 859 (Ct. App. 1999), 98-1607.

Sub. (2) governs the permanent total disability indemnity. "Other cases" of disability under sub. (2) may include a combination of scheduled and unscheduled injuries. Mireles v. LIRC, 2000 WI 96, 237 Wis. 2d 69, 613 N.W.2d 875, 98-1607.

Sub. (6) (b) allows the department to reopen an award to account for loss of earning capacity from an unscheduled injury, even if a scheduled injury causes the termination of employment. Mireles v. LIRC, 2000 WI 96, 237 Wis. 2d 69, 613 N.W.2d 875, 98-1607.

Sub. (2) allows the awarding of permanent total disability that results from a combination of scheduled and unscheduled injuries, provided that the applicant establishes that a clear, ascertainable portion of the disability is attributable to the unscheduled injury or injuries. Secura Insurance v. LIRC, 2000 WI App 237, 239 Wis. 2d 315, 620 N.W.2d 626, 00-0303.

A claimant is not required to present evidence of a job search as part of prima facie case of odd-lot unemployability, provided the claimant shows that because of the injury and other *Balczewski* factors such as age, education, capacity, and training, he or she is unable to secure continuing, gainful employment. If the claimant is within the odd-lot category, it falls to the employer to rebut the prima facie case by demonstrating that the claimant is employable and that jobs exist for him or her. Beecher v. LIRC, 2004 WI 88, 273 Wis. 2d 136, 682 N.W.2d 29, 02-1582.

The burden that shifts from the claimant to the employer under *Balczewski* is a burden of persuasion, but only as to the sub-issue of whether a job exists that the claimant can do. The burden of persuasion on the other aspects of the claimant's case for permanent total disability benefits remains, as always, with the claimant. Beecher v. LIRC, 2004 WI 88, 273 Wis. 2d 136, 682 N.W.2d 29, 02-1582.

Sub. (6) (a) applies to persons "claiming compensation," which does not include persons already receiving compensation. Schreiber Foods, Inc. v. LIRC, 2009 WI App 40, 316 Wis. 2d 516, 765 N.W.2d 850, 08-1977.

Under *Balczewski* and *Beecher*, once a claimant has established a prima facie odd-lot case, the employer must prove that the claimant is probably employable and that an actual, suitable job is regularly and continuously available. It is not sufficient to show that the claimant is physically capable of performing light work and that light work is available. Neither *Balczewski* nor *Beecher* require an employer to disclose any descriptive information of a claimant to a prospective employer to satisfy its rebuttal burden. The employer's duty in ascertaining whether an actual job exists is to obtain information from the prospective employer about the job requirements, not provide information about the claimant. Cargill Feed Division/Cargill Malt v. LIRC, 2010 WI App 115, 329 Wis. 2d 206, 789 N.W.2d 326, 09-1877.

LIRC improperly expanded the evidentiary burden on employers seeking to rebut a claimant's prima facie odd-lot case beyond that established in *Beecher* and *Balczewski* by establishing a preference for evidence that the employer referred the claimant to prospective employers with specific job openings actually available, although an employer may rely on evidence that it actually referred a claimant to a prospective employer to support its rebuttal case. Cargill Feed Division/Cargill Malt v. LIRC, 2010 WI App 115, 329 Wis. 2d 206, 789 N.W.2d 326, 09-1877.

Payment of the supplemental benefit of 102.44 (1) is not precluded to former state employees by Art. IV, s. 26. The second injury fund is not impressed with a constructive trust which prevents its use for payment of such supplemental benefits. 62 Atty. Gen. 69.

102.45 Benefits payable to minors; how paid. Compensation and death benefit payable to an employee or dependent who was a minor when the employee's or dependent's right began to accrue, may, in the discretion of the department, be ordered paid to a bank, trust company, trustee, parent or guardian, for the use of such employee or dependent as may be found best calculated to conserve the employee's or dependent's interests. Such employee or dependent shall be entitled to receive payments, in the aggregate, at a rate not less than that applicable to payments of primary compensation for total disability or death benefit as accruing

from the employee's or dependent's 18th birthday.[228]

History: 1973 c. 150; 1993 a. 492.

102.46 Death benefit. Where death proximately results from the injury and the deceased leaves a person wholly dependent upon him or her for support, the death benefit shall equal 4 times his or her average annual earnings, but when added to the disability indemnity paid and due at the time of death, shall not exceed two-thirds of weekly wage for the number of weeks set out in s. 102.44 (3).[229]

History: 1979 c. 278; 1981 c. 92. Death benefits under the worker's compensation law. Fortune. WBB Apr. 1987.

102.47 Death benefit, continued. If death occurs to an injured employee other than as a proximate result of the injury, before disability indemnity ceases, death benefit and burial expense allowance shall be as follows:

(1) Where the injury proximately causes permanent total disability, they shall be the same as if the injury had caused death, except that the burial expense allowance shall be included in the items subject to the limitation stated in s. 102.46. The amount available shall be applied toward burial expense before any is applied toward death benefit. If there are no surviving dependents the amount payable to dependents shall be paid, as provided in s. 102.49 (5) (b), to the fund created under s. 102.65.

(2) Where the injury proximately causes permanent partial disability, the unaccrued compensation shall first be applied toward funeral expenses, not to exceed the amount specified in s. 102.50. Any remaining sum shall be paid to dependents, as provided in this section and ss. 102.46 and 102.48, and there is no liability for any other payments. All computations under this subsection shall take into consideration the present value of future payments. If there are no surviving dependents the amount payable to dependents shall be paid, as provided in s. 102.49 (5) (b), to the fund created under s. 102.65.

History: 1971 c. 148; 1977 c. 195; 1983 a. 98; 1987 a. 179.

When a deceased worker dies before the level of permanent partial disability is established, the dependent's death benefit is not wiped out. "Unaccrued compensation" under sub. (2) is compensation that has not become due, or compensation for which a claim is not yet enforceable. It is not limited to compensation awarded but not yet paid. Edward Brothers, Inc. v. LIRC, 2007 WI App 128, 300 Wis. 2d 638, 731 N.W.2d 302, 06-2398.

102.475 Death benefit; law enforcement and correctional officers, fire fighters, rescue squad members, diving team members, national or state guard members and emergency management personnel.

(1) SPECIAL BENEFIT. If the deceased employee is a law enforcement officer, correctional officer, fire fighter, rescue squad member, diving team member, national guard member or state defense force member on state active duty as described in s. 102.07 (9) or if a deceased person is an employee or volunteer performing emergency management activities under ch. 323 during a state of emergency or a circumstance described in s. 323.12 (2) (c), who sustained an accidental injury while performing services growing out of and incidental to that employment or volunteer activity so that benefits are payable under s. 102.46 or 102.47 (1), the department shall voucher and pay from the appropriation under s. 20.445 (1) (aa) a sum equal to 75 percent of the primary death benefit as of the date of death, but not less than $50,000 to the persons wholly dependent upon the deceased. For purposes of this subsection, dependency shall be determined under ss. 102.49 and 102.51.

(2) PAYMENTS TO DEPENDENTS.

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[228] The purpose is to conserve the substantial installment payments that may be due to youthful employees. This in no way affects payments by the employer or insurance carrier but merely provides a method by which the department can direct retention and assume supervision of principal in the manner provided and thus conserve compensation payments best to suit the needs of the minor.

[229] This provision is to be read in conjunction with s. 102.44(3), which provides for compensation of permanent total disability during the life of the employee instead of for a given number of weeks. Section 102.46 preserves the old limitation, so that payment of death benefit, following a period of total disability, when added to the amount paid for disability before death, shall not exceed the same number of weeks as was formerly provided for permanent total disability.

(a) If there are more than 4 persons who are wholly dependent upon the deceased employee an additional benefit of $2,000 shall be paid for each dependent in excess of 4.

(b) If there is more than one person who is wholly dependent upon the deceased employee, the benefits under this section shall be apportioned between such dependents on the same proportional basis as the primary death benefit.

(c) Notwithstanding sub. (1), if there are partial dependents of the deceased employee who are entitled to benefits under s. 102.48, they shall be entitled to such portion of the benefit determined under sub. (1) that their partial dependency benefit bears to the primary benefit payable to one wholly dependent upon the deceased. No payment to a partial dependent shall be less than $1,000.

(3) DISPUTES. In case of dispute, dependents may file applications as provided in s. 102.17, and ss. 102.17 to 102.27 shall apply. In such case, if the claim for a primary death benefit is compromised, any claim under this section shall be compromised on the same proportional basis. The attorney general shall represent the interests of the state in case of such dispute.

(5) MINORS. Benefits due to minors under this section may be paid as provided in s. 102.45.

(6) PROOF. In administering this section the department or the division may require reasonable proof of birth, marriage, domestic partnership under ch. 770, relationship, or dependency.[230]

(7) NOT TO AFFECT OTHER RIGHTS, BENEFITS OR COMPENSATION. The compensation provided for in this section is in addition to, and not exclusive of, any pension rights, death benefits or other compensation otherwise payable by law.

(8) DEFINITIONS. As used in this section:

(a) "Correctional officer" means any person employed by the state or any political subdivision as a guard or officer whose principal duties are supervision and discipline of inmates at a penal institution, prison, jail, house of correction or other place of penal detention.

(am) "Diving team member" means a member of a legally organized diving team.[231]

(b) "Fire fighter" means any person employed by the state or any political subdivision as a member or officer of a fire department or a member of a volunteer department, including the state fire marshal and deputies.

(c) "Law enforcement officer" means any person employed by the state or any political subdivision for the purpose of detecting and preventing crime and enforcing laws or ordinances and who is authorized to make arrests for violations of the laws or ordinances the person is employed to enforce, whether that enforcement authority extends to all laws or ordinances or is limited to specific laws or ordinances.

(d) "Political subdivision" includes counties, municipalities and municipal corporations.

(dm) "Rescue squad member" means a member of a legally organized rescue squad.

(e) "State" means the state of Wisconsin and its departments, divisions, boards, bureaus, commissions, authorities and colleges and universities.

History: 1975 c. 274, 421; 1977 c. 29 ss. 1029m to 1029s, 1650; 1977 c. 48, 203, 418; 1979 c. 110 s. 60 (11); 1979 c. 221; 1981 c. 325; 1983 a. 98, 189; 1985 a. 29; 1987 a. 63; 1991 a. 85; 1993 a. 81; 1995 a. 247; 1999 a. 14; 2009 a. 28, 42; 2015 a. 55.

102.48 Death benefit, continued. If no person who survives the deceased employee is wholly dependent upon the deceased employee for support, partial dependency and death benefits therefor shall be as follows:

(1) An unestranged surviving parent or parents to whose support the deceased has contributed less than $500 in the 52 weeks next preceding the injury causing death shall receive a death benefit of $6,500. If the parents are not living together, the department or the division shall divide this sum in such proportion as the department or division considers to be just, considering their ages and other facts bearing on dependency.

(2) In all other cases the death benefit shall be such sum as the department or the division determines to represent fairly and justly the aid to support which the dependent might

[230] The amendment to this subsection provides that a domestic partner under ch. 770 is a dependent eligible to receive special death benefits. 2009 Wis. Act 28, effective July 1, 2009.

[231] See s. 102.07(7)(a) and footnote 27 to that section.

reasonably have anticipated from the deceased employee but for the injury. To establish anticipation of support and dependency, it shall not be essential that the deceased employee made any contribution to support. The aggregate benefits in that case shall not exceed twice the average annual earnings of the deceased or 4 times the contributions of the deceased to the support of his or her dependents during the year immediately preceding the deceased employee's death, whichever amount is the greater. In no event shall the aggregate benefits in that case exceed the amount that would accrue to a person who is solely and wholly dependent. When there is more than one partial dependent the weekly benefit shall be apportioned according to their relative dependency. The term "support" as used in ss. 102.42 to 102.63 shall include contributions to the capital fund of the dependents for their necessary comfort.

(3) Except as otherwise provided, a death benefit, other than burial expenses, shall be paid in weekly installments corresponding in amount to two-thirds of the weekly earnings of the employee, until otherwise ordered by the department or the division.

History: 1975 c. 147; 1979 c. 278; 1989 a. 64; 1993 a. 492; 2015 a. 55.

Cross-reference: See also s. DWD 80.46, Wis. adm. code.

102.49 Additional death benefit for children, state fund. **(1)** Subject to any certificate filed under s. 102.65 (4), when the beneficiary under s. 102.46 or 102.47 (1) is the spouse or domestic partner under ch. 770 of the deceased employee and is wholly dependent on the deceased employee for support, an additional death benefit shall be paid from the funds provided by sub. (5) for each child by their marriage or domestic partnership under ch. 770 who is living at the time of the death of the employee and who is likewise wholly dependent on the deceased employee for support. That payment shall commence when primary death benefit payments are completed or, if advancement of compensation has been paid, when payments would normally have been completed. Payments shall continue at the rate of 10 percent of the surviving parent's weekly indemnity until the child's 18th birthday. If the child is physically or mentally incapacitated, payments may be continued beyond the child's 18th birthday but the payments may not continue for more than a total of 15 years.[232] [233]

(2) A child lawfully adopted by the deceased employee and the surviving spouse or domestic partner under ch. 770, prior to the time of the injury, and a child not the deceased employee's own by birth or adoption but living with the deceased employee as a member of the deceased employee's family at the time of the injury shall for the purpose of this section be taken as a child by their marriage or domestic partnership under ch. 770.

(3) If the employee leaves a spouse or domestic partner under ch. 770 wholly dependent and also a child by a former marriage, domestic partnership under ch. 770, or adoption, likewise wholly dependent, aggregate benefits shall be the same in amount as if the child were the child of the surviving spouse or partner, and the entire benefit shall be apportioned to the dependents in the amounts that the department or the division determines to be just, considering the ages of the dependents and other factors bearing on dependency. The benefit awarded to the surviving spouse or partner shall not exceed 4 times the average annual earnings of the deceased employee.

(4) Dependency of any child for the purposes of this section shall be determined according to s. 102.51 (1), in like manner as would be done if there was no surviving dependent parent.

(5) **(a)** In each case of injury resulting in death, the employer or insurer shall pay into the state treasury the sum of $20,000.[234]

(b) In addition to the payment required under par. (a), in each case of injury resulting in death leaving no person dependent for support, the

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[232] The amendment to this section provides that a domestic partner under ch. 770 and a child of a domestic partnership are dependents and are eligible to receive death benefits under this chapter. 2009 Wis. Act 28, effective July 1, 2009.

[233] Payments will commence at the time primary death benefits are completed and will continue until the child's 18th birthday.

[234] 2005 Wis. Act 172, effective April 1, 2006, increases from $10,000 to $20,000 the payment to the work injury supplemental benefit fund by employers and insurers for injuries resulting in death.

employer or insurer shall pay into the state treasury the amount of the death benefit otherwise payable, minus any payment made under s. 102.48 (1), in 5 equal annual installments with the first installment due as of the date of death.

(c) In addition to the payment required under par. (a), in each case of injury resulting in death, leaving one or more persons partially dependent for support, the employer or insurer shall pay into the state treasury an amount which, when added to the sums paid or to be paid on account of partial dependency and under s. 102.48 (1), shall equal the death benefit payable to a person wholly dependent.

(d) The payment into the state treasury shall be made in all such cases regardless of whether the dependents or personal representatives of the deceased employee commence action against a 3rd party under s. 102.29. If the payment is not made within 20 days after the department makes request therefor, any sum payable shall bear interest at the rate of 7 percent per year.

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

(6) The department or the division may award the additional benefits payable under this section to the surviving parent of the child, to the child's guardian, or to such other person, bank, or trust company for the child's use as may be found best calculated to conserve the interests of the child. If the child dies while benefits are still payable, there shall be paid the reasonable expense for burial, not exceeding $1,500.

(7) All payments received under this section shall be deposited in the fund established by s. 102.65.

History: 1971 c. 260 s. 92 (4); 1975 c. 147, 199; 1977 c. 195; 1979 c. 110 s. 60 (13); 1979 c. 278, 355; 1985 a. 83; 1991 a. 85; 1993 a. 492; 1997 a. 253; 2003 a. 144; 2005 a. 172; 2009 a. 28; 2011 a. 183; 2015 a. 55.

Cross-reference: See also s. DWD 80.48, Wis. adm. code.

102.50 Burial expenses. In all cases in which the death of an employee proximately results from the injury, the employer or insurer shall pay the actual expense for burial, not exceeding $10,000. [235]

History: 1971 c. 148; 1977 c. 195; 1985 a. 83; 1991 a. 85; 1995 a. 117; 2009 a. 206.

102.51 Dependents.

(1) WHO ARE.

(a) The following persons are entitled to death benefits as if they are solely and wholly dependent for support upon a deceased employee:

1. A wife upon a husband with whom she is living at the time of his death.

2. A husband upon a wife with whom he is living at the time of her death.

2m. A domestic partner under ch. 770 upon his or her partner with whom he or she is living at the time of the partner's death.[236]

3. A child under the age of 18 years upon the parent with whom he or she is living at the time of the death of the parent, there being no surviving dependent parent.

4. A child over the age of 18 years, but physically or mentally incapacitated from earning, upon the parent with whom he or she is living at the time of the death of the parent, there being no surviving dependent parent.

(b) Where a dependent who is entitled to death benefits under this subsection survives the deceased employee, all other dependents shall be excluded.[237] The charging of any portion of the support and maintenance of a child upon one of the parents, or any voluntary contribution toward the support of a child by a parent, or an obligation to support a child by a parent

[235] This amendment increased the amount payable for burial expense to the lesser of the actual expense up to a maximum of $10,000. 2009 Wis. Act 206, effective May 1, 2010.

[236] This amendment provides that a domestic partner under ch. 770 is defined as a dependent entitled to receive death benefits under this chapter. 2009 Wis. Act 28, effective July 1, 2009.

[237] This provision excludes all other dependents from consideration when there are persons who are solely and wholly dependent.

constitutes living with any such parent within the meaning of this subsection.[238]

(2) WHO ARE NOT.

(a) No person shall be considered a dependent unless that person is a spouse, a domestic partner under ch. 770, a divorced spouse who has not remarried, or a lineal descendant, lineal ancestor, brother, sister, or other member of the family, whether by blood or by adoption, of the deceased employee.

(b) If for 8 years or more prior to the date of injury a deceased employee has been a resident of the United States, it shall be conclusively presumed that no person who has remained a nonresident alien during that period is either totally or partially dependent upon the deceased employee for support.

(c) No person who is a nonresident alien shall be found to be either totally or partially dependent on a deceased employee for support who cannot establish dependency by proving contributions from the deceased employee by written evidence or tokens of the transfer of money, such as drafts, letters of credit, microfilm or other copies of paid share drafts, canceled checks, or receipts for the payment to any bank, express company, United States post office, or other agency commercially engaged in the transfer of funds from one country to another, for transmission of funds on behalf of said deceased employee to such nonresident alien claiming dependency. This provision shall not be applicable unless the employee has been continuously in the United States for at least one year prior to his or her injury, and has been remuneratively employed therein for at least 6 months.[239]

(3) DIVISION AMONG DEPENDENTS. If there is more than one person wholly or partially dependent on a deceased employee, the death benefit shall be divided between those dependents in such proportion as the department or the division determines to be just, considering their ages and other facts bearing on their dependency.

(4) DEPENDENCY AS OF THE DATE OF DEATH. Questions as to who is a dependent and the extent of his or her dependency shall be determined as of the date of the death of the employee, and the dependent's right to any death benefit becomes fixed at that time, regardless of any subsequent change in conditions.[240] The death benefit shall be directly recoverable by and payable to the dependents entitled to the death benefit or their legal guardians or trustees. In case of the death of a dependent whose right to a death benefit has become fixed, so much of the benefit as is unpaid is payable to the dependent's personal representatives in gross, unless the department or the division determines that the unpaid benefit shall be reassigned under sub. (6) and paid to any other dependent who is physically or mentally incapacitated or a minor.[241] For purposes of this subsection, a child of the employee who is born after the death of

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[238] Where there is no surviving dependent parent, children up to the age of 18 "living with" the deceased at the time of death arbitrarily become entitled to the death benefit based on total dependency. The law formerly provided that in case of divorce the charging of any portion of support and maintenance or voluntary contribution toward support or an obligation to support a child by a parent should constitute a "living with" the parent and thus entitle the child to the presumption of total dependency. There appears no reason why the child should not be equally protected where divorce is pending but no decree entered, or where the parents live apart without divorce pending, or where for any other reason a child may not be factually or physically living with his or her parent.

[239] A nonresident alien is barred from receiving benefits where the deceased employee, because of whose death claim is being made, has been a resident of the United States for eight years or more prior to the date of injury. This section formerly provided that no person who is a nonresident alien should be found either totally or partially dependent who could not establish contributions from the deceased employee by written evidence or tokens of the transfer of money such as drafts, letters of credit, cancelled checks or certain other documentary evidence. In some cases, aliens who come to this country to work may be fatally injured before they have had opportunity to make contributions to their dependents. This provision allows proof of contributions other than by written evidence provided the deceased has not been in the United States for one year, or remuneratively employed for at least six months.

[240] This was amended effective January 1, 1984, to provide that for injuries after that date dependency is determined as of the date of death of an employee rather than as of the date of injury as was formerly the case.

[241] Section 102.51(4) gives the department discretion to reassign benefits payable to a dependent who dies to other minor or incapacitated dependents rather than paying the benefits to the deceased dependent's estate.

the employee is considered to be a dependent as of the date of death.[242]

(5) WHEN NOT INTERESTED. No dependent of an injured employee shall be deemed a party in interest to any proceeding by the employee for the enforcement of the employee's claim for compensation, nor with respect to the compromise thereof by such employee. A compromise of all liability entered into by an employee is binding upon the employee's dependents, except that any dependent of a deceased employee may submit the compromise for review under s. 102.16 (1).

(6) DIVISION AMONG DEPENDENTS. Benefits accruing to a minor dependent child may be awarded to either parent in the discretion of the department or the division. Notwithstanding sub. (1), the department or the division may reassign the death benefit as between a surviving spouse or a domestic partner under ch. 770 and any children specified in sub. (1) and s. 102.49 in accordance with their respective needs for the death benefit.

(7) CERTAIN DEFENSE BARRED. In proceedings for the collection of primary death benefit or burial expense it shall not be a defense that the applicant, either individually or as a partner or member, was an employer of the deceased.

History: 1975 c. 94, 147; 1977 c. 195; 1981 c. 92; 1983 a. 98, 368; 1993 a. 112, 492; 1995 a. 225; 1997 a. 253; 1999 a. 162; 2009 a. 28; 2015 a. 55.

Cross-reference: See also s. DWD 80.48, Wis. adm. code.

A posthumously born illegitimate child does not qualify as a dependent under sub. (4). Claimants not falling within one of the classifications under sub. (2) (a) will not qualify for benefits, regardless of dependency in fact. Larson v. DILHR, 76 Wis. 2d 595, 252 N.W.2d 33 (1977).

Sub. (5) has no application to a claim for a death benefit because a death benefit claim is not an "employee's claim for compensation." While sub. (5) prohibits a dependent from being a party to a worker's claim for disability benefits, a dependent claiming a death benefit is prosecuting only his or her own claim. Edward Brothers, Inc. v. LIRC, 2007 WI App 128, 300 Wis. 2d 638, 731 N.W.2d 302, 06-2398.

102.52 Permanent partial disability schedule. In cases included in the following schedule of permanent partial disabilities indemnity shall be paid for the healing period, and in addition, for the period specified, at the rate of two-thirds of the average weekly earnings of the employee, to be computed as provided in s. 102.11:

(1) The loss of an arm at the shoulder, 500 weeks;

(2) The loss of an arm at the elbow, 450 weeks;

(3) The loss of a hand, 400 weeks;

(4) The loss of a palm where the thumb remains, 325 weeks;

(5) The loss of a thumb and the metacarpal bone thereof, 160 weeks;

(6) The loss of a thumb at the proximal joint, 120 weeks;

(7) The loss of a thumb at the distal joint, 50 weeks;

(8) The loss of all fingers on one hand at their proximal joints, 225 weeks;

(9) Losses of fingers on each hand as follows:

(a) An index finger and the metacarpal bone thereof, 60 weeks;

(b) An index finger at the proximal joint, 50 weeks;

(c) An index finger at the second joint, 30 weeks;

(d) An index finger at the distal joint, 12 weeks;

(e) A middle finger and the metacarpal bone thereof, 45 weeks;

(f) A middle finger at the proximal joint, 35 weeks;

(g) A middle finger at the second joint, 20 weeks;

(h) A middle finger at the distal joint, 8 weeks;

(i) A ring finger and the metacarpal bone thereof, 26 weeks;

(j) A ring finger at the proximal joint, 20 weeks;

(k) A ring finger at the second joint, 15 weeks;

(L) A ring finger at the distal joint, 6 weeks;

(m) A little finger and the metacarpal bone thereof, 28 weeks;

(n) A little finger at the proximal joint, 22 weeks;

(o) A little finger at the second joint, 16 weeks;

(p) A little finger at the distal joint, 6 weeks;

(10) The loss of a leg at the hip joint, 500 weeks;

(11) The loss of a leg at the knee, 425 weeks;

(12) The loss of a foot at the ankle, 250 weeks;

[242] Larson v. ILHR Department, 76 Wis.2d 595 (1977) no longer applies since the amendment to s. 102.52(4) including posthumous children became effective January 1, 1978.

(13) The loss of the great toe with the metatarsal bone thereof, 83 1/3 weeks;
(14) Losses of toes on each foot as follows:
(a) A great toe at the proximal joint, 25 weeks;
(b) A great toe at the distal joint, 12 weeks;
(c) The second toe with the metatarsal bone thereof, 25 weeks;
(d) The second toe at the proximal joint, 8 weeks;
(e) The second toe at the second joint, 6 weeks;
(f) The second toe at the distal joint, 4 weeks;
(g) The third, fourth or little toe with the metatarsal bone thereof, 20 weeks;
(h) The third, fourth or little toe at the proximal joint, 6 weeks;
(i) The third, fourth or little toe at the second or distal joint, 4 weeks;
(15) The loss of an eye by enucleation or evisceration, 275 weeks;
(16) Total impairment of one eye for industrial use, 250 weeks;[243]
(17) Total deafness from accident or sudden trauma, 330 weeks;[244]
(18) Total deafness of one ear from accident or sudden trauma, 55 weeks.[245]

History: 1973 c. 150; 1975 c. 147; 1979 c. 278.

Cross-reference: See also ss. DWD 80.32 and 80.50, Wis. adm. code.

In a proceeding brought by an employee who suffered total deafness in one ear, a skull fracture, loss of taste and smell, facial paralysis, and periods of intermittent headaches and dizziness, the department did not err in determining that the hearing loss was a scheduled disability under sub. (18), with a separate award for the additional physical effects of the deafness, rather than considering the entire range of disabilities as a whole. When a loss is recognized by and compensable under this section, the schedule therein is exclusive. Vande Zande v. ILHR Dept. 70 Wis. 2d 1086, 236 N.W.2d 255 (1975).

The "loss of an arm at the shoulder" under sub. (1) includes injuries to the shoulder. Hagen v. LIRC, 210 Wis. 2d 12, 563 N.W.2d 454 (1997), 94-0374.

102.53 Multiple injury variations. In case an injury causes more than one permanent disability specified in ss. 102.44 (3), 102.52 and 102.55, the period for which indemnity shall be payable for each additional equal or lesser disability shall be increased as follows:[246]
(1) In the case of impairment of both eyes, by 200 percent.
(2) In the case of disabilities on the same hand covered by s. 102.52 (9), by 100 percent for the first equal or lesser disability and by 150 percent for the 2nd and 3rd equal or lesser disabilities.
(3) In the case of disabilities on the same foot covered by s. 102.52 (14), by 20 percent.
(4) In all other cases, by 20 percent.
(5) The aggregate result as computed by applying sub. (1), and the aggregate result for members on the same hand or foot as computed by applying subs. (2) and (3), shall each be taken as a unit for applying sub. (4) as between such units, and as between such units and each other disability.

History: 1973 c. 150; 1979 c. 278.

102.54 Injury to dominant hand. If an injury to an employee's dominant hand causes a disability specified in s. 102.52 (1) to (9) or amputation of more than two-thirds of the distal joint of a finger, the period for which indemnity is payable for that disability or amputation is increased by 25 percent. This increase is in addition to any other increase payable under s. 102.53 but, for cases in which an injury causes more than one permanent disability, the increase under this section shall be based on the periods

[243] See Rule DWD 80.26 for determining loss of visual efficiency.

[244] See Rule DWD 80.25 for determining loss or impairment of hearing.

[245] See s. 102.555 for occupational deafness schedule.

[246] This provides for "stepping up" the value of disabilities to two or more fingers or portions of them so that in case of disabilities to fingers on one hand the increase is an additional 100 percent for the first equal or lesser disability and 150 percent for the second and third equal or lesser disabilities. In case of toes on one foot the corresponding increase is 20 percent as it is in all other cases of multiple injury except for impairment of both eyes, where the increase is 200 percent. When the aggregate result for members on the same hand or foot or for the eyes has been computed, it is taken as a unit and there is increase as between that and other units by 20 percent for each equal or lesser injury unit (except as between both eyes or both ears).

specified in s. 102.52 (1) to (9) for each disability and not on any increased period specified in s. 102.53.[247]

History: 1993 a. 81.

102.55 Application of schedules.

(1) Whenever amputation of a member is made between any 2 joints mentioned in the schedule in s. 102.52 the determined loss and resultant indemnity therefor shall bear such relation to the loss and indemnity applicable in case of amputation at the joint next nearer the body as such injury bears to one of amputation at the joint nearer the body.[248]

(2) For the purposes of this schedule permanent and complete paralysis of any member shall be deemed equivalent to the loss thereof.

(3) For all other injuries to the members of the body or its faculties that are specified in the schedule under s. 102.52 resulting in permanent disability, though the member is not actually severed or the faculty is not totally lost, compensation shall bear such relation to the compensation named in the schedule as the disability bears to the disability named in the schedule. Indemnity in those cases shall be determined by allowing weekly indemnity during the healing period resulting from the injury and the percentage of permanent disability resulting after the healing period as found by the department or the division.

History: 2015 a. 55.

102.555 Occupational deafness; definitions.[249]

(1) In this section:

(a) "Noise" means sound capable of producing occupational deafness.

(b) "Noisy employment" means employment in the performance of which an employee is subjected to noise.

(c) "Occupational deafness" means permanent partial or permanent total loss of hearing of one or both ears due to prolonged exposure to noise in employment.

(2) No benefits shall be payable for temporary total or temporary partial disability under this chapter for loss of hearing due to prolonged exposure to noise.

(3) An employee who because of occupational deafness is transferred by his or her employer to other noisy employment and thereby sustains actual wage loss shall be compensated at the rate provided in s. 102.43 (2), not exceeding $7,000 in the aggregate from all employers. "Time of injury", "occurrence of injury", and "date of injury" in such case mean the date of wage loss.

(4) Subject to the limitations provided in this section, there shall be payable for total occupational deafness of one ear, 36 weeks of compensation; for total occupational deafness of both ears, 216 weeks of compensation; and for partial occupational deafness, compensation shall bear such relation to that named in this section as disabilities bear to the maximum disabilities provided in this section. In cases covered by this subsection, "time of injury", "occurrence of injury", or "date of injury" shall, at the option of the employee, be the date of occurrence of any of the following events to an employee:

(a) Transfer to nonnoisy employment by an employer whose employment has caused occupational deafness;

(b) The last day actually worked before retiring, regardless of vacation pay or time, sick leave or any other benefit to which the employee is entitled;[250]

(c) Termination of the employer-employee relationship; or

(d) Layoff, provided the layoff is complete and continuous for 6 months.

(5) No claim under sub. (4) may be filed until 7 consecutive days of removal from noisy employment after the time of injury except that under sub. (4) (d) the 7 consecutive days' period may commence within the last 2 months of layoff.

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[247] This provides an increase for injuries to the dominant hand that result in any amputation beyond 2/3 of a distal phalanx or 100 percent loss of use of any joint on the hand or arm. This multiple is in addition to the multiples in ss. 102.53(2), (4) and (5) but is not applied on those multiples. This multiple will be treated the same as those in s. 102.53 for computing permanent disabilities per Rule DWD 80.50.

[248] See Rule DWD 80.33 for fingertip amputations.

[249] See Rule DWD 80.25 for determining loss or impairment of hearing. See ss. 102.52(17) and (18) for deafness due to trauma or accident.

[250] The date of injury is the last day of actual work rather than an official retirement date.

(6) The limitation provisions in this chapter shall control claims arising under this section. Such provisions shall run from the first date upon which claim may be filed, or from the date of subsequent death, provided that no claim shall accrue to any dependent unless an award has been issued or hearing tests have been conducted by a competent medical specialist after the employee has been removed from the noisy environment for a period of 2 months.

(7) No payment shall be made to an employee under this section unless the employee shall have worked in noisy employment for a total period of at least 90 days for the employer from whom the employee claims compensation.

(8) An employer is liable for the entire occupational deafness to which his or her employment has contributed; but if previous deafness is established by a hearing test or other competent evidence, whether or not the employee was exposed to noise within the 2 months preceding such test, the employer is not liable for previous loss so established nor is the employer liable for any loss for which compensation has previously been paid or awarded.

(9) Any amount paid to an employee under this section by any employer shall be credited against compensation payable by any employer to such employee for occupational deafness under subs. (3) and (4). No employee shall in the aggregate receive greater compensation from any or all employers for occupational deafness than that provided in this section for total occupational deafness.

(10) No compensation may be paid for tinnitus unless a hearing test demonstrates a compensable hearing loss other than tinnitus. For injuries occurring on or after January 1, 1992, no compensation may be paid for tinnitus.[251]

(11) Compensation under s. 102.66 for permanent partial disability due to occupational deafness may be paid only if the loss of hearing exceeds 20 percent of binaural hearing loss.

(12) (a) An employer, the department, or the division is not liable for the expense of any examination or test for hearing loss, any evaluation of such an exam or test, any medical treatment for improving or restoring hearing, or any hearing aid to relieve the effect of hearing loss unless it is determined that compensation for occupational deafness is payable under sub. (3), (4), or (11).

(b) For a case of occupational deafness in which the date of injury is on or after April 1, 2008, this subsection applies beginning on that date. Notwithstanding ss. 102.03 (4) and 102.17 (4), for a case of occupational deafness in which the date of injury is before April 1, 2008, this subsection applies beginning on January 1, 2012.[252]

History: 1971 c. 148; 1973 c. 150; 1975 c. 147, 199, 200; 1977 c. 195; 1979 c. 278; 1981 c. 92; 1983 a. 98; 1985 a. 83; 1991 a. 85; 2007 a. 185; 2009 a. 206; 2015 a. 55.

Cross-reference: See also s. DWD 80.25, Wis. adm. code.

Committee Note, 1971: Where an employer discontinues a noisy operation and transfers the employees to nonnoisy employment, they have been unable to make claim for occupational deafness until the conditions of sub. (b), (c) or (d) were met. The employee will now have the option of filing a claim at the time of transfer at the current rate of compensation with a 2-1/2 percent reduction for each year of age over 50 or waiting until he meets the conditions of sub. (b), (c) or (d) when he may file claim at the then-current rate of compensation with a 1/2 percent reduction for each year of age over 50. [Bill 371-A]

It is a prerequisite for an award of benefits under sub. (10) that the employee must have suffered some compensable hearing loss other than tinnitus; sub. (10) does not require a compensable hearing loss in both ears or in a particular ear. General Castings Corporation v. LIRC, 152 Wis. 2d 631, 449 N.W.2d 619 (Ct. App. 1989).

Agency interpretation and application of sub. (8) is discussed. Harnischfeger Corporation v. LIRC, 196 Wis. 2d 650, 539 N.W.2d 335 (1995), 93-0947.

102.56 Disfigurement.

(1) Subject to sub. (2), if an employee is so permanently disfigured as to occasion potential wage loss due to the disfigurement, the department or the division may allow such sum as the department or the division considers just

[251] Payment of any compensation for tinnitus is eliminated from occupational hearing loss claims.

[252] This amendment eliminates the liability for expenses for examinations and tests, treatment for hearing loss, evaluation of examination or testing, medical treatment for hearing loss, restoring hearing and hearing aids for occupational hearing loss claims that do not reach the level of hearing loss to qualify for payment of permanent partial disability. 2009 Wis. Act 206, effective May 1, 2010. This amendment applies beginning January 1, 2012.

as compensation for the disfigurement, not exceeding the employee's average annual earnings. In determining the potential for wage loss due to the disfigurement and the sum awarded, the department or the division shall take into account the age, education, training, and previous experience and earnings of the employee, the employee's present occupation and earnings, and likelihood of future suitable occupational change. Consideration for disfigurement allowance is confined to those areas of the body that are exposed in the normal course of employment. The department or the division shall also take into account the appearance of the disfigurement, its location, and the likelihood of its exposure in occupations for which the employee is suited.

(2) If an employee who claims compensation under sub. (1) returns to work for the employer who employed the employee at the time of the injury, or is offered employment with that employer, at the same or a higher wage, the department or the division may not allow that compensation unless the employee suffers an actual wage loss due to the disfigurement.[253]

History: 1971 c. 148; 1977 c. 195; 1987 a. 179; 2011 a. 183; 2015 a. 55.

LIRC's allowance of a disfigurement award based on a limp was a reasonable interpretation of this section. Nothing in sub. (1) limits disfigurement to amputations, scars, and burns. County of Dane v. Labor and Industry Review Commission, 2009 WI 9, 315 Wis. 2d 293, 759 N.W.2d 571, 06-2695.

102.565 Toxic or hazardous exposure; medical examination; conditions of liability.[254]

(1) When, as a result of exposure in the course of employment over a period of time to toxic or hazardous substances or conditions, an employee performing work that is subject to this chapter develops any clinically observable abnormality or condition that, on competent medical opinion, predisposes or renders the employee in any manner differentially susceptible to disability to such an extent that it is inadvisable for the employee to continue employment involving that exposure, is discharged from or ceases to continue the employment, and suffers wage loss by reason of that discharge from, or cessation of, employment, the department or the division may allow such sum as the department or the division considers just as compensation for that wage loss, not exceeding $13,000. If a nondisabling condition may also be caused by toxic or hazardous exposure not related to employment and if the employee has a history of that exposure, compensation as provided under this section or any other remedy for loss of earning capacity shall not be allowed. If the employee is discharged from employment prior to a finding by the department or the division that it is inadvisable for the employee to continue in that employment and if it is reasonably probable that continued exposure would result in disability, the liability of the employer who discharges the employee is primary, and the liability of the employer's insurer is secondary, under the same procedure and to the same effect as provided by s. 102.62.

(2) Upon application of any employer or employee the department or the division may direct any employee of the employer or an employee who, in the course of his or her employment, has been exposed to toxic or hazardous substances or conditions to submit to examination by one or more physicians appointed by the department or the division to determine whether the employee has developed any abnormality or condition under sub. (1), and the degree of that abnormality or condition. The cost of the medical examination shall be borne

[253] This amendment provides that if an injured employee returns to work for that employer for whom he or she worked at the time of the injury without any wage loss, then the employee is not entitled to compensation for disfigurement. However, the employee may show that he or she has or will sustain a wage loss because the disfigurement has impaired his or her ability to obtain other employment. The standard of proof at this level is "probable" rather than "potential."

[254] Section 102.565 was amended to include exposure to toxic or hazardous substances and conditions where further exposure has the risk of creating a disability. If the employee changes employers, he or she becomes entitled to payment of compensation benefits on a wage loss basis. Benefits under this section are for nondisabling conditions. In the event that there is lost time from work or there is permanent disability, there is a date of injury and benefits are paid as they would be for any injury. This section applies to nondisabling conditions occurring after May 13, 1980. It does not apply to occupational hearing loss since termination or transfer to non-noisy employment creates a date of injury under s. 102.555.

by the person making application. The physician conducting the examination shall submit the results of the examination to the department or the division, which shall submit copies of the reports to the employer and employee, who shall have an opportunity to rebut the reports if a request to submit a rebuttal is made to the department or the division within 10 days after the department or the division mails the report to the parties. The department or the division shall make its findings as to whether it is inadvisable for the employee to continue in his or her employment.

(3) If after direction by the commission, or any member of the commission, the department, the division, or an examiner, an employee refuses to submit to an examination or in any way obstructs the examination, the employee's right to compensation under this section shall be barred.

(4) No payment shall be made to an employee under this section unless he or she shall have worked for a reasonable period of time for the employer from whom he or she claims compensation for exposing him or her to toxic or hazardous conditions.

(5) Payment of a benefit under this section to an employee shall stop such employee from any further recovery whatsoever from any employer under this section.

(6) This section does not apply to an employee whose claim of injury is presumed to be caused by employment under s. 102.03 (6).

History: 1977 c. 29, 195; 1979 c. 278; 2015 a. 55; 2019 a. 185.
https://docs.legis.wisconsin.gov/2019/related/acts/185.pdf

Sub. (1) requires that an employee's termination be connected to the employment that caused the susceptibility to disease. General Castings Corp. v. Winstead, 156 Wis. 2d 752, 457 N.W.2d 557 (Ct. App. 1990).

102.57 Violations of safety provisions, penalty. If injury is caused by the failure of the employer to comply with any statute, rule, or order of the department of safety and professional services, compensation and death benefits provided in this chapter shall be increased by 15 percent but the total increase may not exceed $15,000. Failure of an employer reasonably to enforce compliance by employees with any statute, rule, or order of the department of safety and professional services constitutes failure by the employer to comply with that statute, rule, or order.[255]

History: 1981 c. 92; 1983 a. 98; 2001 a. 37; 2015 a. 55.

This section and s. 102.58 may be applicable in the same case if the negligence of both the employer and employee are causes of the employee's injury. Milwaukee Forge v. DILHR, 66 Wis. 2d 428, 225 N.W.2d 476 (1975).

Death benefits for dependent children are not increased by this section. Schwartz v. DILHR, 72 Wis. 2d 217, 240 N.W.2d 173 (1976).

The application of this section is not restricted to statutes "of the" department of workforce development. Statutes are not "of" departments of the state. The reasonable reading of this section is that "of the department" modifies "order" and not "statute." The only word that modifies "statute" in the first sentence of the section is "any." This section allows an administrative law judge to increase worker's compensation benefits if it finds that the employer failed to comply with any statute. A violation of a federal OSHA standard was not a violation of "a statute, rule, or order of the department" but was evidence of a violation of a Wisconsin statute, the safe place statute, s. 101.11. Sohn Manufacturing Inc. v. LIRC, 2013 WI App 112, 350 Wis. 2d 469, 838 N.W.2d 131, 12-2566.

This section is not preempted by federal law. It is not an attempt to regulate in an area that the state has not been authorized to regulate and does not constitute enforcement of federal workplace safety regulations. Rather, this section is a worker's compensation law "with respect to injuries, diseases, or death of employees arising out of, or in the course of, employment" exempted from preemption under 29 U.S.C. § 653 (b) (4). Sohn Manufacturing Inc. v. LIRC, 2013 WI App 112, 350 Wis. 2d 469, 838 N.W.2d 131, 12-2566.

102.58 Decreased compensation. If injury is caused by the failure of the employee to use safety devices that are provided in accordance with any statute, rule, or order of the department of safety and professional services and that are adequately maintained, and the use of which is reasonably enforced by the employer, or if injury results from the employee's failure to obey any reasonable rule adopted and reasonably enforced by the employer for the safety of the employee and of which the employee has notice, the compensation and death benefit provided in this chapter shall be reduced by 15 percent but the

[255] Where an employer fails to enforce compliance with safety orders, the effect is often the same as though safety devices and safe places of work were not provided. This results in increase in the number of injuries. The provision will hold liable the employer who may provide safety devices and then by acquiescence in non-use fail to accomplish the desired result as to safety.

total reduction may not exceed $15,000. If an employee violates the employer's policy concerning employee drug or alcohol use and is injured, and if that violation is causal to the employee's injury, no compensation or death benefits shall be payable to the injured employee or a dependent of the injured employee. Nothing in this section shall reduce or eliminate an employer's liability for incidental compensation under s. 102.42 (1) to (8) or drug treatment under s. 102.425.[256] [257]

History: 1971 c. 148; 1981 c. 92; 1983 a. 98; 1987 a. 179; 1995 a. 448; 2001 a. 37; 2015 a. 55, 180.

The burden of proof is on the employer to establish not only the fact of intoxication, but also a causal connection between the condition and the injury or accident. Haller Beverage Corporation v. DILHR, 49 Wis. 2d 233, 181 N.W.2d 418 (1970).

This section and s. 102.57 may be applicable in the same case if the negligence of both the employer and employee are causes of the employee's injury. Milwaukee Forge v. DILHR, 66 Wis. 2d 428, 225 N.W.2d 476 (1975).

Whether a traveling employee's multiple drinks at a tavern was a deviation was irrelevant when the employee was injured while engaged in a later act reasonably necessary to living. Under this section, intoxication does not defeat a worker's compensation claim but only decreases the benefits. Heritage Mutual Insurance Co. v. Larsen, 2001 WI 30, 242 Wis. 2d 47, 624 N.W.2d 129, 98-3577.

[256] 2015 Wis. Act 180, effective March 2, 2016, provides a total bar to indemnity and death benefits to an employee or dependents when there is a direct cause between an injury or death due to the employee's violation of the employer's drug or alcohol policy. The insurance carrier or self-insured employer continue to have liability for medical expenses, incidental compensation and drug treatment.

[257] Compensation cannot be reduced 15 percent for failure of the employee to use safety devices where provided and adequately maintained except as their use is reasonably enforced. It was felt unfair to permit a reduction of compensation in cases where the employer acquiesced in failure of the employee to make use of a guard or where by failure to enforce use the employer has virtually consented that the employee should be allowed not to use the safety device. It is necessary for the employer to show that he or she made a reasonable effort to enforce such rules. The safety device must be one which is provided in accordance with a statute or lawful order of the department and not merely one adopted but not required. Reduction for failure to obey a reasonable rule adopted by the employer can be made only (1) where a definite order is shown and (2) where the employee had notice of the rule.

102.59 Preexisting disability, indemnity.[258]

(1) Subject to any certificate filed under s. 102.65 (4), if at the time of injury an employee has permanent disability that if it had resulted from that injury would have entitled the employee to indemnity for 200 weeks and if as a result of that injury the employee incurs further permanent disability that entitles the employee to indemnity for 200 weeks, the employee shall be paid from the funds provided in this section additional compensation equivalent to the amount that would be payable for that previous disability if that previous disability had resulted from that injury or the amount that is payable for that further disability, whichever is less, except that an employee may not be paid that additional compensation if the employee has already received compensation under this subsection.[259] If the previous and further disabilities result in permanent total disability, the additional compensation shall be in such amount as will complete the payments that would have been due had the permanent total disability resulted from that injury. This additional compensation accrues from, and may not be paid to any person

[258] This subsection has a two-fold purpose: First, to eliminate any incentive for discrimination against the employee who has serious previous disability when he or she comes to seek re-employment because of the employer's fear, real or otherwise, that the loss of another member may subject the employer to very large indemnities on the ground that such loss would cause total or near total disability; second, to secure to the employee sustaining the loss or total impairment of a second member such amount of indemnity as the seriousness of the combined disabilities calls for. Direct liability of the employer in case of the loss of the second member is made the same as for the loss of the first member, and the injured employee's rights are conserved by orders drawn on the fund for the balance of the indemnity. Primary liability of the employer for payment of $20,000 to the fund is insurable. Payments to the work injury supplemental benefit fund were suspended for injuries occurring in calendar years 1994 through 1998. This subsection was amended by 2011 Wis. Act 183, effective April 17, 2012, to clarify that an employee will be limited to only one claim from the Second Injury Fund.

[259] To illustrate, one who has previously lost an arm at the shoulder would have been entitled to 500 weeks of compensation. By second injury he or she loses the hand at the wrist and becomes entitled to 400 weeks of compensation. Over and above payment for second injury, the employee may receive an additional 400 weeks of compensation from the fund.

before, the end of the period for which compensation for permanent disability resulting from the injury is payable by the employer, and shall be subject to s. 102.32 (6), (6m), and (7). No compromise agreement of liability for this additional compensation may provide for any lump sum payment.[260]

(1m) A compromise order issued under s. 102.16 (1) may not be admitted as evidence in any action or proceeding for benefits compensable under this section.

(2) In the case of the loss or of the total impairment of a hand, arm, foot, leg, or eye, the employer shall pay $20,000 into the state treasury. The payment shall be made in all such cases regardless of whether the employee or the employee's dependent or personal representative commences action against a 3rd party as provided in s. 102.29.[261]

(3) All payments received under this section shall be deposited in the fund established by s. 102.65.

History: 1971 c. 148; 1971 c. 260 s. 92 (4); 1973 c. 150; 1975 c. 147; 1977 c. 195; 1981 c. 92; 1985 a. 83, 173; 1987 a. 179; 2001 a. 37; 2003 a. 144; 2005 a. 172; 2011 a. 183.

Cross-reference: See also s. DWD 80.68, Wis. adm. code.

The fund was not liable for disability benefits when an employer was liable for permanent total disability. Green Bay Soap Co. v. DILHR, 87 Wis. 2d 561, 275 N.W.2d 190 (Ct. App. 1979).

102.60 Minor illegally employed.[262]

(1m) When the injury is sustained by a minor who is illegally employed, the employer, in addition to paying compensation to the minor and death benefits to the dependents of the minor, shall pay the following amounts into the state treasury, for deposit in the fund established under s. 102.65:[263]

(a) An amount equal to the amount recoverable by the injured employee, but not to exceed $7,500, if the injured employee is a minor of permit age and at the time of the injury is employed, required, suffered, or permitted to work without a written permit issued under ch. 103, except as provided in pars. (b) to (d).

(b) An amount equal to double the amount recoverable by the injured employee, but not to exceed $15,000, if the injured employee is a minor of permit age and at the time of the injury is employed, required, suffered, or permitted to work without a permit in any place of employment or at any employment in or for which the department acting under ch. 103, has adopted a written resolution providing that permits shall not be issued.

(c) An amount equal to double the amount recoverable by the injured employee, but not to exceed $15,000, if the injured employee is a minor of permit age or older and at the time of the injury is employed, required, suffered, or permitted to work at prohibited employment.

(d) An amount equal to double the amount recoverable by the injured employee, but not to exceed $15,000, if the injured employee is a minor under permit age and is illegally employed.

(5) (a) A permit or certificate of age that is unlawfully issued by an officer specified in ch. 103, or that is unlawfully altered after issuance, without fraud on the part of the employer, shall be considered a permit for purposes of this section.

(b) If the employer is misled in employing a minor illegally because of fraudulent written evidence of age presented by the minor, the employer is not required to pay the amounts specified in sub. (1m).

(7) This section does not apply to a person selling or distributing newspapers or magazines on the street or from house to house if the agency or publisher for whom the person sells or distributes newspapers or magazines establishes

[260] This amendment clarifies that the benefits are to be paid monthly as they accrue after primary benefits are accrued rather than in lump sum or advancement.

[261] 2005 Wis. Act 172, effective April 1, 2006, increases from $10,000 to $20,000 the payment to the Work Injury Supplemental Benefit Fund from insurers and employers for injuries resulting in dismemberment.

[262] 2005 Wis. Act 172, effective April 1, 2006, redirects payments by employers for double and treble compensation for the illegal employment of minors from the minors to the Work Injury Supplemental Benefit Fund. This amendment also provides that an employer is no longer required to make any payment if the employer is misled in hiring the minor because of fraudulent written evidence of age presented by the minor. Giving a false age on a work application is not to be considered fraudulent written evidence of age.

[263] The amendment to sub. (1m) and repeal of sub (6) eliminates the requirement for employers to pay minors additional compensation for wage loss. 2009 Wis. Act 206, effective May 1, 2010.

by affirmative proof that at the time of the injury the person was not employed with the actual or constructive knowledge of the agency or publisher.

(8) This section does not apply to liability arising under s. 102.06 unless the employer sought to be charged knew or should have known that the minor was illegally employed by the contractor or subcontractor.

History: 1975 c. 147 s. 57; 1975 c. 199; 1977 c. 29, 195; 2005 a. 172; 2009 a. 206; 2015 a. 180; 2017 a. 11.

102.61 Indemnity under rehabilitation law.

(1) Subject to subs. (1g) and (1m), an employee who is entitled to receive and has received compensation under this chapter, and who is entitled to and is receiving instruction under 29 USC 701 to 797b, as administered by the state in which the employee resides or in which the employee resided at the time of becoming physically disabled, shall, in addition to other indemnity, be paid the actual and necessary costs of tuition, fees, books, and travel required for the employee's rehabilitation training program and, if the employee receives that instruction elsewhere than at the place of residence, the actual and necessary costs of maintenance, during rehabilitation, subject to the conditions and limitations specified in sub. (1r).[264] The costs of travel under this subsection shall be paid at the same rate as is provided for state officers and employees under s. 20.916 (8).[265]

(1g) (a) In this subsection, "suitable employment" means employment that is within an employee's permanent work restrictions, that the employee has the necessary physical capacity, knowledge, transferable skills, and ability to perform, and that pays not less than 90 percent of the employee's preinjury average weekly wage, except that employment that pays 90 percent or more of the employee's preinjury average weekly wage does not constitute suitable employment if any of the following apply:[266]

1. The employee's education, training, or employment experience demonstrates that the employee is on a career or vocational path, the employee's average weekly wage on the date of injury does not reflect the average weekly wage that the employee reasonably could have been expected to earn in the demonstrated career or vocational path, and the permanent work restrictions caused by the injury impede the employee's ability to pursue the demonstrated career or vocational path.

2. The employee was performing part-time employment at the time of the injury, the employee's average weekly wage for compensation purposes is calculated under s. 102.11 (1) (f) 1. or 2., and that average weekly wage exceeds the employee's gross average weekly wage for the part-time employment.

(b) If an employer offers an employee suitable employment as provided in par. (c), the employer or the employer's insurance carrier is not liable for temporary disability benefits under s. 102.43 (5) (b) or for the cost of tuition, fees, books, travel, and maintenance under sub. (1). Ineligibility for compensation under this paragraph does not preclude an employee from receiving vocational rehabilitation services

[264] This subsection was amended by 2011 Wis. Act 183, effective April 17, 2012, to provide that worker's compensation insurance carriers and self-insured employers will be liable for the reasonable costs of an employee's retraining program including the cost of tuition, fees and books in cases where the Division of Vocational Rehabilitation ["DVR"] provides services for the retraining program.

[265] This amendment codifies the department's policy of setting the mileage reimbursement rate that employees receive for travel to attend vocational rehabilitation training at the same rate state employees receive for business travel. 2005 Wis. Act 172, effective April 1, 2006. A listing of applicable mileage rates is set forth at the back of this publication.

[266] A carrier or self-insured employer is not liable for retraining if an employer offers suitable employment to the employee. For employees who receive services from the DVR, suitable employment is defined as employment within the employee's permanent work restrictions, the employee has the necessary physical capacity, knowledge, transferable skills, ability to perform, and that pays not less than 90 percent of the employee's preinjury average weekly earnings. 2001 Wis. Act 37, effective Jan. 1, 2002, amended this section to define suitable employment.

For employees who cannot receive services from the DVR, suitable employment remains defined as a job within the employee's permanent work restrictions for which the employee has the necessary physical capacity, knowledge, transferable skills, ability and which pays at least 85 percent of the employee's preinjury average weekly wage. See Rule DWD 80.49(4)(d) and (5).

under 29 USC 701 to 797b if the department determines that the employee is eligible to receive those services.

(c) On receiving notice that he or she is eligible to receive vocational rehabilitation services under 29 USC 701 to 797a, an employee shall provide the employer with a written report from a physician, chiropractor, psychologist, or podiatrist stating the employee's permanent work restrictions. Within 60 days after receiving that report, the employer shall provide to the employee in writing an offer of suitable employment, a statement that the employer has no suitable employment for the employee, or a report from a physician, chiropractor, psychologist, or podiatrist showing that the permanent work restrictions provided by the employee's practitioner are in dispute and documentation showing that the difference in work restrictions would materially affect either the employer's ability to provide suitable employment or a vocational rehabilitation counselor's ability to recommend a rehabilitative training program. If the employer and employee cannot resolve the dispute within 30 days after the employee receives the employer's report and documentation, the employer or employee may request a hearing before the division to determine the employee's work restrictions. Within 30 days after the division determines the employee's work restrictions, the employer shall provide to the employee in writing an offer of suitable employment or a statement that the employer has no suitable employment for the employee.

(1m) (a) If the department has determined under sub. (1) that an employee is eligible for vocational rehabilitation services under 29 USC 701 to 797b, but that the department cannot provide those services for the employee, the employee may select a private rehabilitation counselor[267] certified by the department to determine whether the employee can return to suitable employment without rehabilitative training and, if that counselor determines that rehabilitative training is necessary, to develop a rehabilitative training program[268] to restore as nearly as possible the employee to his or her preinjury earning capacity and potential.

(b) Notwithstanding s. 102.03 (4), an employee whose date of injury is before May 4, 1994, may receive private rehabilitative counseling and rehabilitative training under par. (a).[269]

(c) The employer or insurance carrier shall pay the reasonable cost[270] of any services provided for an employee by a private rehabilitation counselor under par. (a) and, subject to the conditions and limitations specified in sub. (1r) (a) to (c) and by rule, if the private rehabilitation counselor determines that rehabilitative training is necessary, the reasonable cost of the rehabilitative training program recommended by that counselor, including the cost of tuition, fees, books, maintenance, and travel at the same rate as is provided for state officers and employees under s. 20.916 (8). Notwithstanding that the department or the division may authorize under s. 102.43 (5) (b) a rehabilitative training program that lasts longer than 80 weeks, a rehabilitative training program that lasts 80 weeks or less is presumed to be reasonable.[271]

(d) If an employee receives services from a private rehabilitation counselor under par. (a) and later receives similar services from the department under sub. (1) without the prior approval of the employer or insurance carrier, the employer or insurance carrier is not liable for temporary disability benefits under s. 102.43 (5) (b) or for tuition, fee, book, travel, and maintenance costs under sub. (1) that exceed what the employer or insurance carrier would

[267] See Rule DWD 80.49(6) for rules establishing the certification process.

[268] "Training program" is defined by rule to mean a course of instruction on a regular basis which provides an employee with marketable job skills or enhances existing job skills to make them marketable. See Rule DWD 80.49(2)(c).

[269] This is necessary to allow employees who cannot be served by the department, to receive rehabilitative training regardless of the date of injury.

[270] Rule DWD 80.49, as amended effective December 2, 1994, further defines the scope of counselor services for which the carrier or self-insured employer is liable, and the maximum cost for services by private rehabilitation counselors. The department adjusts the maximum cost annually based on the average annual percentage change in the US consumer price index for all urban consumers. A listing of the yearly maximum cost limits is set forth at the back of this publication.

[271] The presumption of reasonableness is intended to be rebuttable.

have been liable for under the rehabilitative training program developed by the private rehabilitation counselor.[272]

(e) Nothing in this subsection prevents an employer or insurance carrier from providing an employee with the services of a private rehabilitation counselor or with rehabilitative training under sub. (3) before the department makes its determination under par. (a).

(f) The department shall promulgate rules establishing procedures and requirements for the private rehabilitation counseling and rehabilitative training process under this subsection. Those rules shall include rules specifying the procedure and requirements for certification of private rehabilitation counselors.

(1r) An employee who receives a course of instruction or other rehabilitative training under sub. (1) or (1m) is subject to the following conditions and limitations:

(a) The employee must undertake the course of instruction within 60 days from the date when the employee has sufficiently recovered from the injury to permit so doing, or as soon thereafter as the officer or agency having charge of the instruction shall provide opportunity for the rehabilitation.

(b) The employee must continue in rehabilitation training with such reasonable regularity as health and situation will permit.

(c) The employee may not have the costs of tuition, fees, books, travel, and maintenance paid under sub. (1) or the costs of private rehabilitation counseling and rehabilitative training paid under sub. (1m) on account of training for a period in excess of 80 weeks in all, except as provided in s. 102.43 (5) (b).

(2) The division, the commission, and the courts shall determine the rights and liabilities of the parties under this section in like manner and with like effect as the division, the commission, and the courts determine other issues under this chapter. A determination under this subsection may include a determination based on the evidence regarding the cost or scope of the services provided by a private rehabilitation counselor under sub. (1m) (a) or the cost or reasonableness of a rehabilitative training program developed under sub. (1m) (a).[273]

(3) Nothing in this section prevents an employer or insurance carrier from providing an employee with the services of a private rehabilitation counselor or with rehabilitative training if the employee voluntarily accepts those services or that training.

History: 1975 c. 147; 1985 a. 83, 135; 1993 a. 370; 1995 a. 27 ss. 3745, 9126 (19), 9130 (4); 1997 a. 3, 112; 2001 a. 37; 2005 a. 172; 2011 a. 183; 2015 a. 55.

Cross-reference: See also s. DWD 80.49, Wis. adm. code.

Under ss. 102.42 (9) (a), 102.43 (5), and 102.61, the department may extend temporary disability, travel expense, and maintenance costs beyond 40 weeks if additional training is warranted. Beloit Corp. v. State, 152 Wis. 2d 579, 449 N.W.2d 299 (Ct. App. 1989).

The provisions of this section encompass formalized courses of instruction only. Johnson v. LIRC, 177 Wis. 2d 736, 503 N.W.2d 1 (Ct. App. 1993).

Nothing in sub. (1g) or ch. 102 provides that an injured employee can be denied vocational rehabilitation benefits when he or she is offered suitable employment after an injury and is subsequently fired for just cause. Oshkosh Corporation v. LIRC, 2011 WI App 42, 332 Wis. 2d 261, 796 N.W.2d 217, 10-1219.

102.62 Primary and secondary liability; unchangeable. In case of liability under s. 102.57 or 102.60, the liability of the employer shall be primary and the liability of the insurance carrier shall be secondary. If proceedings are had before the division for the recovery of that liability, the division shall set forth in its award the amount and order of liability as provided in this section. Execution shall not be issued against the insurance carrier to satisfy any judgment covering that liability

[272] The carrier's or self-insured employer's liability cannot exceed what it would have been if the private counselor's plan had been completed. For example, if the counselor recommended a 60-week plan and after 45 weeks the employee becomes eligible for and switches to a DVR program, without prior approval from the carrier, the carrier is responsible for only the remaining 15 weeks of TTD, maintenance and travel expenses even if DVR were to develop a new 40-week, 50-week or 100-week retraining program.

[273] The limitations on the scope of review of DVR decisions as a result of Massachusetts Bonding & Ins. Co. v. Industrial Comm, 275 Wis. 505 (1957), and the line of cases following that decision, do not apply to a review of the cost, scope and reasonableness of services and programs developed by private rehabilitation counselors. The limitations still apply to determinations by the DVR.

until execution has first been issued against the employer and has been returned unsatisfied as to any part of that liability. Any provision in any insurance policy undertaking to guarantee primary liability or to avoid secondary liability for a liability under s. 102.57 or 102.60 is void. If the employer has been adjudged bankrupt or has made an assignment for the benefit of creditors, if the employer, other than an individual, has gone out of business or has been dissolved, or if the employer is a corporation and its charter has been forfeited or revoked, the insurer shall be liable for the payment of that liability without judgment or execution against the employer, but without altering the primary liability of the employer.

History: 2005 a. 172; 2015 a. 55.

102.63 Refunds by state. Whenever the department shall certify to the secretary of administration that excess payment has been made under s. 102.59 or under s. 102.49 (5) either because of mistake or otherwise, the secretary of administration shall within 5 days after receipt of such certificate draw an order against the fund in the state treasury into which such excess was paid, reimbursing such payor of such excess payment, together with interest actually earned thereon if the excess payment has been on deposit for at least 6 months.

History: 1981 c. 92; 2003 a. 33.

102.64 Attorney general shall represent state and commission.

(1) Upon request of the department of administration, a representative of the department of justice shall represent the state in cases involving payment into or out of the state treasury under s. 20.865 (1) (fm), (kr), or (ur) or 102.29. The department of justice, after giving notice to the department of administration, may compromise the amount of those payments but such compromises shall be subject to review by the department or the division. If the spouse or domestic partner under ch. 770 of the deceased employee compromises his or her claim for a primary death benefit, the claim of the children of the employee under s. 102.49 shall be compromised on the same proportional basis, subject to approval by the department or the division. If the persons entitled to compensation on the basis of total dependency under s. 102.51 (1) compromise their claim, payments under s. 102.49 (5) (a) shall be compromised on the same proportional basis.[274]

(2) Upon request of the department of administration, the attorney general shall appear on behalf of the state in proceedings upon claims for compensation against the state. Except as provided in s. 102.65 (3), the department of justice shall represent the interests of the state in proceedings under s. 102.44 (1), 102.49, 102.59, 102.60, or 102.66.[275] The department of justice may compromise claims in those proceedings, but the compromises are subject to review by the department or the division. Costs incurred by the department of justice in prosecuting or defending any claim for payment into or out of the work injury supplemental benefit fund under s. 102.65, including expert witness and witness fees but not including attorney fees or attorney travel expenses for services performed under this subsection, shall be paid from the work injury supplemental benefit fund.

(3) In any action to review an order or award of the commission, and upon any appeal therein to the court of appeals, the attorney general shall appear on behalf of the commission, whether any other party defendant shall be represented or not, except that in actions brought by the state the governor shall appoint an attorney to appear on behalf of the commission.

History: 1975 c. 147; 1977 c. 187 s. 134; 1977 c. 195; 1979 c. 110 s. 60 (11); 1981 c. 20; 1983 a. 98; 1995 a. 27 ss. 3745g, 9130 (4); 1997 a. 3; 2007 a. 185; 2009 a. 28; 2011 a. 183; 2015 a. 55.

Sub. (3) does not result in providing public counsel for a private party litigant, because nowhere does the statute make the attorney general the claimant's attorney, but expressly states that the attorney general shall appear on behalf of the department. Hunter v. DILHR, 64 Wis. 2d 97, 218 N.W.2d 314 (1974).

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[274] This eliminates the question of whether liability for children's benefits may be denied where compromise of a parent's claim has been made. Issues involved are the same in both cases so adjustment also is on a comparable basis. The same applies on payments into the Work Injury Supplemental Benefit Fund.

[275] This amendment establishes authority for the Attorney General's Office to represent the Work Injury Supplemental Benefit Fund for collection of double and treble compensation payments due for the illegal employment of minors. 2007 Wis. Act 185, effective April 1, 2008.

102.65 Work injury supplemental benefit fund.

(1) The moneys payable to the state treasury under ss. 102.35 (1), 102.47, 102.49, 102.59, and 102.60, together with all accrued interest on those moneys, and all interest payments received under s. 102.75 (2), shall constitute a separate nonlapsible fund designated as the work injury supplemental benefit fund. Moneys in the fund may be expended only as provided in s. 20.445 (1) (t) and may not be used for any other purpose of the state.[276]

(2) For proper administration of the moneys available in the fund the department shall by order, set aside in the state treasury suitable reserves to carry to maturity the liability for benefits under ss. 102.44, 102.49, 102.59 and 102.66. Such moneys shall be invested by the investment board in accordance with s. 25.14 (5).[277]

(3) The department of workforce development may retain the department of administration to process, investigate, and pay claims under ss. 102.44 (1), 102.49, 102.59, and 102.66. If retained by the department of workforce development, the department of administration may compromise a claim processed by that department, but a compromise made by that department is subject to review by the department of workforce development or the division. The department of workforce development shall pay for the services retained under this subsection from the appropriation account under s. 20.445 (1) (t).[278]

(4) The secretary shall monitor the cash balance in, and incurred losses to, the work injury supplemental benefit fund using generally accepted actuarial principles. If the secretary determines that the expected ultimate losses to the work injury supplemental benefit fund on known claims exceed 85 percent of the cash balance in that fund, the secretary shall consult with the council on worker's compensation. If the secretary, after consulting with the council on worker's compensation, determines that there is a reasonable likelihood that the cash balance in the work injury supplemental benefit fund may become inadequate to fund all claims under ss. 102.49, 102.59, and 102.66, the secretary shall file with the secretary of administration a certificate attesting that the cash balance in that fund is likely to become inadequate to fund all claims under ss. 102.49, 102.59, and 102.66 and specifying one of the following:[279]

(a) That payment of those claims will be made as provided in a schedule that the department shall promulgate by rule.

(b) A date after which payment of those claims will be reduced.

(c) A date after which no new claims under those provisions will be paid.

History: 1975 c. 147; 1977 c. 29; 1981 c. 20 s. 2202 (28) (a); 1983 a. 98 s. 31; 1989 a. 64; 1991 a. 174; 1995 a. 117; 2005 a. 172; 2007 a. 185; 2011 a. 183; 2015 a. 55.

[276] The Work Injury Supplemental Benefit Fund is made nonlapsible with this amendment and the money in the fund may only be used for statutory purposes and no other state purposes. 2005 Wis. Act 172, effective April 1, 2006.

[277] With this amendment the Work Injury Supplemental Benefit Fund no longer has a maximum balance limit of three times the amount of payments made in the preceding fiscal year. 2007 Wis. Act 185, effective April 1, 2008.

[278] 2011 Wis. Act 183, effective April 17, 2012, authorizes the department to retain the Department of Administration to handle claims involving the Work Injury Supplemental Benefit Fund.

[279] 2011 Wis. Act 183, effective April 17, 2012, authorizes the department to prioritize, reduce or cease payments from the Work Injury Supplemental Benefit Fund if the cash balance of the fund becomes encumbered more than 85% by known claims after consultation with the Worker's Compensation Advisory Council. The department reduced supplemental benefit reimbursements payments to $0 effective May 14, 2013, after the Worker's Compensation Advisory Council unanimously passed a motion for this and the department filed a certificate with the Secretary of the Department of Administration attesting the cash balance of the fund will likely become inadequate to fund all statutory claims.

102.66 Payment of certain barred claims.

(1) Subject to any certificate filed under s. 102.65 (4), if there is an otherwise meritorious claim for occupational disease, or for a traumatic injury described in s. 102.17 (4) in which the date of injury or death or last payment of compensation, other than for treatment or burial expenses, is before April 1, 2006, and if the claim is barred solely by the statute of limitations under s. 102.17 (4), the department or the division may, in lieu of worker's compensation benefits, direct payment from the work injury supplemental benefit fund under s. 102.65 of such compensation and such medical expenses as would otherwise be due, based on the date of injury, to or on behalf of the injured employee.[280] The benefits shall be supplemental, to the extent of compensation liability, to any disability or medical benefits payable from any group insurance policy whose premium is paid in whole or in part by any employer, or under any federal insurance or benefit program providing disability or medical benefits. Death benefits payable under any such group policy do not limit the benefits payable under this section.

(2) In the case of occupational disease, or of a traumatic injury described in s. 102.17 (4) in which the date of injury or death or last payment of compensation, other than for treatment for burial expenses, is before April 1, 2006, appropriate benefits may be awarded from the work injury supplemental benefit fund when the status or existence of the employer or its insurance carrier cannot be determined or when there is otherwise no adequate remedy, subject to the limitations contained in sub. (1).

History: 1975 c. 147; 1979 c. 278; 2001 a. 37; 2005 a. 172; 2011 a. 183; 2015 a. 55.

Cross-reference: See also s. DWD 80.06, Wis. adm. code.

This section authorizes the award of benefits for otherwise meritorious claims barred by the statute of limitations in effect at the time the claim arose. State v. DILHR, 101 Wis. 2d 396, 304 N.W.2d 758 (1981).

When a disabled worker could have claimed permanent total disability benefits under this section, but failed to do so before dying of causes unrelated to a compensable injury, a surviving dependent may not claim the disability benefits. State v. LIRC, 136 Wis. 2d 281, 401 N.W.2d 578 (1987).

102.75 Administrative expenses.

(1) The department shall assess upon and collect from each licensed worker's compensation insurance carrier and from each employer exempted under s. 102.28 (2) (b) or (bm) from the duty to carry insurance under s. 102.28 (2) (a) the proportion of total costs and expenses incurred by the council on worker's compensation for travel and research and by the department, the division, and the commission in the administration of this chapter for the current fiscal year, plus any deficiencies in collections and anticipated costs from the previous fiscal year, that the total indemnity paid or payable under this chapter by each such carrier and exempt employer in worker's compensation cases initially closed during the preceding calendar year, other than for increased, double, or treble compensation, bore to the total indemnity paid in cases closed the previous calendar year under this chapter by all carriers and exempt employers, other than for increased, double, or treble compensation. The council on worker's compensation, the division, and the commission shall annually certify any costs and expenses for worker's compensation activities to the department at such time as the secretary requires.

(1g) (a) Subject to par. (b), the department shall collect from each licensed worker's compensation carrier the proportion of reimbursement approved by the department under s. 102.44 (1) (c) 1. for supplemental benefits paid in the year before the previous year that the total indemnity paid or payable under this chapter by the carrier in worker's compensation cases initially closed during the

[280] 2015 Wis. Act 55, effective January 1, 2016, terminated reimbursement from the Work Injury Supplemental Benefit Fund for supplemental benefits paid by employers and insurance carriers. Reimbursement for supplemental benefits for injuries occurring before January 1, 2016, will be made to insurance carriers from the worker's compensation operations fund. The revenue to fund the supplemental benefit reimbursements will be from annual assessments on each worker's compensation insurance carrier based on a similar calculation that is used for that insurer in the annual general assessment for the department's operations fund. The calculation will be based on the proportion of an insurance carrier's total indemnity paid for cases initially closed in the previous calendar year compared to the total indemnity paid by all insurance carriers in cases closed in the preceding year.

preceding calendar year, other than for increased, double, or treble compensation, bore to the total indemnity paid in cases closed the previous calendar year under this chapter by all carriers, other than for increased, double, or treble compensation.

(b) The maximum amount that the department may collect under par. (a) in a calendar year is $5,000,000. If the amount determined collectible under par. (a) in a calendar year is $5,000,000 or less, the department shall collect that amount. If the amount determined collectible under par. (a) in a calendar year exceeds $5,000,000, the department shall collect $5,000,000 in the year in which the determination is made and, subject to the maximum amount collectible of $5,000,000 per calendar year, shall collect the excess in the next calendar year or in subsequent calendar years until that excess is collected in full.

(c) This subsection does not apply to claims for reimbursement under s. 102.44 (1) (c) 1. for supplemental benefits paid for injuries that occur on or after January 1, 2016.

(1m) The moneys collected under subs. (1) and (1g) and under ss. 102.28 (2) and 102.31 (7), together with all accrued interest, shall constitute a separate nonlapsible fund designated as the worker's compensation operations fund. Moneys in the fund may be expended only as provided in ss. 20.427 (1) (ra) and 20.445 (1) (ra), (rb), and (rp) and may not be used for any other purpose of the state.[281]

(2) The department shall require each licensed worker's compensation insurance carrier and employer exempted under s. 102.28 (2) (b) or (bm) from the duty to insure under s. 102.28 (2) (a) to make the payments required under sub. (1) for each fiscal year on such dates as the department prescribes. The department shall also require each licensed worker's compensation insurance carrier to make the payments required under sub. (1g) for each fiscal year on those dates. Each such payment shall be a sum equal to a proportionate share of the annual costs and expenses assessed upon each carrier and employer as estimated by the department. Interest shall accrue on amounts not paid within 30 days after the date prescribed by the department under this subsection at the rate of 1 percent per month. All interest payments received under this subsection shall be deposited in the fund established under s. 102.65.[282]

(4) From the appropriation under s. 20.445 (1) (ra), the department shall allocate the amounts that it collects in application fees from employers applying for exemption under s. 102.28 (2) (b) and the annual amount that it collects from employers that have been exempted under s. 102.28 (2) (b) to fund the activities of the department under s. 102.28 (2) (b) and (c) with respect to those employers.

History: 1975 c. 39; 1975 c. 147 s. 54; 1977 c. 195, 418; 1981 c. 20, 92; 1987 a. 27; 1991 a. 85; 1995 a. 117; 2005 a. 172; 2009 a. 206; 2013 a. 20; 2015 a. 55, 180.

Cross-reference: See also s. DWD 80.38, Wis. adm. code.

102.80 Uninsured employers fund.[283]

(1) There is established a separate, nonlapsible trust fund designated as the uninsured employers fund consisting of all the following:

(a) Amounts collected from uninsured employers under s. 102.82.

(b) Uninsured employer surcharges collected under s. 102.85 (4).

(d) Amounts collected from employees or dependents of employees under s. 102.81 (4) (b).

(e) All moneys received by the department for the uninsured employers fund from any other source.

(f) Amounts transferred to the uninsured employers fund from the appropriation account under s. 20.445 (1) (ra) as provided in s. 102.81 (1) (c).[284]

(1m) The moneys collected or received under sub. (1), together with all accrued interest, shall

[281] The worker's compensation operations fund is made a separate nonlapsible fund with this amendment and the money in the fund may only be used for statutory purposes and no other state purposes. This amendment also provides for interest on late assessment payments to be deposited in the Work Injury Supplemental Benefit Fund. 2005 Wis. Act 172, effective April 1, 2006.

[282] This amendment provides that interest on the assessment accrues 30 days after the due date. 2009 Wis. Act 206, effective May 1, 2010.

[283] This creates a fund from which the department will pay worker's compensation benefits to employees whose employers violate the requirement to obtain worker's compensation insurance coverage.

[284] This paragraph was created by 2015 Wis. Act 55, effective January 1, 2016.

constitute a separate nonlapsible fund designated as the uninsured employers fund. Moneys in the fund may be expended only as provided in s. 20.445 (1) (sm) and may not be used for any other purpose of the state.[285]

(3) (a) If the cash balance in the uninsured employers fund equals or exceeds $4,000,000, the secretary shall consult the council on worker's compensation within 45 days after that cash balance equals or exceeds $4,000,000. The secretary may file with the secretary of administration, within 15 days after consulting the council on worker's compensation, a certificate attesting that the cash balance in the uninsured employers fund equals or exceeds $4,000,000.[286]

(ag) The secretary shall monitor the cash balance in, and incurred losses to, the uninsured employers fund using generally accepted actuarial principles. If the secretary determines that the expected ultimate losses to the uninsured employers fund on known claims exceed 85 percent of the cash balance in the uninsured employers fund, the secretary shall consult with the council on worker's compensation. If the secretary, after consulting with the council on worker's compensation, determines that there is a reasonable likelihood that the cash balance in the uninsured employers fund may become inadequate to fund all claims under s. 102.81 (1), the secretary shall file with the secretary of administration a certificate attesting that the cash balance in the uninsured employer's fund is likely to become inadequate to fund all claims under s. 102.81 (1) and specifying a date after which no new claims under s. 102.81 (1) will be paid.[287]

(am) If the secretary files the certificate under par. (a), the department may expend the moneys in the uninsured employers fund, beginning on the first day of the first July after the secretary files that certificate, to make payments under s. 102.81 (1) to employees of uninsured employers and to obtain reinsurance under s. 102.81 (2).[288]

(b) If the secretary does not file the certificate under par. (a), the department may not expend the moneys in the uninsured employers fund.

(c) If, after filing the certificate under par. (a), the secretary files the certificate under par. (ag), the department may expend the moneys in the uninsured employers fund only to make payments under s. 102.81 (1) to employees of uninsured employers on claims made before the date specified in that certificate and to obtain reinsurance under s. 102.81 (2) for the payment of those claims.

(4) (a) If an uninsured employer who owes to the department any amount under s. 102.82 or 102.85 (4) transfers his or her business assets or activities, the transferee is liable for the amounts owed by the uninsured employer under s. 102.82 or 102.85 (4) if the department determines that all of the following conditions are satisfied:

1. At the time of the transfer, the uninsured employer and the transferee are owned or controlled in whole or in substantial part, either directly or indirectly, by the same interest or interests. Without limitation by reason of enumeration, it is presumed unless shown to the contrary that the "same interest or interests" includes the spouse, child or parent of the individual who owned or controlled the business, or any combination of more than one of them.

2. The transferee has continued or resumed the business of the uninsured employer, either in the same establishment or elsewhere; or the transferee has employed substantially the same employees as those the uninsured employer had employed in connection with the business assets or activities transferred.

(b) The department may collect from a transferee described in par. (a) an amount owed under s. 102.82 or 102.85 (4) using the procedures specified in ss. 102.83, 102.835 and 102.87 and the preference specified in s. 102.84 in the same manner as the department may collect from an uninsured employer.[289]

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[285] The Uninsured Employers Fund is made a separate nonlapsible fund with this amendment and the money in the fund may only be used only for statutory purposes and no other state purposes. 2005 Wis. Act 172, effective April 1, 2006.

[286] The $4,000,000 cash balance was reached early in 1996.

[287] This provides for a procedure to stop accepting new claims if the department determines the fund is likely to become insolvent.

[288] This authorized the department to activate the fund on July 1, 1996, and to reinsure its liability.

[289] This applies successorship principles to determine liability for penalties incurred by the prior business.

History: 1989 a. 64; 1991 a. 85; 1993 a. 81; 1995 a. 117; 2003 a. 139; 2005 a. 172; 2007 a. 185; 2015 a. 55.

102.81 Compensation for injured employee of uninsured employer.

(1) (a) If an employee of an uninsured employer, other than an employee who is eligible to receive alternative benefits under s. 102.28 (3), suffers an injury for which the uninsured employer is liable under s. 102.03, the department or the department's reinsurer shall pay to or on behalf of the injured employee or to the employee's dependents an amount equal to the compensation owed them by the uninsured employer under this chapter except penalties and interest due under ss. 102.16 (3), 102.18 (1) (b) 3. and (bp), 102.22 (1), 102.35 (3), 102.57, and 102.60.[290]

(b) The department shall make the payments required under par. (a) from the uninsured employers fund, except that if the department has obtained reinsurance under sub. (2) and is unable to make those payments from the uninsured employers fund, the department's reinsurer shall make those payments according to the terms of the contract of reinsurance.

(c)[291] **1.** The department shall pay a claim under par. (a) in excess of $1,000,000 from the uninsured employers fund in the first instance. If the claim is not covered by excess or stop-loss reinsurance under sub. (2), the secretary of administration shall transfer from the appropriation account under s. 20.445 (1) (ra) to the uninsured employers fund as provided in subds. 2. and 3. an amount equal to the amount by which payments from the uninsured employers fund on the claim are in excess of $1,000,000.

2. Each calendar year the department shall file with the secretary of administration a certificate setting forth the number of claims in excess of $1,000,000 in the preceding year paid from the uninsured employers fund, the payments made from the uninsured employers fund on each such claim in the preceding year, and the total payments made from the uninsured employers fund on all such claims and, based on that information, the secretary of administration shall determine the amount to be transferred under subd. 1. in that calendar year.

3. The maximum amount that the secretary of administration may transfer under subd. 1. in a calendar year is $500,000. If the amount determined under subd. 2. is $500,000 or less, the secretary of administration shall transfer the amount determined under subd. 2. If the amount determined under subd. 2. exceeds $500,000, the secretary of administration shall transfer $500,000 in the calendar year in which the determination is made and, subject to the maximum transfer amount of $500,000 per calendar year, shall transfer that excess in the next calendar year or in subsequent calendar years until that excess is transferred in full.

(2) The department may retain an insurance carrier or insurance service organization to process, investigate and pay claims under this section and may obtain excess or stop-loss reinsurance with an insurance carrier authorized to do business in this state in an amount that the secretary determines is necessary for the sound operation of the uninsured employers fund. In cases involving disputed claims, the department may retain an attorney to represent the interests of the uninsured employers fund and to make appearances on behalf of the uninsured employers fund in proceedings under ss. 102.16 to 102.29. Section 20.930 and all provisions of subch. IV of ch. 16, except s. 16.753, do not apply to an attorney hired under this subsection. The charges for the services retained under this subsection shall be paid from the appropriation under s. 20.445 (1) (rp). The cost of any reinsurance obtained under this subsection shall

[290] The Uninsured Employers Fund (UEF) will pay the basic compensation owed but not penalties.

[291] 2015 Wis. Act 55, effective January 1, 2016 created additional solvency protection for the UEF for claims in excess of $1,000,000. With this amendment the department is required to pay a claim by an employee of an illegally uninsured employer in excess of $1,000,000 in the first instance. If the claim is not covered by excess or stop-loss reinsurance worker's compensation insurance carriers will be responsible to pay reimbursement for claim payments in excess of $1,000,000. The department will assess insurance carriers annually their pro rata portion of payments made by the UEF in excess of $1,000,000 subject to a $500,000 annual limit. Reimbursement in excess of the $500,000 annual limit will be made in the next calendar year or in subsequent calendar years until the reimbursement is paid in full.

be paid from the appropriation under s. 20.445 (1) (sm).

(3) An injured employee of an uninsured employer or his or her dependents may attempt to recover from the uninsured employer, or a 3rd party under s. 102.29, while receiving or attempting to receive payment under sub. (1).

(4) An injured employee, or the dependent of an injured employee, who received one or more payments under sub. (1) shall do all of the following:

(a) If the employee or dependent begins an action to recover compensation from the employee's employer or a 3rd party liable under s. 102.29, provide to the department a copy of all papers filed by any party in the action.

(b) If the employee or dependent receives compensation from the employee's employer or a 3rd party liable under s. 102.29, pay to the department the lesser of the following:

1. The amount after attorney fees and costs that the employee or dependent received under sub. (1).

2. The amount after attorney fees and costs that the employee or dependent received from the employer or 3rd party.

(5) The department of justice may bring an action to collect the payment under sub. (4).

(6) (a) Subject to par. (b), an employee, a dependent of an employee, an uninsured employer, a 3rd party who is liable under s. 102.29 or the department may enter into an agreement to settle liabilities under this chapter.

(b) A settlement under par. (a) is void without the department's written approval.

(7) This section first applies to injuries occurring on the first day of the first July beginning after the day that the secretary files a certificate under s. 102.80 (3) (a), except that if the secretary files a certificate under s. 102.80 (3) (ag) this section does not apply to claims filed on or after the date specified in that certificate.[292]

History: 1989 a. 64; 1995 a. 117; 2003 a. 144; 2005 a. 172, 253, 410; 2007 a. 97; 2009 a. 206; 2015 a. 55, 180.

Cross-reference: See also s. DWD 80.62, Wis. adm. code.

Section 102.18 (1) (bp) does not govern the conduct of the Department or its agent and does not impose any penalty on the department or its agent for bad faith conduct in administering the Uninsured Employers Fund. Section 102.18 (1) (bp) constitutes the exclusive remedy for the bad faith conduct of an employer or an insurance carrier. Because s. 102.18 (1) (bp) does not apply to the department's agent, it does not provide an exclusive remedy for the agent's bad faith. Moreover, sub. (1) (a) exempts the Department and its agent from paying an employee the statutory penalties and interest imposed on an employer or an insurance carrier for their misdeeds, but nothing in sub (1) (a) exempts the department or its agent from liability for its bad faith conduct in processing claims. Aslakson v. Gallagher Bassett Services, Inc. 2007 WI 39, 300 Wis. 2d 92, 729 N.W.2d 712, 04-2588.

102.82 Uninsured employer payments.

(1) Except as provided in sub. (2) (ar), an uninsured employer shall reimburse the department for any payment made under s. 102.81 (1) to or on behalf of an employee of the uninsured employer or to an employee's dependents and for any expenses paid by the department in administering the claim[293] of the employee or dependents, less amounts repaid by the employee or dependents under s. 102.81 (4) (b). The reimbursement owed under this subsection is due within 30 days after the date on which the department notifies the uninsured employer that the reimbursement is owed. Interest shall accrue on amounts not paid when due at the rate of 1 percent per month.[294]

(2) (a) Except as provided in pars. (ag), (am) and (ar), all uninsured employers shall pay to the department the greater of the following:

1. Twice the amount determined by the department to equal what the uninsured employer would have paid during periods of illegal nonpayment for worker's compensation insurance in the preceding 3-year period based on the employer's payroll in the preceding 3 years.

[292] Only injuries occurring after the quarter when the fund activates are paid.

[293] 2003 Wis. Act 144, effective March 30, 2004, authorizes the department to claim reimbursement from uninsured employers for claims administration expenses paid by the department in addition to all payments made to or on behalf of employees or their dependents. With the amendment in 2009 Wis. Act 206, effective May 1, 2010 the department may also waive claim administration expenses in cases where the employer was a victim of fraud, misrepresentation or gross negligence by an insurance agent or by a person whom a reasonable person would believe is an insurance agent or insurance broker.

[294] A 30-day deadline is created within which the employer must reimburse the department.

2. Seven hundred and fifty dollars.[295]

(ag) An uninsured employer who is liable to the department under par. (a) 2 shall pay to the department, in lieu of the payment required under par. (a) 2., $100 per day for each day that the employer is uninsured if all of the following apply:

1. The employer is uninsured for 7 consecutive days or less.

2. The employer has not previously been uninsured.

3. No injury for which the employer is liable under s. 102.03 has occurred during the period in which the employer is uninsured.[296]

(am) The department may waive any payment owed under par. (a) by an uninsured employer if the department determines that the uninsured employer is subject to this chapter only because the uninsured employer has elected to become subject to this chapter under s. 102.05 (2) or 102.28 (2).[297]

(ar) The department may waive any payment owed under par. (a) or (ag) or sub. (1) if the department determines that the sole reason for the uninsured employer's failure to comply with s. 102.28 (2) is that the uninsured employer was a victim of fraud, misrepresentation or gross negligence by an insurance agent or insurance broker or by a person whom a reasonable person would believe is an insurance agent or insurance broker.[298]

(b) The payment owed under par. (a) or (ag) is due within 30 days after the date on which the employer is notified. Interest shall accrue on amounts not paid when due at the rate of 1 percent per month.

(c) The department of justice or, if the department of justice consents, the department of workforce development may bring an action in circuit court to recover payments and interest owed to the department of workforce development under this section.

(3) (a) When an employee dies as a result of an injury for which an uninsured employer is liable under s. 102.03, the uninsured employer shall pay $1,000 to the department.

(b) The payment under par. (a) is in addition to any benefits or other compensation paid to an employee or survivors or the work injury supplemental benefit fund under ss. 102.46 to 102.51.

History: 1989 a. 64, 359; 1991 a. 85; 1993 a. 81; 1995 a. 27 s. 9130 (4); 1997 a. 3, 38; 2003 a. 144; 2009 a. 206.

102.83 Collection of uninsured employer payments.[299]

(1) (a) 1. If an uninsured employer or any individual who is found personally liable under sub. (8) fails to pay to the department any amount owed to the department under s. 102.82 and no proceeding for review is pending, the department or any authorized representative may issue a warrant directed to the clerk of circuit court for any county of the state.

2. The clerk of circuit court shall enter in the judgment and lien docket the name of the uninsured employer or the individual mentioned in the warrant and the amount of the payments, interest, costs, and other fees for which the warrant is issued and the date when the warrant is entered.

3. A warrant entered under subd. 2. shall be considered in all respects as a final judgment constituting a perfected lien on the right, title, and interest of the uninsured employer or the individual in all of that person's real and personal property located in the county where the warrant is entered. The lien is effective when the department issues the warrant under subd. 1. and shall continue until the amount owed,

[295] The minimum payment owed under this paragraph is $750.

[296] This reduces the payment for a one-time lapse in coverage when no compensable injury occurs during the lapse to $100 per day without coverage for up to seven consecutive days.

[297] This waives payments for failure to insure when the employer who has terminated coverage is subject to the act solely because of a voluntary decision to elect coverage in the first place.

[298] In determining whether to waive a payment, the department will rely on a finding of fraud, misrepresentation or gross negligence by the office of the commissioner of insurance.

[299] This allows the department to attach a lien on real or personal property and garnish financial assets when an uninsured employer refuses to pay a penalty for failure to insure. The amendments in 2007 Wis. Act 185, effective April 1, 2008 increase the time limit that liens resulting from warrants remain in effect from 10 years to the date paid and also extend personal liability based on individual, joint and several liability until the date paid.

including interest, costs, and other fees to the date of payment, is paid.

4. After the warrant is entered in the judgment and lien docket, the department or any authorized representative may file an execution with the clerk of circuit court for filing by the clerk of circuit court with the sheriff of any county where real or personal property of the uninsured employer or the individual is found, commanding the sheriff to levy upon and sell sufficient real and personal property of the uninsured employer or the individual to pay the amount stated in the warrant in the same manner as upon an execution against property issued upon the judgment of a court of record, and to return the warrant to the department and pay to it the money collected by virtue of the warrant within 60 days after receipt of the warrant.

(b) The clerk of circuit court shall accept and enter the warrant in the judgment and lien docket without prepayment of any fee, but the clerk of circuit court shall submit a statement of the proper fee semiannually to the department covering the periods from January 1 to June 30 and July 1 to December 31 unless a different billing period is agreed to between the clerk and the department. The fees shall then be paid by the department, but the fees provided by s. 814.61 (5) for entering the warrants shall be added to the amount of the warrant and collected from the uninsured employer or the individual when satisfaction or release is presented for entry.

(2) The department may issue a warrant of like terms, force, and effect to any employee or other agent of the department, who may file a copy of the warrant with the clerk of circuit court of any county in the state, and thereupon the clerk of circuit court shall enter the warrant in the judgment and lien docket and the warrant shall become a lien in the same manner, and with the same force and effect, as provided in sub. (1). In the execution of the warrant, the employee or other agent shall have all the powers conferred by law upon a sheriff, but may not collect from the uninsured employer or the individual any fee or charge for the execution of the warrant in excess of the actual expenses paid in the performance of his or her duty.

(3) If a warrant is returned not satisfied in full, the department shall have the same remedies to enforce the amount due for payments, interest, costs, and other fees as if the department had recovered judgment against the uninsured employer or the individual and an execution had been returned wholly or partially not satisfied.

(4) When the payments, interest, costs, and other fees specified in a warrant have been paid to the department, the department shall issue a satisfaction of the warrant and file it with the clerk of circuit court. The clerk of circuit court shall immediately enter the satisfaction of the judgment in the judgment and lien docket. The department shall send a copy of the satisfaction to the uninsured employer or the individual.

(5) The department, if it finds that the interests of the state will not be jeopardized, and upon such conditions as it may exact, may issue a release of any warrant with respect to any real or personal property upon which the warrant is a lien or cloud upon title. The clerk of circuit court shall enter the release upon presentation of the release to the clerk and payment of the fee for filing the release and the release shall be conclusive proof that the lien or cloud upon the title of the property covered by the release is extinguished.

(6) At any time after the filing of a warrant, the department may commence and maintain a garnishee action as provided by ch. 812 or may use the remedy of attachment as provided by ch. 811 for actions to enforce a judgment. The place of trial of an action under ch. 811 or 812 may be either in Dane County or the county where the debtor resides and may not be changed from the county in which the action is commenced, except upon consent of the parties.

(7) If the department issues an erroneous warrant, the department shall issue a notice of withdrawal of the warrant to the clerk of circuit court for the county in which the warrant is filed. The clerk shall void the warrant and any liens attached by it.

(8) Any officer or director of an uninsured employer that is a corporation and any member or manager of an uninsured employer that is a limited liability company may be found individually and jointly and severally liable for the payments, interest, costs and other fees specified in a warrant under this section if after proper proceedings for the collection of those amounts from the corporation or limited liability

company, as provided in this section, the corporation or limited liability company is unable to pay those amounts to the department. The personal liability of the officers and directors of a corporation or of the members and managers of a limited liability company as provided in this subsection is an independent obligation, survives dissolution, reorganization, bankruptcy, receivership, assignment for the benefit of creditors, judicially confirmed extension or composition, or any analogous situation of the corporation or limited liability company, and shall be set forth in a determination or decision issued under s. 102.82.[300]

History: 1993 a. 81; 1995 a. 117, 224; 1997 a. 35, 38; 2007 a. 185.

102.835 Levy for delinquent payments.[301]

(1) DEFINITIONS. In this section:

(a) "Debt" means a delinquent payment.

(ad) "Debtor" means an uninsured employer or an individual found personally liable under s. 102.83 (8) who owes the department a debt.

(d) "Levy" means all powers of distraint and seizure.

(e) "Payment" means a payment owed to the department under s. 102.82 and includes interest on that payment.

(f) "Property" includes all tangible and intangible personal property and rights to that property, including compensation paid or payable for personal services, whether denominated as wages, salary, commission, bonus or otherwise, amounts paid periodically pursuant to a pension or retirement program, rents, proceeds of insurance and amounts paid pursuant to a contract.

(2) POWERS OF LEVY AND DISTRAINT. If any debtor who is liable for any debt fails to pay that debt after the department has made demand for payment, the department may collect that debt and the expenses of the levy by levy upon any property belonging to the debtor. If the value of any property that has been levied upon under this section is not sufficient to satisfy the claim of the department, the department may levy upon any additional property of the debtor until the debt and expenses of the levy are fully paid.

(3) DUTIES TO SURRENDER. Any person in possession of or obligated with respect to property or rights to property that is subject to levy and upon which a levy has been made shall, upon demand of the department, surrender the property or rights or discharge the obligation to the department, except that part of the property or rights which is, at the time of the demand, subject to any prior attachment or execution under any judicial process.

(4) FAILURE TO SURRENDER; ENFORCEMENT OF LEVY.

(a) Any debtor who fails to surrender any property or rights to property that is subject to levy, upon demand by the department, is subject to proceedings to enforce the amount of the levy.

(b) Any 3rd party who fails to surrender any property or rights to property subject to levy, upon demand of the department, is subject to proceedings to enforce the levy. The 3rd party is not liable to the department under this paragraph for more than 25 percent of the debt. The department shall serve a final demand as provided under sub. (13) on any 3rd party who fails to surrender property. Proceedings may not be initiated by the department until 5 days after service of the final demand. The department shall issue a determination under s. 102.82 to the 3rd party for the amount of the liability.

(c) When a 3rd party surrenders the property or rights to the property on demand of the department or discharges the obligation to the department for which the levy is made, the 3rd party is discharged from any obligation or liability to the debtor with respect to the property or rights to the property arising from the surrender or payment to the department.

(5) ACTIONS AGAINST THIS STATE.

(a) If the department has levied upon property, any person, other than the debtor who is liable to pay the debt out of which the levy arose, who claims an interest in or lien on that property, and who claims that that property was wrongfully

[300] Members of uninsured limited liability companies were added by Chapter 38, Laws of 1997, effective January 1, 1998. This allows the department to collect payments from officers and directors of uninsured corporations.

[301] This procedure for collecting payments from uninsured employers permits the department to levy upon the uninsured employer's personal property administratively without commencing an action in circuit court.

levied upon may bring a civil action against the state in the circuit court for Dane County. That action may be brought whether or not that property has been surrendered to the department. The court may grant only the relief under par. (b). No other action to question the validity of or to restrain or enjoin a levy by the department may be maintained.

(b) In an action under par. (a), if a levy would irreparably injure rights to property, the court may enjoin the enforcement of that levy. If the court determines that the property has been wrongfully levied upon, it may grant a judgment for the amount of money obtained by levy.

(c) For purposes of an adjudication under this subsection, the determination of the debt upon which the interest or lien of the department is based is conclusively presumed to be valid.

(6) DETERMINATION OF EXPENSES. The department shall determine its costs and expenses to be paid in all cases of levy.

(7) USE OF PROCEEDS.

(a) The department shall apply all money obtained under this section first against the expenses of the proceedings and then against the liability in respect to which the levy was made and any other liability owed to the department by the debtor.

(b) The department may refund or credit any amount left after the applications under par. (a), upon submission of a claim for a refund or credit and satisfactory proof of the claim, to the person entitled to that amount.

(8) RELEASE OF LEVY. The department may release the levy upon all or part of property levied upon to facilitate the collection of the liability or to grant relief from a wrongful levy, but that release does not prevent any later levy.

(9) WRONGFUL LEVY. If the department determines that property has been wrongfully levied upon, the department may return the property at any time, or may return an amount of money equal to the amount of money levied upon.

(10) PRESERVATION OF REMEDIES. The availability of the remedy under this section does not abridge the right of the department to pursue other remedies.

(11) EVASION. Any person who removes, deposits or conceals or aids in removing, depositing or concealing any property upon which a levy is authorized under this section with intent to evade or defeat the assessment or collection of any debt is guilty of a Class I felony and shall be liable to the state for the costs of prosecution.

(12) NOTICE BEFORE LEVY. If no proceeding for review permitted by law is pending, the department shall make a demand to the debtor for payment of the debt which is subject to levy and give notice that the department may pursue legal action for collection of the debt against the debtor. The department shall make the demand for payment and give the notice at least 10 days prior to the levy, personally or by any type of mail service which requires a signature of acceptance, at the address of the debtor as it appears on the records of the department. The demand for payment and notice shall include a statement of the amount of the debt, including costs and fees, and the name of the debtor who is liable for the debt. The debtor's failure to accept or receive the notice does not prevent the department from making the levy. Notice prior to levy is not required for a subsequent levy on any debt of the same debtor within one year after the date of service of the original levy.

(13) SERVICE OF LEVY.

(a) The department shall serve the levy upon the debtor and 3rd party by personal service or by any type of mail service which requires a signature of acceptance.

(b) Personal service shall be made upon an individual, other than a minor or incapacitated person, by delivering a copy of the levy to the debtor or 3rd party personally; by leaving a copy of the levy at the debtor's dwelling or usual place of abode with some person of suitable age and discretion residing there; by leaving a copy of the levy at the business establishment of the debtor with an officer or employee of the debtor; or by delivering a copy of the levy to an agent authorized by law to receive service of process.

(c) The department representative who serves the levy shall certify service of process on the notice of levy form and the person served shall acknowledge receipt of the certification by signing and dating it. If service is made by mail, the return receipt is the certificate of service of the levy.

(d) The failure of a debtor or 3rd party to accept or receive service of the levy does not invalidate the levy.

(14) ANSWER BY 3RD PARTY. Within 20 days after the service of the levy upon a 3rd party, the 3rd party shall file an answer with the department stating whether the 3rd party is in possession of or obligated with respect to property or rights to property of the debtor, including a description of the property or the rights to property and the nature and dollar amount of any such obligation. If the 3rd party is an insurance company, the insurance company shall file an answer with the department within 45 days after the service of the levy.[302]

(15) DURATION OF LEVY. A levy is effective from the date on which the levy is first served on the 3rd party until the liability out of which the levy arose is satisfied, until the levy is released or until one year after the date of service, whichever occurs first.

(18) RESTRICTION ON EMPLOYMENT PENALTIES BY REASON OF LEVY. No employer may discharge or otherwise discriminate with respect to the terms and conditions of employment against any employee by reason of the fact that his or her earnings have been subject to levy for any one levy or because of compliance with any provision of this section. Whoever willfully violates this subsection may be fined not more than $10,000 or imprisoned for not more than 9 months or both.

(19) HEARING. Any debtor who is subject to a levy proceeding made by the department may request a hearing under s. 102.17 to review the levy proceeding. The hearing is limited to questions of prior payment of the debt that the department is proceeding against, and mistaken identity of the debtor. The levy is not stayed pending the hearing in any case in which property is secured through the levy.

(20) COST OF LEVY. Any 3rd party is entitled to a levy fee of $5 for each levy in any case where property is secured through the levy. The 3rd party shall deduct the fee from the proceeds of the levy.

[302] The time to file an answer is decreased from 45 to 20 days except the time for filing an answer by insurance carriers remains 45 days. This amendment was effected by 2005 Wis. Act 442, effective November 1, 2006.

History: 1993 a. 81; 1995 a. 117; 1997 a. 187, 283; 2001 a. 109; 2005 a. 442; 2007 a. 185.

102.84 Preference of required payments. Subject to the federal bankruptcy laws, in the event of an uninsured employer's dissolution, reorganization, bankruptcy, receivership, assignment for benefit of creditors, judicially confirmed extension proposal or composition, or any analogous situation including the administration of estates in circuit courts, the payments required of the uninsured employer under s. 102.82 shall have preference over all claims of general creditors and shall be paid next after the payment of preferred claims for wages.[303]

History: 1993 a. 81.

102.85 Uninsured employers; penalties.

(1) (a) An employer who fails to comply with s. 102.16 (3) or 102.28 (2) for less than 11 days shall forfeit not less than $100 nor more than $1,000.

(b) An employer who fails to comply with s. 102.16 (3) or 102.28 (2) for more than 10 days shall forfeit not less than $10 nor more than $100 for each day on which the employer fails to comply with s. 102.16 (3) or 102.28 (2).

(2) An employer who is required to provide worker's compensation insurance coverage under this chapter shall forfeit not less than $100 nor more than $1,000 if the employer does any of the following:

(a) Gives false information about the coverage to his or her employees, the department or any other person who contracts with the employer and who requests evidence of worker's compensation coverage in relation to that contract.

(b) Fails to notify a person who contracts with the employer that the coverage has been canceled in relation to that contract.

(2m) The court may waive a forfeiture imposed under sub. (1) or (2) if the court finds that the employer is subject to this chapter only because the employer elected to become subject to this chapter under s. 102.05 (2) or 102.28 (2).

[303] This gives the department's claim for payments owed preference over general creditors.

(2p) The court may waive a forfeiture imposed under sub. (1) or (2) if the court finds that the sole reason for the uninsured employer's failure to comply with s. 102.82 (2) is that the uninsured employer was a victim of fraud, misrepresentation or gross negligence by an insurance agent or insurance broker or by a person whom a reasonable person would believe is an insurance agent or insurance broker.

(3) An employer who violates an order to cease operations under s. 102.28 (4) is guilty of a Class I felony.

(4) (a) If a court imposes a fine or forfeiture under subs. (1) to (3), the court shall impose under ch. 814 an uninsured employer surcharge equal to 75 percent of the amount of the fine or forfeiture.

(b) If a fine or forfeiture is suspended in whole or in part, the uninsured employer surcharge shall be reduced in proportion to the suspension.

(c) If any deposit is made for an offense to which this section applies, the person making the deposit shall also deposit a sufficient amount to include the uninsured employer surcharge under this section. If the deposit is forfeited, the amount of the uninsured employer surcharge shall be transmitted to the secretary of administration under par. (d). If the deposit is returned, the uninsured employer surcharge shall also be returned.

(d) The clerk of the court shall collect and transmit to the county treasurer the uninsured employer surcharge and other amounts required under s. 59.40 (2) (m). The county treasurer shall then make payment to the secretary of administration as provided in s. 59.25 (3) (f) 2. The secretary of administration shall deposit the amount of the uninsured employer surcharge, together with any interest thereon, in the uninsured employers fund as provided in s. 102.80 (1).

(5) (a) The payment of any judgment under this section may be suspended or deferred for not more than 90 days in the discretion of the court. The court shall suspend a judgment under this section upon the motion of the department, if the department is satisfied that the employer's violation of s. 102.16 (3) or 102.28 (2) was beyond the employer's control and that the employer no longer violates s. 102.16 (3) or 102.28 (2). In cases where a deposit has been made, any forfeitures, surcharges, fees, and costs imposed under ch. 814 shall be taken out of the deposit and the balance, if any, returned to the employer.

(b) In addition to any monetary penalties, the court may order an employer to perform or refrain from performing such acts as may be necessary to fully protect and effectuate the public interest, including ceasing business operations.

(c) All civil remedies are available in order to enforce the judgment of the court, including the power of contempt under ch. 785.

History: 1989 a. 64; 1993 a. 81; 1995 a. 201; 1997 a. 283; 2001 a. 109; 2003 a. 33, 139, 326.

102.87 Citation procedure.

(1) (a) The citation procedures established by this section shall be used only in an action to recover a forfeiture under s. 102.85 (1) or (2). The citation form provided by this section may serve as the initial pleading for the action and is adequate process to give a court jurisdiction over the person if the citation is filed with the circuit court.

(b) The citation may be served on the defendant by registered mail with a return receipt requested.

(2) A citation under this section shall be signed by a department deputy, or by an officer who has authority to make arrests for the violation, and shall contain substantially the following information:

(a) The name, address and date of birth of the defendant.

(b) The name and department of the issuing department deputy or officer.

(c) The violation alleged, the time and place of occurrence, a statement that the defendant committed the violation, the statute or rule violated and a designation of the violation in language which can be readily understood by a person making a reasonable effort to do so.

(d) A date, time and place for the court appearance, and a notice to appear.

(e) The maximum forfeiture, plus costs, fees, and surcharges imposed under ch. 814, for which the defendant is liable.

(f) Provisions for deposit and stipulation in lieu of a court appearance.

(g) Notice that if the defendant makes a deposit and fails to appear in court at the time specified in the citation, the failure to appear will be considered tender of a plea of no contest and submission to a forfeiture, plus costs, fees, and surcharges imposed under ch. 814, not to exceed the amount of the deposit. The notice shall also state that the court, instead of accepting the deposit and plea, may decide to summon the defendant or may issue an arrest warrant for the defendant upon failure to respond to a summons.

(h) Notice that if the defendant makes a deposit and signs the stipulation the stipulation will be treated as a plea of no contest and submission to a forfeiture, plus costs, fees, and surcharges imposed under ch. 814, not to exceed the amount of the deposit. The notice shall also state that the court, instead of accepting the deposit and stipulation, may decide to summon the defendant or issue an arrest warrant for the defendant upon failure to respond to a summons, and that the defendant may, at any time before or at the time of the court appearance date, move the court for relief from the effect of the stipulation.

(i) Notice that the defendant may, by mail before the court appearance, enter a plea of not guilty and request another date for a court appearance.

(j) Notice that if the defendant does not make a deposit and fails to appear in court at the time specified in the citation, the court may issue a summons or an arrest warrant.

(3) A defendant issued a citation under this section may deposit the amount of money that the issuing department deputy or officer directs by mailing or delivering the deposit and a copy of the citation before the court appearance date to the clerk of the circuit court in the county where the violation occurred, to the department, or to the sheriff's office or police headquarters of the officer who issued the citation. The basic amount of the deposit shall be determined under a deposit schedule established by the judicial conference. The judicial conference shall annually review and revise the schedule. In addition to the basic amount determined by the schedule, the deposit shall include the costs, fees, and surcharges imposed under ch. 814.

(4) A defendant may make a stipulation of no contest by submitting a deposit and a stipulation in the manner provided by sub. (3) before the court appearance date. The signed stipulation is a plea of no contest and submission to a forfeiture, plus the costs, fees, and surcharges imposed under ch. 814, not to exceed the amount of the deposit.

(5) Except as provided by sub. (6), a person receiving a deposit shall prepare a receipt in triplicate showing the purpose for which the deposit is made, stating that the defendant may inquire at the office of the clerk of the circuit court regarding the disposition of the deposit, and notifying the defendant that if he or she fails to appear in court at the time specified in the citation he or she shall be considered to have tendered a plea of no contest and submitted to a forfeiture, plus costs, fees, and surcharges imposed under ch. 814, not to exceed the amount of the deposit and that the court may accept the plea. The original of the receipt shall be delivered to the defendant in person or by mail. If the defendant pays by check, the canceled check is the receipt.

(6) The person receiving a deposit and stipulation of no contest shall prepare a receipt in triplicate showing the purpose for which the deposit is made, stating that the defendant may inquire at the office of the clerk of the circuit court regarding the disposition of the deposit, and notifying the defendant that if the stipulation of no contest is accepted by the court the defendant will be considered to have submitted to a forfeiture, plus costs, fees, and surcharges imposed under ch. 814, not to exceed the amount of the deposit. Delivery of the receipt shall be made in the same manner as provided in sub. (5).

(7) If a defendant issued a citation under this section fails to appear in court at the time specified in the citation or by subsequent postponement, the following procedure applies:

(a) If the defendant has not made a deposit, the court may issue a summons or an arrest warrant.

(b) If the defendant has made a deposit, the citation may serve as the initial pleading and the defendant shall be considered to have tendered a plea of no contest and submitted to a forfeiture, plus costs, fees, and surcharges imposed under ch. 814, not to exceed the amount of the deposit. The court may either accept the plea of no contest and enter judgment accordingly, or reject the plea and issue a summons. If the defendant

fails to appear in response to the summons, the court shall issue an arrest warrant. If the court accepts the plea of no contest, the defendant may, within 90 days after the date set for appearance, move to withdraw the plea of no contest, open the judgment, and enter a plea of not guilty if the defendant shows to the satisfaction of the court that failure to appear was due to mistake, inadvertence, surprise, or excusable neglect. If a defendant is relieved from the plea of no contest, the court may order a written complaint or petition to be filed. If on reopening the defendant is found not guilty, the court shall delete the record of conviction and shall order the defendant's deposit returned.

(c) If the defendant has made a deposit and stipulation of no contest, the citation serves as the initial pleading and the defendant shall be considered to have tendered a plea of no contest and submitted to a forfeiture, plus costs, fees, and surcharges imposed under ch. 814, not to exceed the amount of the deposit. The court may either accept the plea of no contest and enter judgment accordingly, or reject the plea and issue a summons or an arrest warrant. After signing a stipulation of no contest, the defendant may, at any time before or at the time of the court appearance date, move the court for relief from the effect of the stipulation. The court may act on the motion, with or without notice, for cause shown by affidavit and upon just terms, and relieve the defendant from the stipulation and the effects of the stipulation.

(8) If a citation or summons is issued to a defendant under this section and he or she is unable to appear in court on the day specified, the defendant may enter a plea of not guilty by mailing a letter stating that inability to the judge at the address indicated on the citation. The letter must show the defendant's return address. The letter may include a request for trial during normal daytime business hours. Upon receipt of the letter, the judge shall reply by letter to the defendant's address setting a time and place for trial. The time shall be during normal business hours if so requested. The date of the trial shall be at least 10 days from the date on which the letter was mailed by the judge. Nothing in this subsection forbids the setting of the trial at any time convenient to all parties concerned.

(9) A department deputy or an officer who collects a forfeiture and costs, fees, and surcharges imposed under ch. 814 under this section shall pay the money to the county treasurer within 20 days after its receipt. If the department deputy or officer fails to make timely payment, the county treasurer may collect the payment from the department deputy or officer by an action in the treasurer's name of office and upon the official bond of the department deputy or officer, with interest at the rate of 12 percent per year from the time when it should have been paid.

History: 1989 a. 64; 1997 a. 27; 1999 a. 14; 2003 a. 139; 2005 a. 172.

102.88 Penalties; repeaters.

(1) When a person is convicted of any violation of this chapter or of any department rule or order, and it is alleged in the indictment, information or complaint, and proved or admitted on trial or ascertained by the court after conviction that the person was previously subjected to a fine or forfeiture within a period of 5 years under s. 102.85, the person may be fined not more than $2,000 or imprisoned for not more than 90 days or both.

(2) When any person is convicted and it is alleged in the indictment, information or complaint and proved or admitted on trial or ascertained by the court after conviction that such person had been before subjected to a fine or forfeiture 3 times within a period of 3 years under s. 102.85 and that those convictions remain of record and unreversed, the person may be fined not more than $10,000 or imprisoned for not more than 9 months or both.

History: 1989 a. 64; 1991 a. 85.

102.89 Parties to a violation.

(1) Whoever is concerned in the commission of a violation of this chapter or of any department rule or order under this chapter for which a forfeiture is imposed is a principal and may be charged with and convicted of the violation although he or she did not directly commit it and although the person who directly committed it has not been convicted of the violation.

(2) A person is concerned in the commission of the violation if the person does any of the following:

(a) Directly commits the violation.

(b) Aids and abets the commission of the violation.

(c) Is a party to a conspiracy with another to commit the violation or advises, hires or counsels or otherwise procures another to commit it.

(3) No penalty for any violation of this chapter or rule or order of this chapter may be reduced or diminished by reason of this section.

History: 1989 a. 64.

Text of Other Statutes Relating to Worker's Compensation

Chapter 15, Structure of the Executive Branch

15.227 Councils

(4) COUNCIL ON WORKER'S COMPENSATION. There is created in the department of workforce development a council on worker's compensation appointed by the secretary of workforce development to consist of a designated employee of the department of workforce development as chairperson, 5 representatives of employers, and 5 representatives of employees. The secretary of workforce development shall also appoint 3 representatives of insurers authorized to do worker's compensation insurance business in this state as nonvoting members of the council.

(11) SELF-INSURERS COUNCIL. There is created in the department of workforce development a self-insurers council consisting of 5 members appointed by the secretary of workforce development for 3-year terms.

Chapter 19, General Duties of Public Officials

19.85 Exemptions.

(1) Any meeting of a governmental body, upon motion duly made and carried, may be convened in closed session under one or more of the exemptions provided in this section. The motion shall be carried by a majority vote in such manner that the vote of each member is ascertained and recorded in the minutes. No motion to convene in closed session may be adopted unless the chief presiding officer announces to those present at the meeting at which such motion is made, the nature of the business to be considered at such closed session, and the specific exemption or exemptions under this subsection by which such closed session is claimed to be authorized. Such announcement shall become part of the record of the meeting. No business may be taken up at any closed session except that which relates to matters contained in the chief presiding officer's announcement of the closed session. A closed session may be held for any of the following purposes:

(eg) Deliberating by the council on worker's compensation in a meeting at which all employer members of the council or all employee members of the council are excluded.

Chapter 20, Appropriations and Budget Management

20.445 Workforce development, department of. There is appropriated to the department of workforce development for the following programs:

(1) WORKFORCE DEVELOPMENT.

(a) *General program operations.* The amounts in the schedule for general program operations.

(aa) *Special death benefit.* A sum sufficient for the payment of death benefits under s. 102.475.

(f) *Death and disability benefit payments; public insurrections.* A sum sufficient for the payment of death and disability benefits under s. 106.25.

(ga) *Auxiliary services.* All moneys received from fees collected under ss. 102.16 (2m) (d), 103.005 (15) and 106.09 (7) for the delivery of services under ss. 102.16 (2m) (f), 103.005 (15) and 106.09 and ch. 108.

(ra) *Worker's compensation operations fund; administration.* From the worker's compensation operations fund, the amounts in the schedule for the administration of the worker's compensation program by the department, for assistance to the department of justice in investigating and prosecuting fraudulent activity related to worker's compensation, for transfer to the uninsured employers fund under s. 102.81 (1) (c), and for transfer to the appropriation accounts under par. (rp) and s. 20.427 (1) (ra). All moneys received under ss. 102.28 (2) (b) and 102.75 shall be credited to this appropriation account. From this appropriation, an amount not to exceed $5,000 may be expended each fiscal year for payment of expenses for travel and research by the council on worker's compensation, an amount not to exceed $500,000 may be transferred in each fiscal year to the uninsured employers fund under s. 102.81

(1) (c), the amount in the schedule under par. (rp) shall be transferred to the appropriation account under par. (rp), and the amount in the schedule under s. 20.427 (1) (ra) shall be transferred to the appropriation account under s. 20.427 (1) (ra).

(rb) *Worker's compensation operations fund; contracts.* From the worker's compensation operations fund, all moneys received in connection with contracts entered into under s. 102.31 (7) for the purpose of carrying out those contracts.

(rp) *Worker's compensation operations fund; uninsured employers program; administration.* From the worker's compensation operations fund, the amounts in the schedule for the administration of ss. 102.28 (4) and 102.80 to 102.89. All moneys transferred from the appropriation account under par. (ra) to this appropriation account shall be credited to this appropriation account.

(s) *Self-insured employers liability fund.* All moneys paid into the self-insured employers liability fund under s. 102.28 (7), to be used for the discharge of liability and claims service authorized under such subsection.

(sm) *Uninsured employers fund; payments.* From the uninsured employers fund, a sum sufficient to make the payments under s. 102.81 (1) and to obtain reinsurance under s. 102.81 (2). No moneys may be expended or encumbered under this paragraph until the first day of the first July beginning after the day that the secretary of workforce development files the certificate under s. 102.80 (3) (a).

(t) *Work injury supplemental benefit fund.* All moneys paid into the work injury supplemental benefit fund under ss. 102.35 (1), 102.47, 102.49, 102.59, 102.60, and 102.75 (2), to be used for the discharge of liabilities payable under ss. 102.44 (1), 102.49, 102.59, 102.63, 102.64 (2), and 102.66 and for the retention of services under s. 102.65 (3).

Chapter 40, Public Employee Trust Fund

40.02 Definitions. In this chapter, unless the context requires otherwise:

(41m) "Monthly salary" means the gross amount paid to a participant making a claim under s. 40.65, at the time he or she becomes disabled within the meaning of s. 40.65 (4), by the employer in whose employ the injury occurred or the disease was contracted. Overtime pay may not be considered part of an employee's monthly salary unless the employee received it on a regular and dependable basis.

(48) (a) "Protective occupation participant" means any participant whose principal duties are determined by the participating employer, or, subject to s. 40.06 (1) (dm), by the department head in the case of a state employee, to involve active law enforcement or active fire suppression or prevention, provided the duties require frequent exposure to a high degree of danger or peril and also require a high degree of physical conditioning.

(am) "Protective occupation participant" includes any participant whose name is certified to the fund as provided in s. 40.06 (1) (d) and (dm) and who is any of the following:

1. A conservation warden.
2. A conservation patrol boat captain.
3. A conservation patrol boat engineer.
4. A conservation pilot.
5. A conservation patrol officer.
6. A forest fire control assistant.
7. A member of the state traffic patrol.
8. A state motor vehicle inspector.
9. A police officer.
10. A fire fighter.
11. A sheriff.
12. An undersheriff.
13. A deputy sheriff.
14. A state probation and parole officer.
15. A county traffic police officer.
16. A state forest ranger.
17. A fire watcher employed at Wisconsin veterans facilities.
18. A state correctional-psychiatric officer.
19. An excise tax investigator employed by the department of revenue.
20. A special criminal investigation agent in the department of justice.
21. An assistant or deputy fire marshal.
22. A person employed under s. 60.553 (1), 61.66 (1), or 62.13 (2e) (a).

40.65 Duty disability and death benefits; protective occupation participants.

(2) (a) This paragraph applies to participants who first apply for benefits before May 3, 1988. Any person desiring a benefit under this section must apply to the department of workforce development, which department shall determine whether the applicant is eligible to receive the benefit and the participant's monthly salary. Appeals from the eligibility decision shall follow the procedures under ss. 102.16 to 102.26. If it is determined that an applicant is eligible, the department of workforce development shall notify the department of employee trust funds and shall certify the applicant's monthly salary. If at the time of application for benefits an applicant is still employed in any capacity by the employer in whose employ the disabling injury occurred or disease was contracted, that continued employment shall not affect that applicant's right to have his or her eligibility to receive those benefits determined in proceedings before the division of hearings and appeals in the department of administration or the labor and industry review commission or in proceedings in the courts. The department of workforce development may promulgate rules needed to administer this paragraph.

(b)

1. This paragraph applies to participants who first apply for benefits under this section on or after May 3, 1988.

2. An applicant for benefits under this section shall submit or have submitted to the department an application that includes written certification of the applicant's disability under sub. (4) by at least 2 physicians, as defined in s. 448.01 (5), who practice in this state and one of whom is approved or appointed by the department, and a statement from the applicant's employer that the injury or disease leading to the disability was duty-related.

3. The department shall determine whether or not the applicant is eligible for benefits under this section on the basis of the evidence in subd. 2. An applicant may appeal a determination under this subdivision to the division of hearings and appeals in the department of administration.

4. In hearing an appeal under subd. 3., the division of hearings and appeals in the department of administration shall follow the procedures under ss. 102.16 to 102.26.

5. The department shall be an interested party in an appeal under subd. 3., and the department shall receive legal assistance from the department of justice, as provided under s. 165.25 (4).

(3) The Wisconsin retirement board shall determine the amount of each monthly benefit payable under this section and its effective date. The board shall periodically review the dollar amount of each monthly benefit and adjust it to conform with the provisions of this section. The board may request any income or benefit information, or any information concerning a person's marital status, which it considers to be necessary to implement this subsection and may require a participant to authorize the board to obtain a copy of his or her most recent state or federal income tax return. The board may terminate the monthly benefit of any person who refuses to submit information requested by the board, who refuses to authorize the board to obtain a copy of his or her most recent state or federal income tax return, or who submits false information to the board.

(4) A protective occupation participant is entitled to a duty disability benefit as provided in this section if:

(a) The employee is injured while performing his or her duty or contracts a disease due to his or her occupation;

(b) The disability is likely to be permanent; and

(c)

1. The disability causes the employee to retire from his or her job;

2. The employee's pay or position is reduced or he or she is assigned to light duty; or

3. The employee's promotional opportunities within the service are adversely affected if state or local employer rules, ordinances, policies or written agreements specifically prohibit promotion because of the disability.

(4m) A protective occupation participant who is a state motor vehicle inspector hired on or after January 1, 1968, is not entitled to a duty disability benefit under this section for an injury or disease occurring before May 1, 1990.

(4r) A protective occupation participant who is an emergency medical technician is not entitled to a duty disability benefit under this section for an injury or disease occurring before the date on which the department receives notification of the

participant's name as provided in s. 40.06 (1) (d) and (dm).

(4v) A state probation and parole officer who becomes a protective occupation participant on or after January 1, 1999, is not entitled to a duty disability benefit under this section for an injury or disease occurring before January 1, 1999.

(5) (a) The monthly benefit payable to participants who qualify for benefits under s. 40.63 or disability benefits under OASDHI is 80 percent of the participant's monthly salary adjusted under par. (b) and sub. (6), except that the 80 percent shall be reduced by 0.5 percent for each month of creditable service over 30 years or over 25 years for persons who are eligible for benefits under subch. II at the date of application, but not to less than 50 percent of the participant's monthly salary. For participants who do not qualify for benefits under s. 40.63 or disability benefits under OASDHI, the monthly benefit under this section is 75 percent of the participant's monthly salary adjusted under par. (b) and sub. (6), except that the 75 percent shall be reduced by 0.5 percent for each month of creditable service over 30 years or over 25 years for persons who are eligible for benefits under subch. II on the date of application.

(b) The Wisconsin retirement board shall reduce the amount of a participant's monthly benefit under this section by the amounts under subds. 1. to 6., except that the board may determine not to reduce a participant's benefit because of income related to therapy or rehabilitation. The Wisconsin retirement board may assume that any benefit or amount listed under subds. 1. to 6. is payable to a participant until it is determined to the board's satisfaction that the participant is ineligible to receive the benefit or amount, except that the department shall withhold an amount equal to 5 percent of the monthly benefit under this section until the amount payable under subd. 3. is determined.

1. Any OASDHI benefit payable to the participant or the participant's spouse, domestic partner, or a dependent because of the participant's work record.

2. Any unemployment insurance benefit payable to the participant because of his or her work record.

3. Any worker's compensation benefit payable to the participant, including payments made pursuant to a compromise settlement under s. 102.16 (1). A lump sum worker's compensation payment or compromise settlement shall reduce the participant's benefit under this section in monthly amounts equal to 4.3 times the maximum benefit which would otherwise be payable under ch. 102 for the participant's disability until the lump sum amount is exhausted.

4. Any disability and retirement benefit payable to the participant under this chapter, or under any other retirement system, that is based upon the participant's earnings record and years of service. A reduction under this subdivision may not be greater in amount than the amount of disability or retirement benefit received by the participant. If the participant is not eligible for a retirement benefit because he or she received a lump sum payment or withdrew his or her contributions on or after the date the participant became eligible to receive a benefit under this section, the amount received or withdrawn shall reduce the participant's benefit under this section in the amount of benefit that would be payable if, on the date the amount was received or withdrawn, the full amount received or withdrawn was applied under s. 40.23 (2m) (d) as additional employee contributions credited to the participant's account.

5. All earnings payable to the participant from the employer under whom the duty disability occurred.

6. All earnings payable to the participant from an employer, other than the employer under whom the duty disability occurred, and all income from self-employment, the total of such earnings and income shall reduce the participant's benefit as follows:

a. For the amount of the total that is less than 40 percent of the participant's monthly salary, one-third of such amount;

b. For the amount of the total that is from 40 percent to 80 percent of the participant's monthly salary, one-half of such amount; and

c. For the amount of the total that is more than 80 percent of the participant's monthly salary, two-thirds of such amount.

(c) The Wisconsin retirement board may not reduce a participant's benefit because of income or benefits that are attributable to the earnings or work record of the participant's spouse, domestic

partner, or other member of the participant's family, or because of income or benefits attributable to an insurance contract, including income continuation programs.

(6) The Wisconsin retirement board shall adjust the monthly salary of every participant receiving a benefit under this section using the salary index for the previous calendar year as follows:

(a) For the purposes of sub. (5) (b) 6., annually on January 1 until the participant's death;

(b) For the purposes of sub. (5) (a), if the participant is receiving an annuity under s. 40.63 (1), annually on January 1 until the participant's death; and

(c) For the purposes of sub. (5) (a), if the participant is not receiving an annuity under s. 40.63 (1), annually on January 1 until the first January 1 after the participant's 60th birthday. Beginning on the January 1 after the participant's 60th birthday the participant's monthly salary shall be increased annually in a percentage amount equal to the percentage amount of dividend awarded under s. 40.27 (2) until the participant's death. Notwithstanding s. 40.27 (2), any benefits payable under this section are not subject to distribution of annuity reserve surpluses.

(7) (a) This paragraph applies to benefits based on applications filed before May 3, 1988. If a protective occupation participant dies as a result of an injury or a disease for which a benefit is paid or would be payable under sub. (4), and the participant is survived by a spouse or an unmarried child under age 18, a monthly benefit shall be paid as follows:

1. To the surviving spouse, if the spouse was married to the participant on the date the participant was disabled within the meaning of sub. (4), one-third of the participant's monthly salary as reflected at the time of death until the surviving spouse marries again.

2. To the guardian of a surviving unmarried child under age 18, $15 per child until the child marries, dies or reaches 18 years of age.

3. The total monthly amount paid under subds. 1. and 2. may not exceed 65 percent of the participant's monthly salary as reflected at the time of death. Any reduction of benefits caused by such limitation shall be done on a proportional basis.

(am) This paragraph applies to benefits based on applications filed on or after May 3, 1988. If a protective occupation participant dies as a result of an injury or a disease for which a benefit is paid or would be payable under sub. (4), and the participant is survived by a spouse, domestic partner, or an unmarried child under the age of 18, a monthly benefit shall be paid as follows:

1. To the surviving spouse or domestic partner until the surviving spouse remarries or the surviving domestic partner enters into a new domestic partnership or marries, if the spouse was married to the participant on the date that the participant was disabled under sub. (4) or the domestic partner was in a domestic partnership with the participant on the date that the participant was disabled under sub. (4), 50 percent of the participant's monthly salary at the time of death, but reduced by any amount payable under sub. (5) (b) 1. to 6.

2. To a guardian for each of that guardian's wards who is an unmarried surviving child under the age of 18, 10 percent of the participant's monthly salary at the time of death, payable until the child marries, dies or reaches the age of 18, whichever occurs first. The marital or domestic partnership status of the surviving spouse or domestic partner shall have no effect on the payments under this subdivision.

3. The total monthly amount paid under subds. 1. and 2. may not exceed 70 percent of the participant's monthly salary at the time of death reduced by any amounts under sub. (5) (b) 1. to 6. that relate to the participant's work record.

4. Benefits payable under this paragraph shall be increased each January 1 by the salary index determined for the prior year.

(ar) 1. This paragraph applies to benefits based on applications filed on or after May 12, 1998. If a protective occupation participant, who is covered by the presumption under s. 891.455, dies as a result of an injury or a disease for which a benefit is paid or would be payable under sub. (4), and the participant is survived by a spouse, domestic partner, or an unmarried child under the age of 18, a monthly benefit shall be paid as follows:

a. To the surviving spouse or domestic partner until the surviving spouse or domestic partner remarries or enters into a new domestic partnership, if the surviving spouse was married

to the participant on the date that the participant was disabled under sub. (4) or the domestic partner was in a domestic partnership with the participant on the date that the participant was disabled under sub. (4), 70 percent of the participant's monthly salary at the time of death, but reduced by any amount payable under sub. (5) (b) 1. to 6.

b. If there is no surviving spouse or domestic partner or the surviving spouse or domestic partner subsequently dies, to a guardian for each of that guardian's wards who is an unmarried surviving child under the age of 18, 10 percent of the participant's monthly salary at the time of death, payable until the child marries, dies or reaches the age of 18, whichever occurs first.

2. Benefits payable under this paragraph shall be increased each January 1 by the salary index determined for the prior year.

(b) Any person entitled to a benefit under both this subsection and ch. 102 because of the death of the same participant, shall have his or her benefit under this subsection reduced in an amount equal to the death benefit payable under ch. 102.

(9) This section is applicable to protective occupation participants who apply for a benefit under this section on or after July 1, 1982. A participant may not apply for a benefit under this section if he or she is receiving a benefit under s. 66.191, 1981 stats., on July 1, 1982.

History: 1981 c. 278; 1983 a. 9; 1983 a. 141 s. 20; 1983 a. 191 s. 6; 1983 a. 255; 1985 a. 332 s. 251 (1); 1987 a. 363; 1989 a. 240, 357; 1995 a. 27 s. 9130 (4); 1997 a. 3, 39, 173, 237; 2007 a. 131; 2009 a. 28; 2015 a. 55.

Cross-reference: See s. 891.45 for provision as to presumption of employment-connected disease for certain municipal fire fighters.

Cross-reference: See also LIRC and ss. ETF 52.01 and HA 4.16, Wis. adm. code.

The Wisconsin Retirement Board may not reduce duty disability benefits under sub. (5) (b) 3. for worker's compensation benefits that are paid to a participant before the duty disability payments commence, and may do so only for worker's compensation not yet paid. Coutts v. Wisconsin Retirement Board, 209 Wis. 2d 655, 563 N.W.2d 917 (1997), 95-1905.

The Retirement Board is authorized to promulgate administrative rules interpreting sub. (3). Kuester v. Wisconsin Retirement Board, 2004 WI App 10, 269 Wis. 2d 462, 674 N.W.2d 877, 03-0056.

The Retirement Board correctly construed sub. (5) (b) in determining duty disability benefits when it reduced those benefits by earnings and lump sum worker's compensation benefits received after the effective date of the duty disability benefits. The board was reasonable in reading *Coutts* to hold that the statutorily specified sums are payable when they are received and that it is proper to offset them against duty disability benefits. Carey v. Wisconsin Retirement Board, 2007 WI App 17, 298 Wis. 2d 373, 728 N.W.2d 22, 06-1233.

Chapter 46, Social Services

46.10 Cost of care and maintenance, liability; collection and deportation counsel; collections; court actions; recovery.

(1) Liability and the collection and enforcement of such liability for the care, maintenance, services, and supplies specified in this section is governed exclusively by this section, except in cases of child support ordered by a court under s. 48.355 (2) (b) 4. or (4g) (a), 48.357 (5m) (a), or 48.363 (2) or ch. 767.

(2) Except as provided in subs. (2m) and (14) (b) and (c), any person, including but not limited to a person admitted, committed, protected, or placed under s. 975.01, 1977 stats., s. 975.02, 1977 stats., s. 975.17, 1977 stats., s. 55.05 (5), 2003 stats., and 55.06, 2003 stats., and ss. 51.10, 51.13, 51.15, 51.20, 51.35 (3), 51.37 (5), 51.45 (10), (11), (12) and (13), 55.05, 55.055, 55.12, 55.13, 55.135, 971.14 (2) and (5), 971.17 (1), 975.06 and 980.06, receiving care, maintenance, services and supplies provided by any institution in this state including University of Wisconsin Hospitals and Clinics, in which the state is chargeable with all or part of the person's care, maintenance, services and supplies, any person receiving care and services from a county department established under s. 51.42 or 51.437 or from a facility established under s. 49.73, and any person receiving treatment and services from a public or private agency under s. 980.06 (2) (c), 1997 stats., s. 980.08 (5), 2003 stats., or s. 971.17 (3) (d) or (4) (e) or 980.08 (4) (g) and the person's property and estate, including the homestead, and the spouse of the person, and the spouse's property and estate, including the homestead, and, in the case of a minor child, the parents of the person, and their property and estates, including their homestead, and, in the case of a foreign child described in s. 48.839 (1) who became dependent on public funds for his or her primary support before an order granting his or her adoption, the resident of this state appointed guardian of the child by a foreign

court who brought the child into this state for the purpose of adoption, and his or her property and estate, including his or her homestead, shall be liable for the cost of the care, maintenance, services and supplies in accordance with the fee schedule established by the department under s. 46.03 (18). If a spouse, widow or minor, or an incapacitated person may be lawfully dependent upon the property for their support, the court shall release all or such part of the property and estate from the charges that may be necessary to provide for those persons. The department shall make every reasonable effort to notify the liable persons as soon as possible after the beginning of the maintenance, but the notice or the receipt thereof is not a condition of liability.

(2m) The liability specified in sub. (2) shall not apply to tuberculosis patients receiving care, maintenance, services and supplies under ss. 252.07 to 252.10, to persons 18 and older receiving care, maintenance, services and supplies provided by prisons named in s. 302.01 or to parents of a minor who receives care for alcohol or drug abuseunder s. 51.47 (1) without consent of the minor's parent or guardian.

(4) (a) If a person liable under sub. (2) fails to make payment or enter into or comply with an agreement for payment, the department may bring an action to enforce the liability or may issue an order to compel payment of the liability. Any person aggrieved by an order issued by the department under this paragraph may appeal the order as a contested case under ch. 227 by filing with the department a request for a hearing within 30 days after the date of the order.

(b) If judgment is rendered in an action brought under par. (a) for any balance that is 90 or more days past due, interest at the rate of 12 percent per year shall be computed by the clerk and added to the liable person's costs. That interest shall begin on the date on which payment was due and shall end on the day before the date of any interest that is computed under s. 814.04 (4).

(c) If the department issues an order to compel payment under par. (a), interest at the rate of 12 percent per year shall be computed by the department and added at the time of payment to the person's liability. That interest shall begin on the date on which payment was due and shall end on the day before the date of final payment.

(5) If any person named in an order to compel payment issued under sub. (4) (a) fails to pay the department any amount due under the terms of the order and no contested case to review the order is pending and the time for filing for a contested case review has expired, the department may present a certified copy of the order to the circuit court for any county. The circuit court shall, without notice, render judgment in accordance with the order. A judgment rendered under this subsection shall have the same effect and shall be entered in the judgment and lien docket and may be enforced in the same manner as if the judgment had been rendered in an action tried and determined by the circuit court.

(14)(e) 1. An order issued under s. 48.355 (2) (b) 4. or (4g) (a), 48.357 (5m) (a), or 48.363 (2) for support determined under this subsection constitutes an assignment of all commissions, earnings, salaries, wages, pension benefits, income continuation insurance benefits under s. 40.62, duty disability benefits under s. 40.65, benefits under ch. 102 or 108, and other money due or to be due in the future to the county department under s. 46.22 or 46.23 in the county where the order was entered or to the department, depending upon the placement of the child as specified by rules promulgated under subd. 5. The assignment shall be for an amount sufficient to ensure payment under the order.

2. Except as provided in subd. 3., for each payment made under the assignment, the person from whom the payer under the order receives money shall receive an amount equal to the person's necessary disbursements, not to exceed $3, which shall be deducted from the money to be paid to the payer.

Chapter 49, Public Assistance and Children and Family Services

49.36 Work experience program for noncustodial parents.

(3) (a) Except as provided in par. (f) and subject to sub. (3m), a person ordered to register under s. 767.55 (2) (am) shall participate in a work experience program if services are available.

(b) A person may not be required to participate for more than 32 hours per week in the program under this section.
(c) A person may not be required to participate for more than 16 weeks during each 12-month period in a program under this section.
(d) If a person is required by a governmental entity to participate in another work or training program, the person may not be required to participate in a program under this section in a week for more than 32 hours minus the number of hours he or she is required to participate in the other work or training program in that week.
(e) If a person is employed, the person may not be required to participate in a program under this section in a week for more than 80 percent of the difference between 40 hours and the number of hours actually worked in the unsubsidized job during that week.
(f) A person who works, on average, 32 hours or more per week in an unsubsidized job is not required to participate in a program under this section.
(3m) A person is not eligible to participate in a program under this section unless the person satisfies all of the requirements related to substance abuse screening, testing, and treatment under s. 49.162 that apply to the individual.
(4) When a person completes 16 weeks of participation in a program under this section, the county, tribal governing body, or Wisconsin works agency operating the program shall inform the clerk of courts, by affidavit, of that completion.
(5) A person participating in work experience as part of the program under this section is considered an employee of the county, tribal governing body, or Wisconsin works agency administering the program under this section for purposes of worker's compensation benefits only.
(6) A county, tribal governing body, or Wisconsin works agency administering the program under this section shall reimburse a person for reasonable transportation costs incurred because of participation in a program under this section up to a maximum of $25 per month.
(7) The department shall pay a county, tribal governing body, or Wisconsin works agency not more than $400 for each person who participates in the program under this section in the region in which the county, tribal governing body, or Wisconsin works agency administers the program under this section. The county, tribal governing body, or Wisconsin works agency shall pay any additional costs of the program.
History: 1987 a. 413; 1989 a. 31; 1991 a. 39; 1993 a. 16; 1995 a. 27 ss. 2135 to 2142; 1995 a. 289; 1997 a. 27; 1999 a. 9; 2001 a. 16; 2005 a. 25; 2005 a. 443 s. 265; 2007 a. 20; 2013 a. 20; 2015 a. 55.

Chapter 59, Counties

59.88 Employee retirement system of populous counties; duty disability benefits for a mental injury.

(1) In this section, "county" means any county having a population of 500,000 or more.
(2) If an employee retirement system of a county offers a duty disability benefit, the employee retirement system may only provide the duty disability benefit for a mental injury if all of the following apply:
(a) The mental injury resulted from a situation of greater dimensions than the day-to-day mental stresses and tensions and post-traumatic stress that all similarly situated employees must experience as part of the employment.
(b) The employer certifies that the mental injury is a duty-related injury.
(3) If an employee retirement system of a county determines that an applicant is not eligible for duty disability benefits for a mental injury, the applicant may appeal the employee retirement system's determination to the department of workforce development. In hearing an appeal under this subsection, the department of workforce development shall follow the procedures under ss. 102.16 to 102.26.
(4) This section applies to participants in an employee retirement system of a county who first apply for duty disability benefits for a mental injury on or after July 14, 2015.
History: 2015 a. 55.

Chapter 62, Cities

62.624 Employee retirement system of a 1st class city; duty disability benefits for a mental injury.

(1) If an employee retirement system of a 1st class city offers a duty disability benefit, the employee retirement system may only provide the duty disability benefit for a mental injury if all of the following apply:

(a) The mental injury resulted from a situation of greater dimensions than the day-to-day mental stresses and tensions and post-traumatic stress that all similarly situated employees must experience as part of the employment.

(b) The employer certifies that the mental injury is a duty-related injury.

(2) If an employee retirement system of a 1st class city determines that an applicant is not eligible for duty disability benefits for a mental injury, the applicant may appeal the employee retirement system's determination to the department of workforce development. In hearing an appeal under this subsection, the department of workforce development shall follow the procedures under ss. 102.16 to 102.26.

(3) This section applies to participants in an employee retirement system of a 1st class city who first apply for duty disability benefits for a mental injury on or after July 14, 2015.

History: 2015 a. 55.

Chapter 101, Department of Safety and Professional Services – Regulation of Industry, Buildings, and Safety

101.11 Employer's duty to furnish safe employment and place. (1) Every employer shall furnish employment which shall be safe for the employees therein and shall furnish a place of employment which shall be safe for employees therein and for frequenters thereof and shall furnish and use safety devices and safeguards, and shall adopt and use methods and processes reasonably adequate to render such employment and places of employment safe, and shall do every other thing reasonably necessary to protect the life, health, safety, and welfare of such employees and frequenters. Every employer and every owner of a place of employment or a public building now or hereafter constructed shall so construct, repair or maintain such place of employment or public building as to render the same safe.

(2) (a) No employer shall require, permit or suffer any employee to go or be in any employment or place of employment which is not safe, and no such employer shall fail to furnish, provide and use safety devices and safeguards, or fail to adopt and use methods and processes reasonably adequate to render such employment and place of employment safe, and no such employer shall fail or neglect to do every other thing reasonably necessary to protect the life, health, safety or welfare of such employees and frequenters; and no employer or owner, or other person shall hereafter construct or occupy or maintain any place of employment, or public building, that is not safe, nor prepare plans which shall fail to provide for making the same safe.

(b) No employee shall remove, displace, damage, destroy or carry off any safety device or safeguard furnished and provided for use in any employment or place of employment, nor interfere in any way with the use thereof by any other person, nor shall any such employee interfere with the use of any method or process adopted for the protection of any employee in such employment or place of employment or frequenter of such place of employment, nor fail or neglect to do every other thing reasonably necessary to protect the life, health, safety or welfare of such employees or frequenters.

(3) This section applies to community-based residential facilities as defined in s. 50.01 (1g).

History: 1971 c. 185; Stats. 1971 s. 101.11; 1975 c. 413; 1987 a. 161 s. 13m.

Cross-reference: See also chs. SPS 361, 362, 363, 364, and 365, Wis. adm. code.

Ordinary negligence can be compared with negligence founded upon the safe place statute. In making the comparison, a violation of the statute is not to be considered necessarily as contributing more than the common-law contributory negligence. Lovesee v. Allied Development Corp. 45 Wis. 2d 340, 173 N.W.2d 196 (1970).

When an apartment complex was managed for a fee by a management company, the company was carrying on a business there. Reduction of rent to one of the tenants for caretaking services constituted employment on the premises. A tenant who fell on the icy parking lot after the caretaker knew of the condition need only prove negligence in maintaining the premises. Wittka v. Hartnell, 46 Wis. 2d 374, 175 N.W.2d 248 (1970).

A public sidewalk is not made a place of employment merely because an employer constructed it and kept it free of ice and snow. Petroski v. Eaton Yale & Towne, Inc. 47 Wis. 2d 617, 178 N.W.2d 53 (1970).

The fact that a violation of the safe place statute is found puts the burden on the owner to rebut the presumption of causation but does not establish as a matter of law that the defendant's negligence was greater than the plaintiff's. Frederick v. Hotel Investments, Inc. 48 Wis. 2d 429, 180 N.W.2d 562 (1970).

A store must be held to have had constructive notice of a dangerous condition when it displayed shaving cream in spray cans on a counter and a 70-year old woman fell in cream sprayed on the white floor. Steinhorst v. H. C. Prange Co. 48 Wis. 2d 679, 180 N.W.2d 525 (1970).

The mere existence of a step up into a hospital lavatory was not an unsafe condition. Prelipp v. Wausau Memorial Hospital, 50 Wis. 2d 27, 183 N.W.2d 24 (1971).

Failure to light a parking lot can support a safe place action, but the evidence must show how long the light was burned out to constitute constructive notice. Low v. Siewert, 54 Wis. 2d 251, 195 N.W.2d 451 (1972).

A parking lot owned by a city that is a continuation of a store parking lot used by the public for attending the city zoo and the store, even though maintained by the private property owner, is not a place of employment. Gordon v. Schultz Savo Stores, Inc. 54 Wis. 2d 692, 196 N.W.2d 633 (1972).

Detailed construction specifications and the presence of engineers to insure compliance does not manifest control over the project so as to make the commission liable. Berger v. Metropolitan Sewerage Commission of Milwaukee, 56 Wis. 2d 741, 203 N.W.2d 87 (1973).

In a safe place action the employee's contributory negligence is less when his or her act or omission has been committed in the performance of job duties. McCrossen v. Nekoosa-Edwards Paper Co. 59 Wis. 2d 245, 208 N.W.2d 148 (1973).

A pier at a beach open to the public for a fee constitutes a place of employment. Any distinction between licensees and invitees is irrelevant, and the statute imposes a higher duty as to safety than the common law. Gould v. Allstar Insurance Co. 59 Wis. 2d 355, 208 N.W.2d 388 (1973).

A private road on the ground of a private racetrack that connected the track and a parking lot was subject to this section as to frequenters. Gross v. Denow, 61 Wis. 2d 40, 212 N.W.2d 2 (1973).

A one-eighth-inch variance in elevation between the sides of a ramp joint was too slight, as a matter of law, to constitute a violation of the safe place statute. Balas v. St. Sebastian's Congregation, 66 Wis. 2d 421, 225 N.W.2d 428 (1975).

An employer may be held liable under the safe place statute not only for failing to construct or maintain safety structures such as fences, but also for knowingly permitting employees or frequenters to venture into a dangerous area. Kaiser v. Cook, 67 Wis. 2d 460, 227 N.W.2d 50 (1975).

The safe place statute applies only to unsafe physical conditions, not to activities conducted on a premises. Korenak v. Curative Workshop Adult Rehabilitation Center, 71 Wis. 2d 77, 237 N.W.2d 43 (1976).

The duty to furnish a safe place of employment to employees does not impose a duty on a contractor for subcontractor's employees. A contractor can owe a duty to a frequenter, but only when a hazardous condition is under the supervision or control of the contractor. Barth v. Downey Co., Inc. 71 Wis. 2d 775, 239 N.W.2d 92 (1976).

Retention of control and supervision is required for recovery against a general contractor by a subcontractor's employee. Lemacher v. Circle Construction Co., Inc. 72 Wis. 2d 245, 240 N.W.2d 179 (1976).

The length of time a safe place defect must exist, in order to impose constructive notice of it on an owner, varies according to the nature of the business, the nature of the defect, and the public policy involved. May v. Skelley Oil Co. 83 Wis. 2d 30, 264 N.W.2d 574 (1978).

In safe place cases, comparative negligence instructions need not direct the jury to consider the defendant's higher duty of care. Brons v. Bischoff, 89 Wis. 2d 80, 277 N.W.2d 854 (1979).

Indemnity in a safe place action creates an effect identical to that of contribution. Barrons v. J. H. Findorff & Sons, Inc. 89 Wis. 2d 444, 278 N.W.2d 827 (1979).

A non-negligent indemnitor was liable to an indemnitee whose breach of a safe place duty was solely responsible for damages under the circumstances of the case. Dykstra v. Arthur G. McKee & Co. 92 Wis. 2d 17, 284 N.W.2d 692 (Ct. App. 1979); (aff'd) 100 Wis. 2d 120, 301 N.W.2d 201 (1981).

Architects have liability under the safe place statute only if they have a right of supervision and control, which must be determined from the agreement between the owner and the architect. If the duty exists, it is nondelagable. Hortman v. Becker Construction Co., Inc. 92 Wis. 2d 210, 284 N.W.2d 621 (1979).

"Safe employment" and "safe place of employment" are distinguished. There is a duty to provide safe employment to employees that does not extend to frequenters, while the duty to provide a safe place of employment does extend to frequenters. Leitner v. Milwaukee County, 94 Wis. 2d 186, 287 N.W.2d 803 (1980).

Evidence of a prior accident was admissible to prove notice of an unsafe condition. Callan v. Peters Construction Co. 94 Wis. 2d 225, 288 N.W.2d 146 (Ct. App. 1979).

That a lease allocates safe place duties between an owner and an employer/tenant does not nullify mutually shared statutory duties. Hannebaum v. Dirienzo & Bomier, 162 Wis. 2d 488, 469 N.W.2d 900 (Ct. App. 1991).

The safe place duty to keep a swimming pool in a condition to protect customers from injury was overcome when a person unreasonably dove into a pool of unknown depth. Wisnicky v. Fox Hills Inn, 163 Wis. 2d 1023, 473 N.W.2d 523 (Ct. App. 1991).

A county house of correction is subject to the safe place statute. Henderson v. Milwaukee County, 198 Wis. 2d 748, 543 N.W.2d 544 (Ct. App. 1995).

An alarm system does not relate to the structure of a building and therefore does not relate to a safe place of employment. It is a safety device that is the responsibility of the employer and not the building owner. Naaj v. Aetna Insurance Co. 218 Wis. 2d 121, 579 N.W.2d 815 (Ct. App. 1998), 96-3640.

The obligation of a lessor of a building is limited to structural or physical defects. A temporary condition maintained by the lessee does not impose safe place liability on the lessor. Powell v. Milwaukee Area Technical

College District Bd. 225 Wis. 2d 794, 594 N.W.2d 403 (Ct. App. 1999), 97-3040.

A defect is "structural" if it resulted from materials used in its construction or from improper layout or construction. Conditions "associated with the structure" are those that involve the structure being out of repair or not being maintained in a safe manner. An owner sustains safe place liability for a structural defect regardless of knowledge of the defect, but with conditions related to the structure, no liability attaches without actual or constructive notice. Barry v. Employers Mutual Casualty Co. 2001 WI 101, 245 Wis. 2d 560, 630 N.W.2d 517, 98-2557.

The duties imposed on employers and property owners under this section are nondelegable. Barry v. Employers Mutual Casualty Co. 2001 WI 101, 245 Wis. 2d 560, 630 N.W.2d 517, 98-2557.

This section does not apply to unsafe conditions caused by an injured party's own negligence or recklessness. If a structure's alleged disrepair requires reckless or negligent conduct by the plaintiff for the plaintiff to injure herself or himself, the initial disrepair may not be construed as having caused the injury. Hofflander v. St. Catherine's Hospital, 2003 WI 77, 262 Wis. 2d 539, 664 N.W.2d 545, 00-2467.

Land that is merely appurtenant to a place where business is carried on is not a place of employment under s. 101.01 (11). An owner must have ownership, custody, or control of the place of employment and the premises appurtenant thereto. An owner of appurtenant land who does not also have ownership, custody, or control of the place cannot be liable for injuries sustained at the place. Binsfeld v. Conrad, 2004 WI App 77, 272 Wis. 2d 341, 679 N.W.2d 341, 03-1077.

If constructive notice is relied on, generally, evidence of the length of time that the unsafe condition existed is required to establish it. Constructive notice, without a showing of temporal evidence of the unsafe condition, may be imputed in a narrow class of cases where the method of merchandizing articles for sale to the public in the area where the harm occurred should have made that harm reasonably foreseeable at that location. Megal v. Green Bay Area Visitor & Convention Convention Bureau, Inc. 2004 WI 98, 274 Wis. 2d 162, 682 N.W.2d 857, 02-2932.

Ten years after a structure is substantially completed, s. 893.89 bars safe place claims under this section resulting from injuries caused by structural defects, as opposed to safe place claims resulting from injuries caused by unsafe conditions associated with the structure. Mair v. Trollhaugen Ski Resort, 2006 WI 61, 291 Wis. 2d 132, 715 N.W.2d 598, 04-1252.

The owner of a public building is liable for: 1) structural defects; and 2) unsafe conditions associated with the structure of the building. A structural defect is a hazardous condition inherent in the structure by reason of its design or construction. An unsafe condition arises from the failure to keep an originally safe structure in proper repair or properly maintained. A property owner is liable for injuries caused by a structural defect regardless of whether it had notice of the defect, but only liable for an unsafe condition when it had actual or constructive notice of the condition. Rosario v. Acuity, 2007 WI App 194, 304 Wis. 2d 713, 738 N.W.2d 608, 06-2421.

Safe is a relative term that does not mean completely free of any hazards. What constitutes a safe place depends on the facts and conditions present and the use to which the place is likely to be put. That a place could be made more safe does not mean that an owner has breached the duty of care established by sub. (1). When the agency having power to adopt orders to secure the safety of employees and frequenters of public buildings has issued a safety order concerning a particular situation, it establishes what is safe, and a jury or court cannot establish any other standard. Szalacinski v. Campbell, 2008 WI App 150, 314 Wis. 2d 286, 760 N.W.2d 420, 07-0667.

The trial court erred in finding no unsafe condition under the safe place statute when it applied a height requirement to a sidewalk crack. There is no mathematical deviation rule that is a standard for a safe sidewalk. The ultimate question is not what is a defect, or how many inches high was the obstruction or deep the depression, but solely whether under all circumstances affecting the sidewalk it was in a reasonably safe condition for public travel by persons exercising ordinary care for their own safety. Gulbrandsen v. H & D, Inc. 2009 WI App 138, 321 Wis. 2d 410, 773 N.W.2d 506, 08-2990.

The safe place statute includes a duty on employers to inspect premises to ensure that they are safe. Failure to comply renders the employer liable for the violation of the safe place statute. The duty to maintain does not arise until constructive knowledge of the defect exists, but if an adequate inspection would have revealed the defect and that inspection was not performed, the jury may infer constructive notice of the defect. The safe place statute applies the duty to maintain to both owners and employers alike. Gennrich v. Zurich American Insurance Company, 2010 WI App 117, 329 Wis. 2d 91, 789 N.W.2d 106, 09-2111.

A "structural defect" for which an owner sustains safe place liability for the defect regardless of knowledge of the defect arises from design or construction flaws when a building element is put in place, whether as an original part of a structure or as a replacement. This contrasts with features of a structure that were installed safely and then developed into a hazard. Wagner v. Cincinnati Casualty Co. 2011 WI App 85, 334 Wis. 2d 516, 800 N.W.2d 27, 10-1195.

The presence of asbestos in the air during and following routine repairs to defendant's buildings constituted an unsafe condition associated with the premises. Viola v. Wisconsin Electric Power Co. 2014 WI App 5, 352 Wis. 2d 541, 842 N.W.2d 515, 13-0022.

The safe place statute does not extend to vehicles. Hopkins v. Ros Stores, Inc. 750 F. Supp. 379 (1990).

Under the safe place statute, an owner is only absolved of its statutory duty if it relinquishes complete control of the premises to a contractor, and the premises are in a safe condition at that time. The owner must have control over the place such that it can carry out its duty to furnish a safe place of employment, but the control and custody of the premises need not be exclusive, nor is it necessary to have control for all purposes. Anderson v. P&G Paper Products Co. 924 F. Supp. 2d 996 (2013).

Chapter 106, Apprentice, Employment and Equal Rights Programs

106.25 Public insurrection; death and disability benefits.

(1) DEFINITION. In this section, "public insurrection" means a civil disturbance in which a group or groups of persons are simultaneously engaged in acts of violence against persons or property by the illegal use of weapons, by burning, pillaging or looting or by committing any other illegal acts, and which is of such a magnitude as to result in any of the following:

(am) Extraordinary utilization of off-duty local law enforcement personnel.

(b) Declaration of a public emergency by the governor.

(c) The calling of the national guard or other troops.

(2) DEATH AND DISABILITY BENEFITS. If the department finds that the injury or death of a state or local government officer or employee arose out of the performance of duties in connection with a public insurrection, and finds that death or disability benefits are payable under ch. 102, a supplemental award equal to the amount of the benefits, other than medical expense, payable under ch. 102 shall be made to the persons and in the same manner provided by ch. 102, except that when benefits are payable under s. 102.49, a supplemental award equal to one-half the benefits payable under that section shall be made.

(3) PAYMENTS. All payments under this section shall be made from the general fund.

(4) BENEFITS ADDITIONAL TO ALL OTHERS. Death and disability benefits under this section are in addition to all other benefits provided by state law or by action of any municipality or public agency.

History: 1971 c. 40; 1975 c. 199; 1975 c. 404 s. 7; 1975 c. 405 s. 7; Stats. 1975 s. 101.47; 1977 c. 29 s. 1651; 1995 a. 27 s. 3726; Stats. 1995 s. 106.25; 1995 a. 225, 257.

Chapter 108, Unemployment Insurance and Reserves

108.04(5) DISCHARGE FOR MISCONDUCT. An employee whose work is terminated by an employing unit for misconduct by the employee connected with the employee's work is ineligible to receive benefits until 7 weeks have elapsed since the end of the week in which the discharge occurs and the employee earns wages after the week in which the discharge occurs equal to at least 14 times the employee's weekly benefit rate under s. 108.05 (1) in employment or other work covered by the unemployment insurance law of any state or the federal government. For purposes of requalification, the employee's weekly benefit rate shall be the rate that would have been paid had the discharge not occurred. The wages paid to an employee by an employer which terminates employment of the employee for misconduct connected with the employee's employment shall be excluded from the employee's base period wages under s. 108.06 (1) for purposes of benefit entitlement. This subsection does not preclude an employee who has employment with an employer other than the employer which terminated the employee for misconduct from establishing a benefit year using the base period wages excluded under this subsection if the employee qualifies to establish a benefit year under s. 108.06 (2) (a). The department shall charge to the fund's balancing account any benefits otherwise chargeable to the account of an employer that is subject to the contribution requirements under ss. 108.17 and 108.18 from which base period wages are excluded under this subsection. For purposes of this subsection, "misconduct" means one or more actions or conduct evincing such willful or wanton disregard of an employer's interests as is found in deliberate violations or disregard of standards of behavior which an employer has a right to expect of his or her employees, or in carelessness or negligence of such degree or recurrence as to manifest culpability, wrongful intent, or evil design of equal severity to such disregard, or to show an intentional and substantial disregard of an employer's interests, or of an employee's duties and obligations to his or her employer. In addition, "misconduct" includes:

(a) A violation by an employee of an employer's reasonable written policy concerning the use of alcohol beverages, or use of a controlled substance or a controlled substance analog, if the employee:

1. Had knowledge of the alcohol beverage or controlled substance policy; and

2. Admitted to the use of alcohol beverages or a controlled substance or controlled substance analog or refused to take a test or tested positive for the use of alcohol beverages or a controlled substance or controlled substance analog in a test used by the employer in accordance with a testing methodology approved by the department.

(b) Theft of an employer's property or services with intent to deprive the employer of the property or services permanently, theft of currency of any value, felonious conduct connected with an employee's employment with his or her employer, or intentional or negligent conduct by an employee that causes substantial damage to his or her employer's property.

(c) Conviction of an employee of a crime or other offense subject to civil forfeiture, while on or off duty, if the conviction makes it impossible for the employee to perform the duties that the employee performs for his or her employer.

(d) One or more threats or acts of harassment, assault, or other physical violence instigated by an employee at the workplace of his or her employer.

(e) Absenteeism by an employee on more than 2 occasions within the 120-day period before the date of the employee's termination, unless otherwise specified by his or her employer in an employment manual of which the employee has acknowledged receipt with his or her signature, or excessive tardiness by an employee in violation of a policy of the employer that has been communicated to the employee, if the employee does not provide to his or her employer both notice and one or more valid reasons for the absenteeism or tardiness.

(f) Unless directed by an employee's employer, falsifying business records of the employer.

(g) Unless directed by the employer, a willful and deliberate violation of a written and uniformly applied standard or regulation of the federal government or a state or tribal government by an employee of an employer that is licensed or certified by a governmental agency, which standard or regulation has been communicated by the employer to the employee and which violation would cause the employer to be sanctioned or to have its license or certification suspended by the agency.

(5g) DISCHARGE FOR SUBSTANTIAL FAULT.

(a) An employee whose work is terminated by an employing unit for substantial fault by the employee connected with the employee's work is ineligible to receive benefits until 7 weeks have elapsed since the end of the week in which the termination occurs and the employee earns wages after the week in which the termination occurs equal to at least 14 times the employee's weekly benefit rate under s. 108.05 (1) in employment or other work covered by the unemployment insurance law of any state or the federal government. For purposes of requalification, the employee's benefit rate shall be the rate that would have been paid had the discharge not occurred. For purposes of this paragraph, "substantial fault" includes those acts or omissions of an employee over which the employee exercised reasonable control and which violate reasonable requirements of the employee's employer but does not include any of the following:

1. One or more minor infractions of rules unless an infraction is repeated after the employer warns the employee about the infraction.

2. One or more inadvertent errors made by the employee.

3. Any failure of the employee to perform work because of insufficient skill, ability, or equipment.

(b) The department shall charge to the fund's balancing account the cost of any benefits paid to an employee that are otherwise chargeable to the account of an employer that is subject to the contribution requirements under ss. 108.17 and 108.18 if the employee is discharged by the employer and paragraph (a) applies.

108.101 Effect of finding, determination, decision or judgment.

(1) No finding of fact or law, determination, decision or judgment made with respect to rights or liabilities under this chapter is admissible or binding in any action or administrative or judicial proceeding in law or in equity not arising under this chapter, unless the department is a party or has an interest in the action or proceeding because of the discharge of its duties under this chapter.

(2) No finding of fact or law, determination, decision or judgment made with respect to rights

or liabilities under s. 108.09 is binding in an action or proceeding under s. 108.10.

(3) No finding of fact or law, determination, decision or judgment made with respect to rights or liabilities under s. 108.10 is binding in an action or proceeding under s. 108.09.

(4) No finding of fact or law, determination, decision or judgment in any action or administrative or judicial proceeding in law or equity not arising under this chapter made with respect to the rights or liabilities of a party to an action or proceeding under this chapter is binding in an action or proceeding under this chapter.

History: 1989 a. 77; 1991 a. 89.

No administrative decision made under a chapter other than ch. 108 is binding on an unemployment insurance claim. A worker's compensation decision does not bind an administrative hearing on an unemployment insurance claim or the commission reviewing it. Goetsch v. DWD, 2002 WI App 128, 254 Wis. 2d 807, 646 N.W.2d 389, 01-2777.

Chapter 227, Administrative Procedure and Review

227.43 Division of hearings and appeals.

(1) The administrator of the division of hearings and appeals in the department of administration shall:

(a) Serve as the appointing authority of all hearing examiners under s. 230.06.

(b) Assign a hearing examiner to preside over any hearing of a contested case which is required to be conducted by the department of natural resources and which is not conducted by the secretary of natural resources.

(bd) Assign a hearing examiner to preside over any hearing of a contested case which is referred by the state superintendent under s. 118.134 (1).

(bg) Assign a hearing examiner to preside over any hearing or review under ss. 84.30 (18), 84.305, 84.31 (6) (a), 85.013 (1), 86.073 (3), 86.16 (5), 86.195 (9) (b), 86.32 (1), 101.935 (2) (b), 101.951 (7) (a) and (b), 114.134 (4) (b), 114.135 (9), 114.20 (19), 175.05 (4) (b), 194.145 (1), 194.46, 218.0114 (7) (d) and (12) (b), 218.0116 (2), (4), (7) (a), (8) (a) and (10), 218.0131 (3), 218.11 (7) (a) and (b), 218.22 (4) (a) and (b), 218.32 (4) (a) and (b), 218.41 (4), 218.51 (5) (a) and (b), 341.09 (2m) (d), 342.26, 343.69, 348.105 (5) (h), and 348.25 (9).

(bm) Assign a hearing examiner to preside over any hearing or review of a worker's compensation claim or other dispute under ch. 102.

(br) Assign a hearing examiner to preside over any hearing of a contested case which is required to be conducted by the department of transportation and which is not conducted by the secretary of transportation.

(bu) Assign a hearing examiner to preside over any hearing of a contested case that is required to be conducted by the department of health services and that is not conducted by the secretary of health services.

(by) Assign a hearing examiner to preside over any hearing of a contested case that is required to be conducted by the department of children and families under ch. 48 or subch. III of ch. 49 and that is not conducted by the secretary of children and families.

(c) Supervise hearing examiners in the conduct of the hearing and the rendering of a decision, if a decision is required.

(d) Promulgate rules relating to the exercise of the administrator's and the division's powers and duties under this section.

(1g) The administrator of the division of hearings and appeals shall establish a system for assigning hearing examiners to preside over any hearing under this section. The system shall ensure, to the extent practicable, that hearing examiners are assigned to different subjects on a rotating basis. The system may include the establishment of pools of examiners responsible for certain subjects.

(1m) Upon the request of an agency that is not prohibited from contracting with a 3rd party for contested case hearing services, the administrator of the division of hearings and appeals in the department of administration may contract with the agency to provide the contested case hearing services and may assign a hearing examiner to preside over any hearing performed under such a contract.

(2) (a) The department of natural resources shall notify the division of hearings and appeals of every pending hearing to which the administrator of the division is required to assign a hearing examiner under sub. (1) (b) after the

department of natural resources is notified that a hearing on the matter is required.

(am) The department of workforce development shall notify the division of hearings and appeals of every pending hearing to which the administrator of the division is required to assign a hearing examiner under sub. (1) (bm) after the department of workforce development is notified that a hearing on the matter is required.

(b) The department of transportation shall notify the division of hearings and appeals of every pending hearing to which the administrator of the division is required to assign a hearing examiner under sub. (1) (br) after the department of transportation is notified that a hearing on the matter is required.

(c) The department of health services shall notify the division of hearings and appeals of every pending hearing to which the administrator of the division is required to assign a hearing examiner under sub. (1) (bu) after the department of health services is notified that a hearing on the matter is required.

(d) The department of children and families shall notify the division of hearings and appeals of every pending hearing to which the administrator of the division is required to assign a hearing examiner under sub. (1) (by) after the department of children and families is notified that a hearing on the matter is required.

(3) (a) The administrator of the division of hearings and appeals may set the fees to be charged for any services rendered to the department of natural resources by a hearing examiner under this section. The fee shall cover the total cost of the services.

(b) The administrator of the division of hearings and appeals may set the fees to be charged for any services rendered to the department of transportation by a hearing examiner under this section. The fee shall cover the total cost of the services.

(bm) The administrator of the division of hearings and appeals may set the fees to be charged for any services rendered to the department of workforce development by a hearing examiner under this section. The fee shall cover the total cost of the services.

(br) The administrator of the division of hearings and appeals may set the fees to be charged for any services rendered to the department of public instruction by a hearing examiner under this section. The fee shall cover the total cost of the services.

(c) The administrator of the division of hearings and appeals may set the fees to be charged for any services rendered to the department of health services by a hearing examiner under this section in a manner consistent with a federally approved allocation methodology. The fees shall cover the total cost of the services.

(**d)** The administrator of the division of hearings and appeals may set the fees to be charged for any services rendered to the department of children and families by a hearing examiner under this section in a manner consistent with a federally approved allocation methodology. The fees shall cover the total cost of the services.

(e) The administrator of the division of hearings and appeals may set the fees to be charged for any services contracted for under sub. (1m).

(4) (a) The department of natural resources shall pay all costs of the services of a hearing examiner assigned to the department under sub. (1) (b), according to the fees set under sub. (3) (a).

(b) The department of transportation shall pay all costs of the services of a hearing examiner assigned under sub. (1) (bg) or assigned to the department under sub. (1) (br), according to the fees set under sub. (3) (b).

(bm) The department of workforce development shall pay all costs of the services of a hearing examiner assigned under sub. (1) (bm), according to the fees set under sub. (3) (bm).

(br) The department of public instruction shall pay all costs of the services of a hearing examiner, including support services, assigned under sub. (1) (bd), according to the fees set under sub. (3) (br).

(c) The department of health services shall pay all costs of the services of a hearing examiner, including support services, assigned under sub. (1) (bu), according to the fees set under sub. (3) (c).

(d) The department of children and families shall pay all costs of the services of a hearing examiner, including support services, assigned under sub. (1) (by), according to the fees set under sub. (3) (d).

(e) The agency contracting out for contested case hearing services under sub. (1m) shall pay all costs of the services of a hearing examiner, including support services, assigned under sub. (1m), according to the fees set under sub. (3) (e).

History: 1977 c. 418; 1981 c. 20 s. 2202 (1) (b); 1983 a. 27; 1985 a. 182 ss. 16 to 18, 29, 31; Stats. 1985 s. 227.43; 1993 a. 16; 1995 a. 370; 1997 a. 3, 27; 1999 a. 9, 31, 185, 186; 2003 a. 118; 2005 a. 465; 2007 a. 20 ss. 2998 to 3001, 9121 (6) (a); 2013 a. 115; 2015 a. 55, 137.

Cross-reference: See also HA, Wis. adm. code.

Chapter 303, Prison Labor

303.07 County Reforestation Camps.

(7) If any inmate of a reforestation camp, in the performance of work in connection with the maintenance of the camp, is injured so as to be permanently incapacitated, or to have materially reduced earning power, the inmate may upon discharge be allowed and paid such compensation as the department of workforce development finds the inmate entitled to. The inmate shall be compensated on the same basis as if the injury had been covered by ch. 102, except that the total paid to any such inmate shall not exceed $1,000 and may be paid in installments. If the inmate is from an adjoining county such county shall pay such compensation. In case of dispute the procedure for hearing, award and appeal shall be as set forth in ss. 102.16 to 102.26.

Cross-reference: See also LIRC, Wis. adm. code.

303.21 Compensation to injured prisoners.

(1) (a) If an inmate of a state institution, in the performance of assigned work is injured so as to be permanently incapacitated or to have materially reduced earning power, the inmate may, upon being released from such institution, either upon release on parole or extended supervision or upon final discharge, be allowed and paid such compensation as the department of workforce development finds the inmate entitled to. The inmate shall be compensated on the same basis as if the injury had been covered by ch. 102, except that the total paid to any inmate may not exceed $10,000 and may be paid in installments. If the injury results from employment in a prison industry, the payment shall be made from the revolving appropriation for its operation. If there is no revolving appropriation, payment shall be made from the general fund. In case of dispute, the procedure for hearing, award and appeal shall be as set forth in ss. 102.16 to 102.26.

(b) Inmates are included under par. (a) if they are participating in a structured work program away from the institution grounds under s. 302.15 or a secure work program under s. 303.063. Inmates are not included under par. (a) if they are employed in a prison industry under s. 303.06 (2), participating in a work release program under s. 303.065 (2), participating in employment with a private business under s. 303.01 (2) (em) or participating in the transitional employment program, but they are eligible for worker's compensation benefits under ch. 102. Residents subject to s. 303.01 (1) (b) are not included under par. (a) but they are eligible for worker's compensation benefits under ch. 102.

(2) Section 102.29 applies to compensation paid under this section.

(3) This section does not apply if the inmate has made a recovery against an officer, employee or agent of the state, arising out of the same incident under s. 895.46. If recovery has already been made under this section at the time that a recovery is made under s. 895.46, the state is entitled to a credit in the amount of the recovery against any obligation it has under s. 895.46 arising out of the same incident.

History: 1975 c. 147 s. 54; 1975 c. 199; 1977 c. 29, 195; 1981 c. 20; 1985 a. 29; 1989 a. 31 s. 1696; Stats. 1989 s. 303.21; 1993 a. 81; 1995 a. 27 ss. 6400, 6401, 9130 (4); 1995 a. 416; 1997 a. 3, 283.

Cross-reference: See also LIRC, Wis. adm. code.

Compensation of prisoners for injuries under this section is not determined in the same manner as worker's compensation under s. 102.03 The rules followed under s. 102.03 do not apply. Kopacka v. DILHR, 49 Wis. 2d 255, 181 N.W.2d 487 (1970).

303.215 Compensation to prisoners or residents injured in prison industries employment. In accordance with s. 102.03 (2), for an inmate of a state institution or a resident subject to s. 303.01 (1) (b) employed under s. 303.06 (2), compensation under ch. 102 on being released from the applicable institution, on parole, on extended supervision, on final discharge or in accordance with ch. 938, whichever is applicable, is the exclusive remedy against the department and any employee of the

department for any injury sustained by the inmate or resident while performing service growing out of and incidental to that employment. The department shall make any payments required under this section from the revolving appropriation for the operation of prison industries or, if there is no revolving appropriation for the operation of prison industries, from the general fund.

History: 1993 a. 81; 1995 a. 27, 77; 1997 a. 283.

Chapter 626, Rate Regulation in Worker's Compensation Insurance

626.12 Rating methods. In determining whether rates comply with the standards under s. 626.11, the following criteria shall be applied:

(1) BASIC FACTORS IN RATES. Due consideration shall be given to past and prospective loss and expense experience within and outside this state, to catastrophe hazards and contingencies, to a reasonable margin for profit, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, and to all other relevant factors.

(2) CLASSIFICATION. Risks may be classified in any reasonable way for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(3) PHYSICAL IMPAIRMENT. Rates or rating plans may not take into account the physical impairment of employees. Any employer who applies or promotes any oppressive plan of physical examination and rejection of employees or applicants for employment shall forfeit the right to experience rating. If the department of workforce development determines that grounds exist for such forfeiture it shall file with the commissioner a certified copy of its findings, which shall automatically suspend any experience rating credit for the employer. The department shall make the determination as prescribed in ss. 103.005 (5) (b) to (f), (6) to (11), (13) (b) to (d) and (16), so far as such subsections are applicable, subject to review under ch. 227. Restoration of an employer to the advantages of experience rating shall be by the same procedure.

History: 1975 c. 148; 1995 a. 27 ss. 7037, 9130 (4); 1997 a. 3.

Chapter 814, Court Costs, Fees and Surcharges

814.67 Fees of witnesses and interpreters.

(1) The fees of witnesses and interpreters shall be as follows:

(a) For attending before a municipal judge, an arbitrator, or any officer, board or committee:

1. For witnesses, $5 per day.

2. For interpreters, $10 per one-half day or such higher fees as the municipality or county board may establish.

(am) For witnesses attending before a circuit court, $16 per day.

(c) 1. For a witness, the rate of 20 cents per mile for either of the following:

a. Traveling from his or her residence to the place of attendance, and returning by the usually traveled route between such points if his or her residence is within the state.

b. Traveling from the point where he or she crosses the state boundary to the place of attendance and returning by the usually traveled route between such points if his or her residence is outside the state.

2.

a. Except as provided in subd. 2. b., for an interpreter, the mileage rate set under s. 20.916 (8) for traveling from his or her residence to the place of attendance and returning by the usually traveled route between such points.

b. For an interpreter traveling to the place of attendance from his or her place of residence outside the state, the number of miles between the interpreter's residence and the point at which he or she crosses the state boundary for which the interpreter may receive reimbursement under this subdivision may not exceed 100 miles each way, following the usually traveled route between such points.

(2) A witness or interpreter is entitled to fees only for the time he or she is in actual and

necessary attendance as such; and is not entitled to receive pay in more than one action or proceeding for the same attendance or travel on behalf of the same party. A person is not entitled to fees as a witness or interpreter while attending court as an officer or juror. An attorney or counsel in any cause may not be allowed any fee as a witness or interpreter therein.

History: 1981 c. 317; 1987 a. 27; 1995 a. 27; 2001 a. 16; 2009 a. 28; 2013 a. 20.

Chapter 891, Presumptions

891.45 Presumption of employment-connected disease; heart or respiratory impairment or disease.

(1) In this section:

(a) "County fire fighter" means any person employed by a county whose duties primarily include active fire suppression or prevention.

(b) "Municipal fire fighter" includes any person designated as primarily a fire fighter under s. 60.553 (2), 61.66 (2), or 62.13 (2e) (b) and any person under s. 60.553, 61.66, or 62.13 (2e) whose duties as a fire fighter during the 5-year qualifying period took up at least two-thirds of his or her working hours.

(c) "State fire fighter" means any person employed by the state whose duties primarily include active fire suppression or prevention and who is a protective occupation participant, as defined in s. 40.02 (48).

(2) Except as provided in s. 891.453, in any proceeding involving the application by a state, county, or municipal fire fighter or his or her beneficiary for disability or death benefits under s. 40.65 (2) or any pension or retirement system applicable to fire fighters, where at the time of death or filing of application for disability benefits the deceased or disabled fire fighter had served a total of 5 years as a state, county, or municipal fire fighter and a qualifying medical examination given prior to the time of his or her becoming a state, county, or municipal fire fighter showed no evidence of heart or respiratory impairment or disease, and where the disability or death is found to be caused by heart or respiratory impairment or disease, such finding shall be presumptive evidence that such impairment or disease was caused by such employment.

History: 1977 c. 83; 1981 c. 278 s. 6; 1983 a. 191 s. 6; 1987 a. 399; 1987 a. 403 s. 256; 1997 a. 173; 2001 a. 16; 2009 a. 284; 2011 a. 32.

891.453 Presumption of employment-connected disease; infectious disease.

(1) In this section:

(a) "Correctional officer" means any person employed by the state or by a county or a municipality as a guard or officer whose principal duties are the supervision and discipline of inmates.

(b) "Emergency medical service provider" means a person employed by the state or by a county or municipality and who is an emergency medical technician under s. 256.01 (5) or a first responder under s. 256.01 (9).

(c) "Fire fighter" means a state, county, or municipal fire fighter who is covered under s. 891.45 and any person under s. 60.553, 61.66, or 62.13 (2e) whose duties as a fire fighter took up at least two-thirds of his or her working hours.

(d) "Law enforcement officer" means any person employed by the state or by a county or a municipality for the purpose of detecting and preventing crime and enforcing laws or ordinances, who is authorized to make arrests for violations of the laws or ordinances which he or she is employed to enforce. "Law enforcement officer" includes a person under s. 60.553, 61.66, or 62.13 (2e) whose duties as a police officer took up at least two-thirds of his or her working hours.

(2) (a) In this subsection, "infectious disease" includes the human immunodeficiency virus, acquired immunodeficiency syndrome, tuberculosis, hepatitis A, hepatitis B, hepatitis C, hepatitis D, diphtheria, meningococcal meningitis, methicillin-resistant staphylococcus aureus, and severe acute respiratory syndrome.

(b) In any proceeding involving the application by a correctional officer, an emergency medical service provider, a fire fighter, or a law enforcement officer or his or her beneficiary for disability or death benefits under s. 40.65 (2) or any pension or retirement system applicable to correctional officers, emergency medical service providers, fire fighters, or law enforcement officers, if a qualifying medical examination given prior to the time of his or her becoming a correctional officer, an emergency medical

service provider, a fire fighter, or a law enforcement officer showed no evidence of an infectious disease, and if the disability or death is found to be caused by an infectious disease, the finding shall be presumptive evidence that the infectious disease was caused by the employment.

History: 2009 a. 284; 2011 a. 32.

891.455 Presumption of employment-connected disease; cancer.

(1) In this section, "state, county, or municipal fire fighter" means a fire fighter who is covered under s. 891.45 and any person under s. 60.553, 61.66, or 62.13 (2e) whose duties as a fire fighter during the 10-year qualifying period specified in sub. (2) took up at least two-thirds of his or her working hours.

(2) In any proceeding involving an application by a state, county, or municipal fire fighter or his or her beneficiary for disability or death benefits under s. 40.65 (2) or any pension or retirement system applicable to fire fighters, where at the time of death or filing of application for disability benefits the deceased or disabled fire fighter had served a total of 10 years as a state, county, or municipal fire fighter and a qualifying medical examination given prior to the time of his or her becoming a state, county, or municipal fire fighter showed no evidence of cancer, and where the disability or death is found to be caused by cancer, such finding shall be presumptive evidence that the cancer was caused by such employment.

(3) The presumption under sub. (2) shall only apply to cancers affecting the skin, breasts, central nervous system or lymphatic, digestive, hematological, urinary, skeletal, oral or reproductive systems.

(4) The presumption under sub. (2) for cancers caused by smoking or tobacco product use shall not apply to any municipal fire fighter who smokes cigarettes, as defined in s. 139.30 (1m), or who uses a tobacco product, as defined in s. 139.75 (12), after January 1, 2001.

History: 1997 a. 173; 1999 a. 9; 2001 a. 16; 2005 a. 25; 2011 a. 32.

Chapter 943, Crimes Against Property

943.395 Fraudulent insurance and employee benefit program claims.

(1) Whoever, knowing it to be false or fraudulent, does any of the following may be penalized as provided in sub. (2):

(a) Presents or causes to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance.

(b) Prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing, with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance.

(c) Presents or causes to be presented a false or fraudulent claim or benefit application, or any false or fraudulent proof in support of such a claim or benefit application, or false or fraudulent information which would affect a future claim or benefit application, to be paid under any employee benefit program created by ch. 40.

(d) Makes any misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership in or noninsurance benefit from any fraternal subject to chs. 600 to 646, for himself or herself or any other person.

(2) Whoever violates this section:

(a) Is guilty of a Class A misdemeanor if the value of the claim or benefit does not exceed $2,500.

(b) Is guilty of a Class I felony if the value of the claim or benefit exceeds $2,500.

History: 1971 c. 214; 1975 c. 373, 421; 1977 c. 173; 1979 c. 89; 1981 c. 96; 1987 a. 349; 1991 a. 39; 2001 a. 16, 109; 2015 a. 197 s. 51.

The "value of the claim" under sub. (2) refers to the amount of the entire claim and not the fraudulent portion. State v. Briggs, 214 Wis. 2d 281, 571 N.W.2d 881 (Ct. App. 1997), 97-0439.

Rules of Practice - Administrative Code

Chapter DWD 80, Worker's Compensation

DWD 80.01	Definitions.
DWD 80.02	Reports.
DWD 80.025	Inspection and copying of records.
DWD 80.03	Compromise.
DWD 80.06	Parties.
DWD 80.07	Service.
DWD 80.10	Stipulations.
DWD 80.20	License to appear.
DWD 80.21	Reports by practitioners and expert witnesses.
DWD 80.23	Common insurance of employer and third party.
DWD 80.25	Loss of hearing.
DWD 80.26	Loss of vision; determination.
DWD 80.27	Forms.
DWD 80.29	Value of room or meals.
DWD 80.30	Average weekly earnings for members of volunteer fire companies or fire departments.
DWD 80.32	Permanent disabilities.
DWD 80.33	Permanent disabilities; fingertip amputations.
DWD 80.34	Loss of earning capacity.
DWD 80.38	Assessment of administrative expenses.
DWD 80.39	Advance payment of unaccrued compensation.
DWD 80.40	Assessment for unpaid claims of insolvent self-insurer.
DWD 80.41	Computation of monthly salary and reimbursement to retirement fund under s. 66.191, 1981 Stats.
DWD 80.42	Vocational rehabilitation; reporting requirement.
DWD 80.43	Fees and costs.
DWD 80.46	Contribution to support of unestranged surviving parent.
DWD 80.47	Medical release of employee for restricted work in the healing period.
DWD 80.48	Reassignment of death benefits.
DWD 80.49	Vocational rehabilitation benefits.
DWD 80.50	Computation of permanent disabilities.
DWD 80.51	Computation of weekly wage.
DWD 80.52	Payment of permanent disability where the degree of permanency is disputed.
DWD 80.60	Exemption from duty to insure (self-insurance).
DWD 80.61	Divided-insurance and partial-insurance requirements under s. 102.31 (1) and (6), for all employers, including contractors working on a wrap-up project.
DWD 80.62	Uninsured employers fund.
DWD 80.65	Notice of cancellation or termination, or nonrenewal.
DWD 80.67	Insurer name change.
DWD 80.68	Payment of benefits under s. 102.59, Stats.
DWD 80.70	Malice or bad faith.
DWD 80.72	Health service fee dispute resolution process.
DWD 80.73	Health service necessity of treatment dispute resolution process.

Note: Chapter Ind 80 was renumbered chapter DWD 80 under s. 13.93 (2m) (b) 1., Stats., Register, July, 1996, No. 487.

Note: Sections DWD 80.05, 80.08, 80.09, 80.11, 80.12, 80.13, 80.14, 80.22, 80.31, and 80.44 were renumbered to ss. HA 4.04, 4.07, 4.08, 4.10, 4.11, 4.12, 4.13, 4.15, 4.16, and 4.17 by the legislative reference bureau under s. 13.92 (4) (b) 1. and 2. and pursuant to 2015 Wisconsin Act 55, section 9151 (2) (g) in Register May 2018 No. 749.

DWD 80.01 Definitions. (1) "Act," "compensation act" or "worker's compensation act" means ch. 102, Stats.

(2) "Department" means the department of workforce development.

(3) "Commission" means the labor and industry review commission.

History: 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82; correction in (2) made under s. 13.93 (2m) (b) 6., Stats., July, 1996, No. 487.

DWD 80.02 Reports. (1) EMPLOYERS. An employer covered by the provisions of ch. 102, Stats., shall, within one day after the death of an employee due to a compensable injury, report the death to the department and the employer's insurance carrier by telegraph, telephone, letter, facsimile transmission or other means authorized by the department on a case-by-case basis as communication technologies change. An insured employer shall also notify its insurance carrier of a compensable injury within 7 days after the accident or beginning of a disability from occupational disease related to the employee's compensable injury if any of the following occurs:

(a) Disability exists beyond the 3rd day after the employee leaves work as a result of the accident or disease. In counting the days on which disability exists, include Sunday only if the employee usually works on Sunday.

(b) An employer's insurance carrier has primary liability for unpaid medical treatment.

(2) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES; REPORTS. Except as provided in sub. (3m), for injuries under sub. (1) (a) self-insured employers and insurance companies shall submit all of the following reports to the department:

(a) A first report of injury with the information required by a completed form WKC-12 on or before the 14th day after an accident or the beginning of a disability from occupational disease. If an employer does not notify the insurance carrier of the injury until after the 14th day, the insurance carrier shall submit the WKC-12 to the department within 7 days of receiving notice of the injury from any source.

(b) A supplementary report with the information required by form WKC-13 on or before the 30th day following the day on which the injury in par. (a) occurred or on or before the 30th day following the day the injury was reported to the department, if the injury was not required to be reported under par. (a).

(c) The wage information required by form WKC-13-A if the wage is less than the maximum wage as defined by s. 102.11 (1), Stats. The WKC-13 required in par. (b) and the WKC-13-A shall be submitted together, except that if the wage information required by form WKC-13-A is not available at the time the WKC-13 is submitted, the insurance carrier or self-insured employer shall estimate on the WKC-13 the date by which the WKC-13-A will be submitted.

(d) If applicable, a signed statement from the employee verifying that the employee restricts his or her availability on the labor market to part-time employment, and is not actively employed elsewhere. The employee's statement shall accompany the WKC-13-A, but no statement is required if the employee is under the age of 16.

(e) A report within 30 days after each of the following events occurs, with a copy to the employee, using form WKC-13 indicating all worker's compensation payments to date and the periods of time for which any of the following payments were made or salary continuation paid in lieu of compensation:

1. Payment of compensation is changed from temporary disability or salary continuation in lieu of compensation to permanent disability.

2. Temporary disability benefits or salary continuation in lieu of compensation are reinstated.

3. Temporary partial disability is paid. The insurance carrier or self-insured employer shall also include the information required by form WKC-7359.

4. Final payment of compensation is made or salary continuation in lieu of compensation ended. If there are more than 3 weeks of temporary disability or any permanent disability, or if the injured employee has undergone surgery to treat the injured employee's injury, other than surgery to correct a hernia, or if the injured employee sustained an eye injury requiring treatment on 3 or more occasions outside of the employers premises, the insurance carrier or self-

insured employer shall submit a final treating practitioner's report together with the final form WKC-13 or shall explain why the report is not being submitted and shall estimate when the final practitioner's report will be submitted.

5. When a self-insured employer or insurance company transfers an open claim, with 26 weeks or more of temporary disability or permanent total disability paid, to a new claims handling office or third party administrator, the self-insured employer or insurance company shall file a paper form WKC-13 with the new claims handling office or third party administrator. The self-insured employer or insurance company shall file a paper copy of the form WKC-13 with the department upon request made by the department. The department may require a self-insured employer or insurance company to submit form WKC-13 for open claims with less than 26 weeks of temporary disability or permanent total disability paid upon request made by the department.

(f) When submitting a stipulation or compromise, and at the time of hearing, a current form WKC-13 indicating all worker's compensation payments to date and the periods of time for which these payments were made.

(g) Written notice within 7 days, with a copy to the employee, after each of the following:

1. Payments are stopped for any reason. If any payments are stopped for a reason other than the employee's return to work, the self-insured employer or insurance carrier shall explain why it stopped payments and shall advise the employee what to do to reinstate payments.

2. A decision to deny liability for payment of compensation for reported claims after a concession of liability is made, giving the reason for the denial and advising the employee of the right to a hearing before the department.

3. Amputation will require an artificial member or appliance.

(i) If increased compensation is due, a final receipt within 30 days of the final payment to the employee, as proof of payment of that increased compensation.

(j) If the employee fails to return to a practitioner for a final examination, written notice within 30 days, with a copy to the employee, advising the employee that in order to determine permanent disability, if any, the final examination is necessary.

(k) By June 30 of each calendar year, a self-insured employer or insurance company shall file a report with the department that lists the date and amount of payment for permanent total disability and supplemental benefits during the previous calendar year on a form prescribed by the department.

Note: To obtain a copy of the forms under this subsection, contact the Department of Workforce Development, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707-7901 or access forms online at http://www.dwd.wisconsin.gov.

(2m) SELF-INSURED EMPLOYERS AND INSURANCE COMPANIES; NOTICE TO EMPLOYEE. (a) For all injuries under sub. (1) (a), self-insured employers and insurance companies shall provide written notice to the employee within 14 days of the date of an alleged injury indicating one of the following:

1. A decision to deny liability for payment of compensation giving the specific reason for the denial and advising the employee of the right to a hearing before the department.

2. An explanation that the claim is not paid because the insurance company or self-insured employer is still investigating the claim. The notice shall specify if additional medical or other information is needed to complete the investigation. The notice shall advise the employee of the right to a hearing before the department if the claim is subsequently denied.

(b) If the notice of injury from the employee to the insured employer or from the insured employer to its insurance company was not made within 7 days of the date of the alleged injury, the insurance company shall provide notice under par. (a) 1. or 2. within 14 days of receiving notice of the alleged injury from any source.

(3) EVALUATION. In evaluating whether payments of compensation and reports made by insurance carriers and self-insured employers were prompt and proper under the provisions of ss. 102.28 (2) and 102.31 (3), Stats., and before undertaking to revoke the exemption from insurance under s. 102.28 (2) (c), Stats., or before recommending under s. 102.31 (3), Stats., to the commissioner of insurance that enforcement proceedings under s. 601.64, Stats., be invoked the department will consider all of the following

performance standards together with all other factors bearing on the performance and activities of the insurance carrier or self-insured employer:

(a) *Payment of first indemnity.* Whether 80% or more of first indemnity payments are mailed to the injured employee in 14 days or less following the date of injury or the last day worked after the injury before the first day of compensable lost time.

(b) *First report of injury*. Whether 70% or more of reports required under sub. (2) (a) are received by the department within 14 days of the date of injury or the last day worked after injury before the first day of compensable lost time.

(c) *Correct and complete names.* Names of self-insured employers on reports filed with the department must be correct and complete. The name of an insurance group is not a substitute for the name of the individual company insuring the risk. The name of an insurance service company is not a substitute.

(d) *Penalty frequency and severity.* The number and amount of penalties assessed for violations of ss. 102.18 (1) (bp), 102.22 (1), 102.57, and 102.60, Stats.

(3m) REPORTING BY ELECTRONIC, MAGNETIC OR OTHER MEDIA. (a) *Employer or insurer request.* 1. An employer, self-insured employer or insurer may make a written request to the department to submit the information in reports or amendments to reports required to be filed with the department in sub. (1) or (2) via electronic, magnetic or other media satisfactory to the department. The department may authorize an employer, self-insured employer or insurer to use electronic, magnetic or other reporting media after considering the extent to which it will help the employer, self-insured employer or insurer meet or exceed the applicable reporting requirements and performance standards in subs. (1) to (3).

2. The authorization shall be in writing and shall state the terms and conditions for granting and revoking the privilege to use electronic, magnetic or other reporting media, including any terms and conditions relating to reporting requirements or performance standards in subs. (1) to (3). The written authorization shall specify what variations exist, if any, between the data required to be submitted on forms WKC-12, WKC-13, WKC-13-A, or other forms that are used by the department and the data required to be submitted via electronic, magnetic or other media.

(b) *Department requirement*. 1. The department may require an employer, self-insured employer, or insurer to submit all or selected information in reports or amendments to reports required to be filed with the department in sub. (1) or (2) via electronic, magnetic, or other media satisfactory to the department. The department may require an employer, self-insured employer, or insurer to use electronic, magnetic, or other reporting media after considering the extent to which it will help the employer, self-insured employer, or insurer meet or exceed the applicable reporting requirements and performance standards in subs. (1) to (3).

2. The directive that requires reporting by electronic, magnetic, or other media shall be in writing and shall set forth terms and conditions that include a deadline for compliance.

3. An employer, self-insured employer, or insurer may request a waiver within 60 days of the date of the department's directive that requires reporting by electronic, magnetic, or other media. The department may grant the waiver if the department is satisfied that the employer, self-insured employer, or insurer has established good cause.

History: 1-2-56; am. (1) and (2), Register, October, 1965, No. 118, eff. 11-1-66; am. Register, April, 1975, No. 232, eff. 5-1-75; am. (1), r. and recr. (2), Register, September, 1982, No. 321, eff. 10-1-82; am. (2) (intro.) and cr. (3), Register, September, 1986, No. 369, eff. 10-1-86; renum. (1) to be (1) (a) and am., cr. (1) (b) and (3m), am. (2) (intro.), Register, November, 1993, No. 455, eff. 12-1-.93**;** r. and recr. (1) and (2), am. (3) (intro.), (a), (b), (3m) (b) and r. (3m) (c), Register, December, 1997, No. 504, eff. 1-1-98; CR 03-125: am. (2) (b) and (g) 2., r. (2) (h), cr. (2m) and (3m) (b), renum. (3m) (a) and (b) to be (3m) (a) 1. and 2. Register June 2004 No. 582, eff. 7-1-04; CR 07-019: am. (2) (e) 4., Register October 2007 No. 622, eff. 11-1-07; **CR 15-030: am. (2) (e) (intro), 1., 2., 4., cr. (2) (e) 5., (k) Register October 2015 No. 718, eff. 11-1-15**.

DWD 80.025 Inspection and copying of records. (1) The policy of the state on public access to records is set forth in ss. 19.31 to 19.37, Stats. The policy of the department is to provide, to the greatest extent possible, ready and open access to public records. In the worker's compensation division, access may be limited in particular cases only when consideration of the information in a file leads to the conclusion that

the public interest served by nondisclosure is greater than the public interest served by disclosure. The inspection and copying of worker's compensation records shall be subject to the conditions specified in this section.

(2) The requester shall provide sufficient information on each individual file requested to permit identification and location of the specific file. Desirable information on claim files includes:

(a) The correct name of the individual who has claimed a work-related disability;

(b) The claimant's social security number;

(c) The date the claimed injury or illness occurred;

(d) The name of the employing firm or firms at the time of the claimed injury or illness;

(e) The name of the employing firm's insurance carrier.

(3) Requesters may inspect claim files only in the division's Madison office and under the supervision of division staff. Requesters shall direct requests to inspect files to the receptionist between the hours of 7:45 a.m. and 4:30 p.m. Requesters shall return all files by 4:30 p.m.

(4) Requesters may not remove files from the division offices without written authorization from the administrator of the division.

(5) Requesters wishing to make copies of all or a part of a file may do so under the supervision of division staff on the coin-operated copy machine provided for that purpose.

(6) The division shall provide transcripts of testimony taken or proceedings had before the division only in accordance with s. HA 4.13.

(7) The division shall furnish copies of documents from worker's compensation claim files as requested, with the following limits:

(a) At least one week must be allowed before copies can be delivered or mailed.

(b) Advance payment shall not be required except as provided in par. (e). The division shall send an invoice to the requester for the necessary costs as set forth in par. (c).

(c) The following fees shall apply:

1. 20 cents per page for photocopying.
2. $2.00 for certifying copies.
3. $3.00 per request for postage and handling when copies are to be mailed.

(d) Upon a proper showing of inability to pay, the division shall furnish the requested copies upon such terms as may be agreed.

(e) If the requester has unpaid copying fees from prior requests outstanding in an amount that exceeds $5.00, the division shall require the requester to pay the amount owed before providing more copies.

History: Cr. Register, March, 1986, No. 363, eff. 4-1-86.

DWD 80.03 Compromise. (1) Whenever an employer and an employee enter into a compromise agreement concerning the employer's liability under ch. 102, Stats., for a particular injury to that employee, the following conditions shall be fulfilled:

(a) The compromise agreement shall be in writing, or in the alternative, oral on the record at the time of scheduled hearing;

(b) The compromise agreement shall be mailed to the department unless made on the record;

(c) The compromise agreement must be approved by the department; and

(d) No compromise agreement may provide for a lump sum payment of more than the incurred medical expenses plus sums accrued as compensation or death benefits to the date of the agreement and $10,000 in unaccrued benefits where the compromise settlement in a claim other than for death benefits involves a dispute as to the extent of permanent disability. Lump sum payments will be considered after approval of the compromise in accordance with s. DWD 80.39.

(e) Compromise agreements which provide for payment of a lump sum into an account in a bank, trust company or other financial institution, which account is subject to release as the department directs, will be authorized.

(f) Appropriate structured settlements will be approved.

(g) All written compromise agreements submitted to the department shall contain the following:

The employee has the right to petition the department of workforce development to set aside or modify this compromise agreement within one year of its approval by the department. The department may set aside or modify the compromise agreement. The right to request the department to set aside or modify the

compromise agreement does not guarantee that the compromise will in fact be reopened.

(2) If the department approves the compromise agreement, an order shall be issued by the department directing payment in accordance with the terms of the compromise agreement. No compromise agreement is valid without an order of the department approving the agreement.

(3) Section 102.16 (1), Stats., places upon the department the responsibility for reviewing, approving, modifying, setting aside and issuing awards on compromise agreements. The action that is taken on any individual claim is dependent upon the facts, circumstances and judgment of the merits of compromise in that specific case. In arriving at a judgment of the merits the department will take into account the following general considerations:

(a) Medical reports, statements or other information submitted by the parties to show that there is a genuine and significant basis for a dispute between the parties.

(b) Estimates of the disability by the physicians, chiropractors or podiatrists which do not vary significantly in estimates of the scheduled or nonscheduled disability will not be presumed to demonstrate a basis for dispute.

(c) The length of time since active treatment has been necessary. The presumption is that the longer the interval the less likely that treatment will be required in the future.

(d) Scientific knowledge or experience indicating that there may be further progression of the disability or that future treatment may be required. Examples of such conditions are: skull fractures with laceration of the dura, sub-capitol fractures of the femur, silicosis and asbestosis.

(e) The length of time since the date of injury.

(f) Any and all other factors that bear on the equity of the proposed compromise.

History: 1-2-56; am., Register, April, 1975, No. 232, eff. 5-1-75; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82; am. (1) (d), cr. (1) (f) and (g) and (3), Register, September, 1986, No. 369, eff. 10-1-86; CR 07-019: am. (1) (d) and (g), Register October 2007 No. 622, eff. 11-1-07.

DWD 80.06 Parties. The parties to the controversy shall be known as the applicant and the respondent. The party filing the application for relief shall be known as the applicant and an adverse party as the respondent. Any party may appear in person or by an attorney or agent.

History: 1-2-56; am. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.07 Service. All service of papers, unless otherwise directed by the department or by law, may be made by mail and proof of such mailing shall be prima facie proof of such service. Time within which service shall be made shall be the same as in courts of record unless otherwise specified by rule or order of the department.

History: 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75.

DWD 80.10 Stipulations. Parties to a controversy may stipulate the facts in writing, and the department may thereupon make its order or award. Stipulations must set forth in detail the manner of computing the compensation due and must be accompanied by a report from a physician stating the extent of the disability.

History: 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75.

DWD 80.20 License to appear. (1) The following rules shall govern the issuance, suspension, or revocation of licenses to appear before the department in compensation matters under the provisions of s. 102.17 (1) (c), Stats.

(a) Permission to appear at a single hearing may be issued by the department through any examiner upon application evidencing qualifications provided by statute and the department's rules. Such permission may be given to appear in 3 cases before the issuing of license. When appearance has been made in 3 cases, license shall be required, which shall be issued only upon execution and filing with the department of application upon form prescribed by the department.

(b) Before license shall be issued applicant shall have appeared in representation of a party before the department on at least 3 formal hearings.

(c) The following conditions shall operate as grounds for refusal, suspension, or revocation of license.

1. Charging of excessive or unconscionable fees, misrepresentation of clients, dishonesty, fraud, sharp practice, neglect of duty, or other improper conduct in the representation of a party before the department, unless satisfactorily

explained or excused by the department on the grounds of subsequent good conduct.

2. Disbarment from the practice of law, or resignation by request of properly constituted authorities, unless there has been subsequent reinstatement and continuance in good standing.

3. Contumacious conduct in hearing, gross discourtesy toward department representatives, or failure to conform to rulings or instructions of the department or its representatives.

4. Intentional or repeated failure to observe provisions of the compensation act or rules of procedure adopted by the department.

5. Any other gross evidence of lack of good moral character, fitness or act of fraud, or serious misconduct.

History: 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75; am. (1) (intro.), Register, September, 1986, No. 369, eff. 10-1-86.

DWD 80.21 Reports by practitioners and expert witnesses. (1) Upon the request of the department, any party in interest to a claim under ch. 102, Stats., shall furnish to the department and to all parties in interest copies of all reports by practitioners and expert witnesses in their possession or procurable by them.

(2) In cases involving nonscheduled injuries under s. 102.44 (2) or (3), Stats., any party in interest to a claim under the act shall, upon the request of the department, also furnish to the department and to all parties in interest any reports in their possession or reasonably available to them relating to the loss of earning capacity as set forth in s. DWD 80.34.

(3) Any party who does not comply with the request of the department under sub. (1) or (2) shall be barred from presenting the reports or the testimony contained therein at the hearing.

(4) No testimony or reports from expert witnesses on the issue of loss of earning capacity may be received unless the party offering the evidence has notified the department and the other parties of interest of the party's intent to provide the testimony or reports and the names of expert witnesses involved as required under the provisions of s. 102.17 (7), Stats.

History: 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75; am. (1), cr. (2), (3) and (4), Register, September, 1982, No. 321, eff. 10-1-82; CR 02-094: r. and recr. (4) Register November 2002 No. 563, eff. 12-1-02.

DWD 80.23 Common insurance of employer and third party. In all cases where compensation becomes payable and the insurance carrier of an employer and of a third party shall be the same, or if there is common control of the insurer of each, the insurance carrier of the employer shall promptly notify the parties in interest and the department of that fact.

History: 1-2-56; am. Register, April, 1975, No. 232, eff. 5-1-75.

DWD 80.25 Loss of hearing. The department adopts the following standards for the determination and evaluation of noise induced hearing loss, other occupational hearing loss and accidental hearing loss:

(1) HARMFUL NOISE. Hearing loss resulting from hazardous noise exposure depends upon several factors, namely, the overall intensity (sound pressure level), the daily exposure, the frequency characteristic of the noise spectrum and the total lifetime exposure. Noise exposure level of 90 decibels or more as measured on the A scale of a sound level meter for 8 hours a day is considered to be harmful.

(2) MEASUREMENT OF NOISE. Noise shall be measured with a sound level meter which meets ANSI standard 1983 and shall be measured on the "A" weighted network for "slow response." Noise levels reaching maxima at intervals of one second or less shall be classified as being continuous. The measurement of noise is primarily the function of acoustical engineers and properly trained personnel. Noise should be scientifically measured by properly trained individuals using approved calibrated instruments which at the present time include sound level meters, octave band analyzers and oscilloscopes, the latter particularly for impact-type noises.

(3) MEASURE OF HEARING ACUITY. The use of pure tone air and bone conduction audiometry performed under proper testing conditions is recommended for establishing the hearing acuity of workers. The audiometer should be one which meets the specifications of ANSI standard 53.6-1969 (4). The audiometer should be periodically calibrated. Preemployment records should include a satisfactory personal and occupational history as they may pertain to hearing status. Otological examination should be made where indicated.

(4) FORMULA FOR MEASURING HEARING IMPAIRMENT. For the purpose of determining the hearing impairment, pure tone air conduction audiometry is used, measuring all frequencies between 500 and 6,000 Hz. This formula uses the average of the 4 speech frequencies of 500, 1,000, 2,000, and 3,000 Hz. Audiometric measurement for these 4 frequencies averaging 30 decibels or less on the ANSI calibration does not constitute any practical hearing impairment. A table for evaluating hearing impairment based upon the average readings of these 4 frequencies follows below. No deduction is made for presbycusis.

(5) DIAGNOSIS AND EVALUATION. The diagnosis of occupational hearing loss is based upon the occupational and medical history, the results of the otological and audiometric examinations and their evaluation.

(6) TREATMENT. There is no known medical or surgical treatment for improving or restoring hearing loss due to hazardous noise exposure. Hearing loss will be improved in non-occupational settings with the use of a hearing aid. Since a hearing aid relieves from the effect of injury the cost is compensable where prescribed by a physician.

(7) ALLOWANCE FOR TINNITUS. In addition to the above impairment, if tinnitus has permanently resulted due to work exposure, an allowance of 5% loss of hearing impairment for the affected ear or ears shall be computed.

(8) HEARING IMPAIRMENT TABLE.

Average Decibel Loss ANSI	Percent of Compensable Hearing Impairment	Average Decibel Loss ANSI	Percent of Compensable Hearing Impairment
30	0.0	62	51.2
31	1.6	63	52.8
32	3.2	64	54.4
33	4.8	65	56.0
34	6.4	66	57.6
35	8.0	67	59.2
36	9.6	68	60.8
37	11.2	69	62.4
38	12.8	70	64.0
39	14.4	71	65.6
40	16.0	72	67.2
41	17.6	73	68.8
42	19.2	74	70.4
43	20.8	75	72.0
44	22.4	76	73.6
45	24.0	77	75.2
46	25.6	78	76.8
47	27.2	79	78.4
48	28.8	80	80.0
49	30.4	81	81.6
50	32.0	82	83.2
51	33.6	83	84.8
52	35.2	84	86.4
53	36.8	85	88.0
54	38.4	86	89.6
55	40.0	87	91.2
56	41.6	88	92.8
57	43.2	89	94.4
58	44.8	90	96.0
59	46.4	91	97.6
60	48.0	92	99.2
61	49.6	93	100.0

(9) METHOD FOR DETERMINING PERCENT OF HEARING IMPAIRMENT. (a) Obtain for each ear the average hearing level in decibels at the 4 frequencies, 500, 1,000, 2,000 and 3,000 Hz.

(b) See Table for converting to percentage of hearing impairment in each ear.

(c) To determine the percentage of impairment for both ears, multiply the lesser loss by 5, add the greater loss and divide by 6. Following are examples of the calculation of hearing loss:

A. Mild to Marked Bilateral Hearing Loss

	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right Ear	15	25	45	55
Left Ear	30	45	60	85

1. Calculation of average hearing threshold level:

$$\text{Right Ear}: \frac{15 + 25 + 45 + 55}{4} = \frac{140}{4} = 35 \text{ db} = 8\% \text{ loss}$$

2. Calculation of hearing handicap:

Smaller number (better ear)

8% × 5 = 40

Larger number (poorer ear)

40% × 1 = 40

Total 80 ÷ 6 = 13.33% loss

Therefore, a person with the hearing threshold levels shown in this audiogram would have a 13.33% hearing handicap.

B. Slight Bilateral Hearing Loss

	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right Ear	15	15	20	30
Left Ear	25	30	35	40

1. Average hearing threshold level:

$$\text{Right Ear}: \frac{15 + 15 + 20 + 30}{4} = \frac{80}{4} = 20 \text{ db} = 0\% \text{ loss}$$

$$\text{Left Ear}: \frac{25 + 30 + 35 + 40}{4} = \frac{130}{4} = 33.0 \text{ db} = 4.8\% \text{ loss}$$

Therefore, the hearing loss is 4.8% left ear

C. Severe to Extreme Bilateral Hearing Loss

	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right Ear	80	90	100	110
Left Ear	75	80	90	95

1. Average hearing threshold level (use 93 db maximal value):

$$\text{Right Ear}: \frac{80 + 90 + 100 + 110}{4} = \frac{380}{4} = 95 \text{ db} = 100\% \text{ loss}$$

$$\text{Left Ear}: \frac{75 + 80 + 90 + 95}{4} = \frac{340}{4} = 85 \text{ db} = 88\% \text{ loss}$$

2. Hearing handicap:
   Smaller number (better ear)
   88% × 5 = 440
   Larger number (poorer ear)
   100% × 1 = 100%
   Total 540 ÷ 6 = 90% loss

Therefore, the hearing handicap is 90%.

History: 1-2-56; am. Register, January, 1960, No. 49, eff. 2-1-60; am. Register, October, 1965, No. 118, eff. 11-1-65; r. and recr. Register, September, 1972, No. 201, eff. 10-1-72; am. (1) to (4), r. (5), renum. (6) and (7) to be (5) and (6), cr. (7) and am. (8), Register, September, 1975, No. 237, eff. 10-1-75; am. (intro.), (2) to (4), (6), (8) and (9), Register, September, 1986, No. 369, eff. 10-1-86.

DWD 80.26 Loss of vision; determination. The following rules for determining loss of visual efficiency shall be applicable to all cases settled after December 1, 1941, irrespective of the date of injury, except that, in the examples for computations of compensation payable and of the percentage of permanent total disability, the computation of the percentage of visual impairment must be applied to the provisions of the worker's compensation act as they existed at the date of the injury.

(1) MAXIMUM AND MINIMUM LIMITS OF THE PRIMARY COORDINATE FACTORS OF VISION. In order to determine the various degrees of visual efficiency, a) normal or maximum, and b) minimum, limits for each coordinate function must be established; i.e., the 100% point and the 0% point.

(a) *Maximum limits.* The maximum efficiency for each of these is established by existing and accepted standards.

1. Central visual acuity. The ability to recognize letters or characters which subtend an angle of 5 minutes, each unit part of which subtends a 1 minute angle at the distance viewed is accepted as standard. Therefore a 20/20 Snellen or A.M.A. and a 14/14 A.M.A. are employed as the maximum acuity of central vision, or 100% acuity for distance vision and near vision respectively.

2. Field vision. A visual field having an area which extends from the point of fixation outward 65, down and out 65, down 55, down and in 45, inward 45, in and up 45, upward 45, and up and out 55 is accepted as 100% industrial visual field efficiency.

3. Binocular vision. Maximum binocular vision is present if there is absence of diplopia in all parts of the field of binocular fixation, and if the 2 eyes give useful binocular vision.

(b) *Minimum limits.* The minimum limit, or the 0% of the coordinate functions of vision, is established at that degree of deficiency which reduces vision to a state of industrial uselessness.

1. Central visual acuity. The minimum limit of this function is established as the loss of light perception, light perception being qualitative vision. The practical minimum limit of quantitative visual acuity is established as the ability to distinguish form. Experience, experiment and authoritative opinion show that for distance vision 20/200 Snellen or A.M.A. Chart is 80% loss of visual efficiency, 20/380 is 96% loss, and 20/800 is 99.9% loss, and that for near vision 14/141 A.M.A. Reading Card is 80% loss of visual efficiency, 14/266 is 96% loss, and 14/560 is 99.9% loss. Table 1 shows the percentage loss of visual efficiency corresponding to the Snellen and other notations for distant and for near vision, for the measurable range of quantitative visual acuity.

2. Field vision. The minimum limit for this function is established as a concentric central contraction of the visual field to 5. This degree of contraction of the visual field of an eye reduces the visual efficiency to zero.

3. Binocular vision. The minimum limit is established by the presence of diplopia in all parts of the motor field, or by lack of useful binocular vision. This condition constitutes 50% motor field efficiency.

(c) Where distance vision is less than 20/200 and the A.M.A. Chart is used, readings will be at 10 feet. The percentage of efficiency and loss may be obtained from this table by comparison with corresponding readings on the basis of 20 feet, interpolating between readings if necessary. In view of the lack of uniform standards among the various near vision charts, readings for near

vision, within the range of vision covered thereby, are to be according to the American Medical Association Rating Reading Card of 1932.

(2) MEASUREMENT OF COORDINATE FACTORS OF VISION AND THE COMPUTATION OF THEIR PARTIAL LOSS. (a) *Central visual acuity.* 1. Central visual acuity shall be measured both for distance and for near, each eye being measured separately, both with and without correction. Where the purpose of the computation is to determine loss of vision resulting from injury, if correction is needed for a presbyopia due to age or for some other condition clearly not due to the injury (see section on miscellaneous regulations), the central visual acuity "without correction", as the term is used herein, shall be measured with a correction applied for such presbyopia or other preexisting condition but without correction for any condition which may have resulted from the injury. The central visual acuity "with correction" shall be measured with correction applied for all conditions present.

2. The percentage of central visual acuity efficiency of the eye for distance vision shall be based on the best percentage of central visual acuity between the percentage of central visual acuity with and without correction. However, in no case shall such subtraction for glasses be taken at more than 25%, or less than 5%, of total central visual acuity efficiency. If a subtraction of 5%, however, reduces the percentage of central visual acuity efficiency below that obtainable without correction, the percentage obtainable without correction shall be adopted unless correction is nevertheless necessary to prevent eye strain or for other reasons.

TABLE 1
Percentage of Central Visual Efficiency Corresponding to Specified Readings for Distant and for Near Vision for Measurable Range of Quantitative Visual Acuity

A.M.A. Test Chart or Snellen Reading for Distance	A.M.A. Card Reading for Near	Percentage of Visual Efficiency	Percentage Loss of Vision	A.M.A. Test Chart or Snellen Reading for Distance	A.M.A. Card Reading for Near	Percentage of Visual Efficiency	Percentage Loss of Vision
20/20	14/14	100.0	0.0	20/122.5	——	40.0	60.0
20/15	14/17.5	95.7	4.3	20/137.3	——	35.0	65.0
20/25.7	——	95.0	5.0	20/140	14/98	34.2	65.8
20/30	14/21	91.5	8.5	20/155	——	30.0	70.0
20/32.1	——	90.0	10.0	20/160	14/112	28.6	71.4
20/35	14/24.5	87.5	12.5	20/175	——	25.0	75.0
20/38.4	——	85.0	15.0	20/180	14/126	23.9	76.1
20/40	14/28	83.6	16.4	20/200	14/141	20.0	80.0
20/44.9	14/31.5	80.0	20.0	20/220	14/154	16.7	83.3
20/50	14/35	76.5	23.5	20/240	14/168	14.0	86.0
20/52.1	——	75.0	25.0	——	14/178	12.3	87.7
20/60	14/42	69.9	30.1	20/260	14/182	11.7	88.3
20/60.2	——	70.0	30.0	20/280	14/196	9.7	90.3
20/68.2	——	65.0	35.0	20/300	14/210	8.2	91.8
20/70	14/49	64.0	36.0	20/320	14/224	6.8	93.2
20/77.5	——	60.0	40.0	20/340	14/238	5.7	94.3
20/80	14/56	58.5	41.5	20/360	14/252	4.8	95.2
20/86.8	——	55.0	45.0	20/380	14/266	4.0	96.0
20/90	14/63	53.4	46.6	20/400	14/280	3.3	96.7
20/97.5	——	50.0	50.0	20/450	14/315	2.1	97.9
20/100	14/70	48.9	51.1	20/500	14/350	1.4	98.6
20/109.4	——	45.0	55.0	20/600	14/420	0.6	99.4
20/120	14/84	40.9	59.1	20/700	14/490	0.3	99.7
——	14/89	38.4	61.6	20/800	14/560	0.1	99.9

3. The percentage of central visual acuity efficiency of the eye for near vision shall be based on a similar computation from the near vision readings, with and without correction.

4. The percentage of central visual acuity efficiency of the eye in question shall be the result of the weighted values assigned to these 2 percentages for distance and for near. A onefold value is assigned to distance vision and a twofold value to near vision. Thus, if the central visual efficiency for distance is 70% and that for near is 40%, the percentage of central visual efficiency for the eye in question would be:

Distance (taken once)	70%
Near (taken twice)	40
	40
	150 ÷ 3 = 50% central visual acuity efficiency

5. The Snellen test letters or characters as published by the Committee on Compensation for Eye Injuries of the American Medical Association and designated "Industrial Vision Test Charts" subtend a 5 minute angle, and their component parts a 1 minute angle. These test letters or the equivalent are to be used at an examining distance of 20 feet for distant vision (except as otherwise noted on the Chart where vision is very poor), and of 14 inches for near vision, from the patient. The illumination is to be not less than three foot candles, nor more than ten foot candles on the surface of the chart.

6. Table 1 shows the percentage of central visual acuity efficiency and the percentage loss of such efficiency, both for distance and for near, for partial loss between 100% and zero vision for either eye.

(b) *Field vision.* 1. The extent of the field of vision shall be determined by the use of the usual perimetric test methods, a white target being employed which subtends a 1 degree angle under illumination of not less than 3 foot candles, and the result plotted on the industrial visual field chart. The readings should be taken, if possible, without restriction to the field covered by the correction worn.

2. The amount of radial contraction in the 8 principal meridians shall be determined. The sum of the degrees of field vision remaining on these meridians, divided by 420 (the sum of the 8 principal radii of the industrial visual field) will give the visual field efficiency of one eye in per cent, subject to the proviso stated in the section on "Minimum Limits" that a concentric central contraction of the field to a diameter of 5 degrees reduces the visual efficiency to zero.

3. Where the impairment of field is irregular and not fairly disclosed by the 8 radii, the impaired area should be sketched upon the diagram on the report blank, and the computation be based on a greater number of radii, or otherwise, as may be necessary to a fair determination.

(c) *Binocular vision.* 1. Binocular vision shall be measured in all parts of the motor field, recognized methods being used for testing. It shall be measured with any useful correction applied.

2. Diplopia may involve the field of binocular fixation entirely or partially. When diplopia is present, this shall be plotted on the industrial motor field chart. This chart is divided into 20 rectangles, 4 by 5 degrees in size. The partial loss due to diplopia is that proportional area which shows diplopia as indicated on the plotted chart compared with the entire motor field area.

3. When diplopia involves the entire motor field, causing an irremediable diplopia, or when there is absence of useful binocular vision due to lack of accommodation or other reason, the loss of coordinate visual efficiency is equal to 50% loss of the vision existing in one eye (ordinarily the injured, or the more seriously injured, eye); and when the diplopia is partial, the loss in visual efficiency shall be proportional and based on the efficiency factor value of one eye as stated in table 2. When useful correction is applied to relieve diplopia, 5% of total motor field efficiency of one eye shall be deducted from the percent of such efficiency obtainable with the correction. A correction which does not improve motor field efficiency by at least 5% of total will not ordinarily be considered useful.

(3) INDUSTRIAL VISUAL EFFICIENCY OF ONE EYE. The industrial visual efficiency of one eye is determined by obtaining the product of the computed coordinate efficiency values of central visual acuity, of field of vision, and of binocular vision. Thus, if central visual acuity efficiency is 50%, visual field efficiency is 80% and the

binocular vision efficiency is 100%, the resultant visual efficiency of the eye will be 50 × 80 × 100 = 40%. Should useful binocular vision be absent in all of the motor field so that binocular efficiency is reduced to 50%, the visual efficiency would be 50 × 80 × 50 = 20%.

(4) COMPUTATION OF COMPENSATION FOR IMPAIRMENT OF VISION. When the percentage of industrial visual efficiency of each eye has been thus determined, it is subtracted from 100%. The difference represents the percentage impairment of each eye for industrial use. These percentages are applied directly to the specific schedules of the Worker's Compensation Act.

(5) TYPES OF OCULAR INJURY NOT INCLUDED IN THE DISTURBANCE OF COORDINATE FACTORS. Certain types of ocular disturbance are not included in the foregoing computations and these may result in disabilities, the value of which cannot be computed by any scale as yet scientifically possible of deduction. Such are disturbances of accommodation not previously provided for in these rules, of color vision, of adaptation to light and dark, metamorphopsia, entropion, ectropion, lagophthalmos, epiphora, and muscle disturbances not included under diplopia. For such disabilities additional compensation shall be awarded, but in no case shall such additional award make the total compensation for loss in industrial visual efficiency greater than that provided by law for total permanent disability.

TABLE 2
Loss in Binocular Vision

No loss	equals	100.0%	Motor	Field	Efficiency
1/20	"	99.0	"	"	"
2/20	"	97.7	"	"	"
3/20	"	96.3	"	"	"
4/20	"	95.0	"	"	"
5/20	"	93.7	"	"	"
6/20	"	92.3	"	"	"
7/20	"	90.7	"	"	"
8/20	"	89.0	"	"	"
9/20	"	87.3	"	"	"
10/20	"	85.7	"	"	"
11/20	"	83.7	"	"	"
12/20	"	81.7	"	"	"
13/20	"	79.7	"	"	"
14/20	"	77.3	"	"	"
15/20	"	75.0	"	"	"
16/20	"	72.7	"	"	"
17/20	"	69.7	"	"	"
18/20	"	66.0	"	"	"
19/20	"	61.0	"	"	"
20/20	"	50.0	"	"	"

(6) MISCELLANEOUS RULES.

(a) Compensation shall not be computed until all adequate and reasonable operations and treatment known to medical science have been attempted to correct the defect. Further, before there shall be made the final examination on which compensation is to be computed, at least 3 months shall have elapsed after the last trace of visible inflammation has disappeared, except in cases of disturbance of extrinsic ocular muscles, optic nerve atrophy, injury of the retina, sympathetic ophthalmia, and traumatic cataract; in such cases, at least 12 months and preferably not more than 16 months shall intervene before the examination shall be made on which final compensation is to be computed. In case the injury is one which may cause cataract, optic atrophy, disturbance of the retina, or other conditions, which may further impair vision after the time of the final examination, note thereof should be made by the examining physician on his report.

(b) In cases of additional loss in visual efficiency, when it is known that there was present a preexisting subnormal vision, compensation shall be based on the loss incurred as a result of eye injury or occupational condition specifically responsible for the additional loss. In case there exists no record or no adequate and positive evidence of preexisting subnormal vision, it shall be assumed that the visual efficiency prior to any injury was 100%. In order to effect the above purpose, the examining physician should carefully distinguish, in regard to each of the coordinate factors, between impairments resulting from the injury and impairments not so resulting as established by the type of proof here stated. Such other impairments should, however, be also reported, separately. Computation must occasionally also be made of impairment of vision not resulting from the injury, as, for instance, for the purpose of computing additional indemnity due under the provisions of the Worker's Compensation Act on account of preexisting disability of one or both eyes.

Note: Example of computation covering partial disability to a single eye

A. Central Visual Acuity:

Distance—Reading of 20/32.1 with glasses equals visual efficiency of ……..... 90.0%

Reading of 20/200 without glasses equals visual efficiency of……. 20.0%

Difference ……..... **70.0%**

Rated efficiency is 90.0% minus 25% (Because one-half of 70.0% exceeds 25) or 65.0%

Near—Reading of 14/21 with glasses equals visual efficiency of …… 91.5%

Reading of 14/35 without glasses (except that correction is applied for presbyopia due to age) equals visual efficiency of... 76.5%

Difference **15.0%**

Rated efficiency is 91.5% minus 7.5% (which is one-half of 15%) or 84.0%

Final Central Visual Acuity Efficiency is:

65.0 + 84.0 + 84.0 = 233.0 ÷ 3 = 77.7%

B. Field Vision:

Sum of eight principal meridians of the field remaining divided by 420 is:

40
50
50
50
40
40
40
40
350 ÷ 420=83.3%

C. Binocular Vision:

Diplopia in 3 rectangles (3/20) is 96.3% motor field efficiency.

D. Industrial Visual Efficiency of the one eye is:

77.7% × 83.3% × 96.3% or 62.3%

E. Impairment of the one eye for industrial use is:

100.0% — 62.3% = 37.7%

F. Compensation payable is:

Total impairment of one eye 250 weeks.

250 weeks × 37.7% = 94.25 weeks

Note: Example of computation covering partial disability to both eyes

1. Left Eye is 62.3% efficient, see Example I.

2. Right Eye:

A. Central Visual Acuity:

Distance—Reading of 20/30 with correction equals visual efficiency of ……..... 91.5%

Reading of 20/35 without glasses equals visual efficiency of 87.5%..... 87.5%

Difference …….. **4.0%**

Rated efficiency is the vision without correction (because correction gives improvement of less than the 5% minimum allowance for glasses, and is not necessary to prevent eye strain, etc.) 87.5%.

Near—Reading of 14/14 with glasses equals visual efficiency of…….. 100.0%

Reading of 14/21 without glasses equals visual efficiency of…… 91.5%

Difference …… 8.5%

Rated efficiency is 100.0% minus 5% (because 5% is the minimum allowance for glasses) or 95.0%

Final Central Visual Acuity Efficiency is:

87.5%+ 95% + 95% = 277.5 ÷ 3 = 92.5%

B. Field vision is 100%

C. Binocular vision is 100%

D. Industrial visual efficiency of the right eye is:

92.5% × 100% × 100% or 92.5%

E. Impairment of right eye for industrial use is:

100.0% — 92.5% = 7.5%

3. Compensation payable is:

Left eye (Example I): 94.25 weeks

Right eye:

250 weeks × 7.5% = 18.75 + 200% multiple 56.25 weeks

Total 150.5 weeks

Note: Example of compensation covering enucleation of one eye and partial disability of the other eye

1. Left eye is 35.28% impaired (77.7% × 83.3% = 64.72%; 100% - 64.72% = 35.28%, as allowance for binocular vision is inapplicable when the other eye is enucleated or blind), in indemnity payable for 88.2 weeks

2. Right eye is enucleated, which, results in indemnity payable for 275 weeks

3. Total payable: 88.2 weeks × 3 (multiple injury) = 264.6 + 275 = 539.6 weeks

The number of weeks indemnity indicated as payable for impairment of vision or for enucleation is in addition to indemnity for temporary disability. All results are subject to the limitation that the total amount of indemnity payable, including that for temporary disability, shall not exceed the indemnity which would be payable for permanent total disability. The statutory and legal rules applicable to the determination of additional compensation payable out of the special state fund on account of preexisting disabilities are not here stated.

DWD 80.27 Forms. A sample copy of all forms referred to in these rules may be obtained upon a request to the Worker's Compensation Division, Department of Workforce Development, Post Office Box 7901, Madison, WI 53707.

History: Cr. Register, October, 1957, No. 22, eff. 11-1-57; am. (1), Register, October, 1965, No. 118, eff. 12-1-65; am. Register, April, 1975, No. 232, eff. 5-1-75; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82**;** correction made under s. 13.93 (2m) (b) 6., Stats., Register, July, 1996, No. 487, eff. 8-1-96.

DWD 80.29 Value of room or meals. For the purpose of determining the value of lodging and meals for wage purposes under ch. 102, Stats., the allowance provided under ch. DWD 272 shall apply.

History: Cr. Register, October, 1960, No. 58, eff. 11-1-60; am. (1) (a) and (b), Register, October, 1963, No. 94, eff. 11-1-63; r. and recr. Register, January, 1967, No. 133, eff. 2-1-67; am. Register, November, 1970, No. 179, eff. 12-1-70; r. and recr. Register, April, 1975, No. 232, eff. 5-1-75**;** correction made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1996, No. 487, eff. 8-1-96; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1997, No. 504**.**

DWD 80.30 Average weekly earnings for members of volunteer fire companies or fire departments. The maximum average weekly earnings under the provisions of s. 102.11, Stats., which are in effect on the date of injury shall be used in computing the amount of compensation payable to an employee as defined by s. 102.07 (7), Stats., except as specific showing may be made in an individual case that such wage is not proper.

History: Cr. Register, June, 1961, No. 66, eff. 7-1-61.

DWD 80.32 Permanent disabilities. Minimum percentages of loss of use for amputation levels, losses of motion, sensory losses and surgical procedures.

(1) The disabilities set forth in this section are the minimums for the described conditions.

However, findings of additional disabling elements shall result in an estimate higher than the minimum. The minimum also assumes that the member, the back, etc., was previously without disability. Appropriate reduction shall be made for any preexisting disability.

Note: An example would be where in addition to a described loss of motion, pain and circulatory disturbance further limits the use of an arm or a leg. A meniscectomy in a knee with less than a good result would call for an estimate higher than 5% loss of use of the leg at the knee. The same principle would apply to surgical procedures on the back. The schedule of minimum disabilities contained in this section was adopted upon the advice of a worker's compensation advisory council subcommittee after a survey of doctors experienced in treating industrial injuries.

(2) Amputations, upper or lower extremities

At functional level	Equivalent to amputation at midpoint
Stump unsuitable to accommodate prosthesis	Equivalent to amputation at next most proximal joint
Stump not functional	Grade upward

All ranges of joint motion or degrees of ankylosis not listed below are to be interpolated from existing percent of disability listed.

(3) Hip

Ankylosis, optimum position, generally 15° to 30° flexion	50%
Mal position	Grade upward

To compute disabilities for loss of motion relate % of motion lost to average range

Shortening of leg (no posterior or lateral angulation)

No disability for shortening less than 3/4 inch

3/4 inch……....	5%
1 inch……...	7%
1-1/2inches……..	14%
2 inches……	22%

Greater than 2 inches of shortening results in greater proportionate rating than above

Prosthesis Total…….	Minimum of 40%
Partial……	35%

(4) Knee

Ankylosis, optimum position, 170°….	40%
Remaining range, 180° - 135°…….	25%
Remaining range, 180° - 90°……	10%
Prosthesis Total…….	50%
Partial…….	45%
Removal of patella…….	To be based on functional impairment

Total or partial meniscectomy (open or closed procedure)

Excellent to good result…….	5%
Anterior cruciate ligament repair…….	Minimum of 10%

(5) Ankle

Total ankylosis, optimum position, total loss of motion…….	40%
Ankylosis ankle joint	
Loss of dorsi and plantar flexion……	30%
Subtalar ankylosis	
Loss of inversion and eversion…….	15%

(6) Toes

Ankylosis great toe at proximal joint…..	50%
All other toes at proximal……..	40%
Ankylosis great toe at distal joint……	15%
All other toes at any interphalangeal joint	If no deformity, no disability
Mal position……	On merits
Loss of motion……	No disability

(7) Shoulder

Ankylosis, optimum position, scapula free…….	55%
In mal position……..	Grade upward
Limitation of active elevation in flexion and abduction to 45° but otherwise normal…….	30%
Limitation of active elevation in flexion and abduction to 90° but otherwise normal…….	20%
Limitation of active elevation in flexion and abduction to 135° but otherwise normal……	5%
Prosthesis……..	50%

(8) Elbow

Ankylosis, optimum position, 45° angle	
With radio-ulnar motion destroyed..	60%
With radio-ulnar motion in tact……	45%
Rotational ankylosis in neutral position.	20%
Any mal position……..	Grade upward

Limitation of motion elbow joint, radio-ulnar motion unaffected

Remaining range—180° - 135°……..	35%
Remaining range—135° - 90°…….	20%
Remaining range—180° - 90°……	10%
Rotation at elbow joint	
Neutral to full pronation……...	
Neutral to full supination……..	

(9) Wrist

Ankylosis, optimum position 30' dorsiflexion…….	
Mal position…….	
Total loss dorsiflexion…….	
Total loss palmarflexion…….	
Total loss inversion…….	
Total loss eversion……..	

(10) Complete Sensory Loss

Any digit	50% lesser involvement to be graded appropriately—35% for palmar, 15% for dorsal surface
Total median sensory loss to hand…….	65-75%
Total ulnar sensory loss to hand……	25%
Ulnar nerve paralysis	
Above elbow, sensory involvement…...	50% at wrist
Below elbow, motor and sensory involvement ……..	45-50% at wrist
Below elbow, motor involvement only……	35-45% at wrist
Below elbow, sensory involvement only	5-10% at wrist
Median nerve paralysis	
Above elbow, motor and sensory involvement……..	55-65% at wrist
Thenar paralysis with sensory loss…….	40-50% at wrist
Radial nerve paralysis	
Complete loss of extension, wrist and fingers……..	45-55% at wrist
Paroneal nerve paralysis	
At level below knee……..	25-30% at knee

(11) Back

Removal of disc material, no undue symptomatic complaints or any objective findings	5%
Chymopapain injection	To be rated by doctor
Spinal fusion, good results	5% minimum per level
Implantation of an artificial spinal disc	7.5% per level
Removal of disc material and fusion	10% per level
Cervical fusion, successful	5%
Compression fractures of vertebrae of such degree to cause permanent disability may be rated 5% and graded upward	

Note: It is the subcommittee's intention that a separate minimum 5% allowance be given for every surgical procedure (open or closed, radical or partial) that is done to relieve from the effects of a disc lesion or spinal cord pressure. Each disc treated or surgical procedure performed will qualify for a 5% rating. Due to the fact a fusion involves 2 procedures a 1) laminectomy (discectomy) and a 2) fusion procedure, 10% permanent total disability will apply when the 2 surgical procedures are done at the same time or separately.

Examples:

Patient A	12/01/1990	Laminectomy	5% PTD
	05/01/1992	Fusion	increases to 10% PTD
Patient B	12/01/1990	Laminectomy & Fusion	10% PTD
	05/01/1992	Re-fusion	increases to 15% PTD
	12/01/1992	Laminectomy at New Level	increases to 20% PTD
	05/01/1993	Fusion at 12/1/92 Level	increases to 25% PTD
	12/01/1993	Re-fusion at 5/1/93 Level	increases to 30% PTD

(12) Fingers

(a) Complete ankylosis

	Mid-position	Complete Extension
Thumb		
Distal joint only……	25%	35%
Proximal joint only……	15%	20%
Distal and proximal joints..	35%	65%
Carpometacarpal joint only..	20%	20%
Distal, proximal and carpometacarpal joints……	85%	100%
Fingers		
Distal joint only……	25%	35%
Middle joint only……..	75%	85%
Proximal joint only……..	40%	50%
Distal and middle joints……	85%	100%
Distal, middle and proximal joints……..	100%	100%

(b) Loss of Motion

Fingers	Loss of Flexion	Loss of Use	Loss of Extension	Loss of Use
Distal joint only…….	10% -	1%	10% -	2%
	20% -	2%	20% -	4%
	30% -	3%	30% -	6%
	40% -	5%	40% -	8%
	50% -	10%	50% -	15%
	60% -	15%	60% -	20%
	70% -	20%	70% -	30%
	80% -	25%	80% -	40%
			100% -	60%
Middle joint only…	10% -	5%	10% -	2½%
	20% -	10%	20% -	5%
	30% -	15%	30% -	10%
	40% -	25%	40% -	15%
	50% -	40%	50% -	30%
	60% -	50%	60% -	50%
	70% -	60%	70% -	70%
	80% -	70%	80% -	90%
			100% -	100%
Proximal joint only...	10% -	5%	10% -	2½%
	20% -	10%	20% -	5%
	30% -	15%	30% -	15%
	40% -	20%	40% -	20%
	50% -	25%	50% -	25%
	60% -	30%	60% -	40%
	70% -	35%	70% -	75%
	80% -	40%	80% -	85%
			90% -	100%

Thumb
Distal joint same as fingers
Proximal joint 40% of the loss of use indicated for fingers

(13) Kidney

Loss of one kidney 5% permanent total disability.

(14) Loss of Smell

Total loss of sense of smell 2-1/2% permanent total disability.

History: Cr. Register, October, 1965, No. 118, eff. 11-1-65; r. and recr. Register, April, 1975, No. 232, eff. 5-1-75; r. and recr. (1), Register, September, 1982, No. 321, eff. 10-1-82; cr. (13) and (14), Register, September, 1986, eff. 369, eff. 10-1-86; am. (intro.), (3) to (5), (7), (9), (11) and (12) (a) and (b), Register, June, 1994, No. 462, eff. 7-1-94; reprinted to restore dropped copy in (1), Register, March, 1995, No. 471; CR 07-019: am. (11), Register October 2007 No. 622, eff. 11-1-07.

DWD 80.33 Permanent disabilities; fingertip amputations. In estimating permanent disability as a result of fingertip amputations, amputation of the distal one-third or less shall be considered the equivalent of 45% loss of use of the distal phalanx, amputation of not more than the distal two-thirds but more than the distal one-third shall be considered the equivalent of 80% loss of use of the distal phalanx, and amputation of more than the distal two-thirds shall be considered as 100% loss of the distal phalanx, provided there is not added disability as a result of malformed nail or tissue. In no case shall the allowance be greater than it would have been for amputation of the entire distal phalanx.

History: Cr. Register, October, 1965, No. 118, eff. 11-1-65; am. Register, November, 1970, No. 179, eff. 12-1-70.

DWD 80.34 Loss of earning capacity. (1) Any department determinations as to loss of earning capacity for injuries arising under s. 102.44 (2) and (3), Stats., shall take into account the effect of the injured employee's permanent physical and mental limitations resulting from the injury upon present and potential earnings in view of the following factors:

(a) Age;

(b) Education;

(c) Training;

(d) Previous work experience;

(e) Previous earnings;

(f) Present occupation and earnings;

(g) Likelihood of future suitable occupational change;

(h) Efforts to obtain suitable employment;

(i) Willingness to make reasonable change in a residence to secure suitable employment;

(j) Success of and willingness to participate in reasonable physical and vocational rehabilitation program; and

(k) Other pertinent evidence.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.38 Assessment of administrative expenses. (1) For purposes of determining assessment payments under s. 102.75, Stats., "indemnity paid or payable" excludes:

(a) Payments made for medical, hospital or related expenses.

(b) Additional payments for penalties and increased compensation.

(c) Payments made into the work injury supplemental benefit fund.

(d) Payments made from the work injury supplemental benefit fund other than those paid under s. 102.44 (1), Stats.

(e) Payments made under ss. 102.475, 102.35, and 102.18 (1) (bp), Stats.

(f) Payments made under statutory provisions other than those of ch. 102, Stats.

(g) Payments made pursuant to a compromise agreement to the extent that they cannot be determined to be indemnity paid or payable under sub. (2).

(2) For purposes of determining assessment payments under s. 102.75, Stats., "indemnity paid or payable" includes:

(a) Supplemental benefit payments made under s. 102.44 (1), Stats., from the work injury supplemental benefit fund if they were determined to be payable prior to the time the case is initially closed.

(b) Death benefits paid under ss. 102.46, 102.47, 102.48 and 102.50, Stats.

(c) Portions of social security benefits, sick leave, holiday pay, salary and other wage continuation payments which offset or are paid in lieu of the daily or weekly indemnity due.

History: Cr. Register, September, 1984, No. 345, eff. 10-1-84.

DWD 80.39 Advance payment of unaccrued compensation. (1) The department may order partial or full payment of unaccrued compensation to an employee or his or her dependents pursuant to s. 102.32 (6m), Stats., upon consideration of the following factors:

(a) The length of time since the injury;

(b) The total income of the employee or the dependent;

(c) The income of others in the employee's or the dependent's household;

(d) The age of the employee or the dependent;

(e) The other available assets of the employee or the dependent;

(f) The loss of benefits because of interest credit due to self-insured employer or insurance carrier;

(g) The purpose for which the advancement is requested;

(h) The other financial obligations of the employee or the dependent;

(i) The employment status of the employee or the dependent;

(j) If the advancement is requested for the purchase of real estate, the cost of the real estate and availability of other necessary financing for the real estate;

(k) The employee's or the dependent's previous experience in and likelihood of success in a proposed business venture;

(L) The probable income and security of any proposed investment; and

(m) Other information indicating whether an advancement is in the best interest of the applicant.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82; CR 07-019: am. (1), Register October 2007 No. 622, eff. 11-1-07.

DWD 80.40 Assessment for unpaid claims of insolvent self-insurer. If an employer currently or formerly exempted from the duty to insure by order of the department under s. 102.28 (7) (b), Stats., is unable to pay any award and if judgement against such employer is returned unsatisfied, the department shall determine payment into the fund established by s. 102.28 (8), Stats., as follows:

(1) The department shall prepare an estimate of the payments that should be made by the insolvent exempt employer for a period of one year. If the department elects to retain an insurance carrier or insurance service organization under s. 102.28 (7), Stats., the department will prepare an estimate of the charges that will be made by such carrier or organization to process, investigate and pay such claims for the same one year period. The sum of these 2 amounts shall be divided by the total number of employers exempted under s. 102.28 (2), Stats.

(2) The department shall assess and order payment within 30 days by each exempt employer the amount determined under sub. (1) to the state treasurer for deposit in the fund created by s. 102.28 (8), Stats.

(3) The department shall prepare an estimate of the total remaining liability of the insolvent exempt employer and an estimate of the amount that may be recovered from that employer, its receiver or trustee in bankruptcy. Such estimates shall be communicated to all exempt employers.

(4) At least annually following the original order the department shall estimate the amount due and payable during the following year and the charges expected from any insurance carrier or claims service for such year and assess and order payment by each exempt employer its pro rata share determined as provided by s. 102.28 (7) (b), Stats.

(5) At the time orders are issued under sub. (4) the department shall prepare an estimate of the remaining liability of the insolvent exempt employer and the amount that may reasonably be expected to be recovered from such employer, its receiver or trustee in bankruptcy. Such estimates will be communicated to all exempt employers.

(6) All money due and payable to injured employees which remain unpaid shall be considered money payable during the following year in making estimates.

(7) All money recovered by the attorney general and paid into the fund shall be used in the payment of unpaid claims and shall be taken into account in making estimates and assessments.

History: Cr. Register, September, 1986, No. 369, eff. 10-1-86.

DWD 80.41 Computation of monthly salary and reimbursement to retirement fund under s. 66.191, 1981 Stats. (1) Fringe benefits shall not be included in the computation of salary, earnings or wages under s. 66.191, 1981 Stats., unless such benefits are income for Wisconsin income tax purposes.

(2) An eligible employee under s. 66.191, 1981 Stats., shall file with the department before an award is entered, as provided in s. 66.191, 1981

Stats., a waiver of disability annuity payments which may be due under s. 40.63, Stats., and further shall consent to reimbursement to the Wisconsin retirement fund of all disability benefits recovered under the provisions of s. 40.63, Stats.

Note: 1983 Wis. Act 191 repealed s. 66.191, Stats. However, people are still receiving benefits under this statute.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.42 Vocational rehabilitation; reporting requirement. In order to determine whether or not an employee should be referred to the division of vocational rehabilitation for services, the self-insured employer or insurance carrier shall notify the department whenever temporary total disability will exceed 13 weeks. This report shall be made within 13 weeks from the date of the initial disability or when such disability can be determined, whichever is earlier, and shall include a current practitioner's report.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.43 Fees and costs. Section 102.26, Stats., provides for a maximum attorney's fee of 20% of the amount in dispute. Section 102.26 (3), Stats., places upon the department the responsibilities for fixing the fee and providing for the direct payment of the fee. In the exercise of this responsibility, the department shall take into account the following considerations:

(1) The department shall balance the need to preserve the maximum amount of benefits for the injured employee and the need for fees which are sufficient to insure adequate representation for claimants under ch. 102, Stats.

(2) Fees shall not be allowed on medical expenses to the extent that other sources, such as group insurance, are available to pay such expenses.

(3) Fees for permanent total disability shall not be allowed on compensation awards due beyond 500 weeks.

(4) The existence of a dispute under s. 102.26 (2), Stats., is dependent upon a disagreement after the employer or insurer has had adequate time and information to take a position on liability. Neither the holding of a hearing nor the filing of an application for a hearing alone may determine the existence of a dispute. However, a finding that a dispute exists shall not be precluded by an employer's or insurer's purposeful inactivity on the issue of liability.

(5) Where representation is the result of the representative's employment by an insurance carrier, an employer, a union, a social service agency or a public agency, the representative may not charge a fee on a contingency basis.

(6) Where there has been successive representation by various representatives, the division of fees by the department shall take into account the relative value of the services performed by each representative, any concessions of disability, offers of settlement and other matters.

(7) Where a claimant appears by an attorney of record any fee shall be payable to such attorney regardless of the cooperation or involvement of agents or other non-attorneys. The division of such fee with agents or other non-attorneys shall be at the discretion of the attorney of record. If there is disagreement among successive attorneys the department will make appropriate apportionment of any or all fees for services.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82; cr. (7), Register, September, 1986, No. 369, eff. 10-1-86.

DWD 80.46 Contribution to support of unestranged surviving parent. In assessing support under s. 102.48, Stats., the payment of room and board by a child to his or her parent shall not be considered as contribution to support of the parent.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.47 Medical release of employee for restricted work in the healing period. Even though an employee could return to a restricted type of work during the healing period, unless suitable employment within the physical and mental limitations of the employee is furnished by the employer or some other employer, compensation for temporary disability shall continue during the healing period.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.48 Reassignment of death benefits. When a spouse who is entitled to death benefits remarries, the department shall reassign the death benefits to the children designated in ss. 102.51 (1) and 102.49, Stats., unless a showing is made that undue hardship would result for the spouse because of the reassignment.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.49 Vocational rehabilitation benefits. (1) PURPOSE. The primary purpose of vocational rehabilitation benefits is to provide a method to restore an injured worker as nearly as possible to the worker's preinjury earning capacity and potential.

(2) ELIGIBILITY. The determination of eligibility for vocational rehabilitation training and whether a person is a suitable subject for training is the responsibility of the division of vocational rehabilitation. If the division of vocational rehabilitation determines that an employee is eligible to receive services under 29 USC 701 to 797b, but that the division of vocational rehabilitation cannot provide those services for the employee, the employee may select a private rehabilitation specialist certified by the department to determine whether the employee can return to suitable employment without rehabilitative training and whether rehabilitative training is necessary to develop a retraining program to restore as nearly as possible the employee to his or her preinjury earning capacity and potential.

(3) 80-WEEK RULE. Extension of vocational rehabilitation benefits beyond 80 weeks may not be authorized pursuant to s. 102.61 (1) or (1m), Stats., if the primary purpose of further training is to improve upon preinjury earning capacity rather than restoring it.

(4) DEFINITIONS. In subs. (4) to (11), all of the following definitions apply:

(a) "IPE" means an individualized plan for employment developed by a specialist which identifies the vocational goal of a retraining program, the intermediate objectives to reach that goal and the methods by which progress will be measured.

(b) "Retraining program" means a course of instruction on a regular basis which provides an employee with marketable job skills or enhances existing job skills to make them marketable.

(c) "Specialist" means a person certified by the department to provide vocational rehabilitation services to injured employees under s. 102.61 (1m), Stats.

(d) Except as provided in sub. (5), "suitable employment" means a job within the employee's permanent work restrictions for which the employee has the necessary physical capacity, knowledge, transferable skills and ability and which pays at least 85 percent of the employee's preinjury average weekly wage.

(5) SUITABLE EMPLOYMENT EXCEPTIONS. (a) A job offer at or above 85% of the average weekly wage shall not constitute suitable employment if:

1. An employee's education, training or employment experience demonstrates a career or vocational path; the average weekly wage on the date of injury does not reflect the earnings which the employee could reasonably have expected in the demonstrated career or vocational path; and the permanent work restrictions caused by the injury impede the employee's ability to pursue the demonstrated career or vocational path; or,

2. The employee's average weekly wage is calculated pursuant to the part-time wage rules in s. 102.11 (1) (f), Stats., or s. DWD 80.51 (4) and the employee's average weekly wage for compensation purposes exceeds the gross average weekly wages of the part-time employment.

(b) The average weekly wage for purposes of determining suitable employment under par. (a) 1. shall be determined by expert vocational evidence regarding the average weekly wage that the employee may have reasonably expected in the demonstrated career or vocational path.

(c) The average weekly wage for purposes of determining suitable employment under par. (a) 2. shall be determined by expert vocational evidence regarding the employee's age, educational potential, past job experience, aptitude, proven abilities, and ambitions on the date of injury.

(6) SPECIALIST CERTIFICATION. (a) A person may apply to the department for certification as a specialist at any time. The department may require applicants to submit, and certified specialists to regularly report, information describing their services, including the geographic areas served by the specialist and the nature, cost and outcome of services provided to employees under this section.

(b) After evaluating the information submitted under par. (a), the department shall certify a person as a specialist if the person has a license or certificate which is current, valid and otherwise in good standing as one of the following, or may certify the person as provided in par. (c):

1. Certified professional counselor with specialty in vocational rehabilitation from the department of safety and professional services.

2. Certified disability management specialist from the certification of disability management specialist commission.

3. Certified rehabilitation counselor from the commission on rehabilitation counselor certification.

4. Certified vocational evaluator from the commission on certification of work adjustment and vocational evaluation specialists.

Note: The Commission on Rehabilitation Counselor Certification (CRCC) is located at 1699 E. Woodfield Road, Suite 300, Schaumburg, Illinois 60173. The Certification of Disability Management Specialist Commission (CDMS) is located at 8735 W. Higgins Road, Suite 300, Chicago, Illinois 60631. The Commission on Certification of Work Adjustment and Vocational Evaluation Specialists is located at 7910 Woodmont Avenue, Suite 1430, Bethesda, Maryland 20814-3015.

(c) The department may certify a person as a specialist if the person has state or national certification, licensing or accreditation in vocational rehabilitation other than that required in par. (b) which is acceptable to the department. The department may require a specialist certified under this paragraph to serve a period of probation up to 3 years as a condition of certification. The department shall specify the conditions of the probationary certification. The department may revoke the probationary certification at any time without a hearing for conduct which violated the conditions of probation established by the department or conduct sufficient to decertify the specialist under par. (e).

(d) Unless certification is suspended or revoked under par. (e), certification by the department under par. (b) is valid for 3 years. If a specialist applies to the department to renew his or her certification before the expiration of the certification period, the certification shall remain in effect until the department renews or denies the application to renew. A renewal is valid for three years.

(e) Only the department may initiate a proceeding to suspend or revoke a specialist's certification under this section. The department may suspend or revoke a specialist's certification, after providing the specialist with a hearing, when the department determines that the specialist did not maintain a current, valid certificate or license specified in par. (b) or the specialist intentionally or repeatedly:

1. Fails to comply with the provisions of ch. 102, Stats., or ch. DWD 80;

2. Fails to comply with the orders, rulings, reporting requirements or other instructions of the department or its representatives;

3. Charges excessive fees compared to the value of the services performed or ordered to be performed; or,

4. Misrepresents the employee's work history, age, education, medical history or condition, diagnostic test results or other factors significantly related to an employee's retraining program.

(f) The department shall maintain a current listing of all specialists certified by the department, including the areas they serve, and provide the list upon request.

(7) EMPLOYEE CHOICE. (a) At the end of the medical healing period, the self-insured employer or insurance carrier shall notify the employee, on a form provided by the department, of the employee's potential eligibility to receive rehabilitation services.

(b) The department shall arrange with the division of vocational rehabilitation to receive timely notice whenever the division of vocational rehabilitation determines under s. 102.61 (1m), Stats., that it cannot serve an eligible employee. When the division of vocational rehabilitation notifies the department that it cannot serve an eligible employee, the department shall mail to the employee and the self-insured employer or insurance carrier a list of certified specialists serving the area where the employee resides.

(c) The employee may choose any certified specialist. The employee may choose a second certified specialist only by mutual agreement with the self-insured employer or insurance carrier or with the permission of the department. Partners are deemed to be one specialist.

(d) A specialist selected by an employee under par. (c) shall notify the department and the self-insured employer or insurance carrier within 7 days of that selection. The department may develop a form for this purpose.

(e) The self-insured employer or insurance carrier is liable for the reasonable and necessary cost of the specialist's services and the reasonable cost of the training program recommended by the specialist provided that the employee and the specialist substantially comply with the requirements in subs. (8) to (11). Except with the prior consent of the self-insured employer or insurance carrier, the reasonable cost of any specialist's services to the employee shall not exceed $1,000 for each date of injury as defined in s. 102.01 (2) (g), Stats. Effective on the first day of January each year after 1995, the department shall adjust the $1,000 limit by the same percentage change as the average annual percentage change in the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, for the 12 months ending on September 30 of the prior year. The department shall notify insurance carriers, self-insured employers and specialists likely to be affected by the annual change in the limit.

Note: To obtain a copy of all forms under this subsection, contact the Department of Workforce Development, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin, 53707-7901 or access forms online at http://www.dwd.wisconsin.gov.

(8) EMPLOYER'S DUTIES UPON RECEIPT OF PERMANENT RESTRICTIONS. Upon receiving notice that the division of vocational rehabilitation cannot serve the employee under s. 102.61 (1m), Stats., the employee or a person authorized to act on the employee's behalf shall provide the employer with a written report from a physician, podiatrist, psychologist or chiropractor stating the employee's permanent work restrictions. Within 60 days of receiving the practitioner's work restrictions, the employer shall provide to the employee or the employee's authorized representative, in writing:

(a) An offer of suitable employment for the employee;

(b) A statement that the employer has no suitable employment available for the employee; or,

(c) A medical report from a physician, podiatrist, psychologist or chiropractor showing that the permanent work restrictions provided by the employee's practitioner are in dispute, and medical or vocational documentation that the difference in work restrictions would materially affect either the employer's ability to provide suitable employment or a specialist's ability to recommend a retraining program. If after 30 days the employee and employer cannot resolve the dispute, either party may request a hearing before the department to determine the employee's work restrictions. Within 30 days after the department determines the restrictions, the employer shall provide the written notice required in par. (a) or (b).

(9) 90-DAY PLACEMENT EFFORT. (a) If the employer fails to respond as required in sub. (8), it shall be conclusively presumed for the purposes of s. 102.61 (1m), Stats., that the employer has no suitable employment available and the employee is entitled to receive vocational rehabilitation services from a specialist.

(b) If the employer does not make a written offer of suitable employment under sub. (8), the specialist shall determine whether there is suitable employment available for the employee in the general labor market without retraining. If suitable employment is reasonably likely to be available, the specialist shall attempt to place the employee in alternative suitable employment for

at least 90 days prior to developing a retraining program. The employee shall cooperate fully in the specialist's placement efforts and may not refuse an offer of suitable employment made within the 90-day period. In determining whether the offer is suitable the department shall consider age, education, training, previous work experience, previous earnings, present occupation and earnings, travel distance, goals of the employee, and the extent to which it would restore the employee's preinjury earning capacity and potential.

(c) If the employee is placed in or refuses to accept suitable employment, the self-insured employer or insurance carrier is not liable for any further costs of the specialist's services unless that suitable employment ends within the statute of limitations in s. 102.17 (4), Stats.

(10) RETRAINING. (a) If, after reasonably diligent effort by the employee and the specialist, the employee does not obtain suitable employment, then there is a rebuttable presumption that the employee needs retraining. The presumption is rebuttable by evidence that:

1. No retraining program can help restore as nearly as possible the employee's wage earning capacity;

2. The employee or the specialist did not make a reasonably diligent effort under sub. (9) (b) to obtain suitable employment for the employee; or

3. The employee or specialist withheld or misrepresented highly material facts.

(b) A retraining program of 80 weeks or less is presumed to be reasonable and the employer shall pay the cost of the program, mileage and maintenance benefits, and temporary total disability benefits.

(c) A retraining program more than 80 weeks may be reasonable, but there is no presumption that training over 80 weeks is required. Extension of vocational rehabilitation benefits beyond 80 weeks may not be authorized if the primary purpose of further training is to improve upon preinjury earning capacity rather than restoring it.

(d) If the retraining program developed by the specialist is for more than 80 weeks, the self-insured employer or the insurance carrier may offer an alternative retraining program which will restore the employee's preinjury earning capacity in less time than the retraining program developed by the specialist. An employee may not refuse a self-insured employer's or insurance carrier's timely, good-faith, written offer of an alternative retraining program without reasonable cause.

(11) SPECIALIST'S SERVICES. (a) A specialist shall develop an IPE for a retraining program for the employee, and may amend it to achieve suitable employment.

(b) A specialist shall make periodic written reports at reasonable intervals to the employee, employer and insurance carrier describing vocational rehabilitation activities which have occurred during that interval.

(c) Within a reasonable period of time after receiving a written request from an employee, employer, worker's compensation insurance carrier or department or their representatives, a specialist shall provide that person with any information or written material reasonably related to the specialist's services to the employee undertaken as a result of any injury for which the employee claims compensation.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82; emerg. am. (2), r. (3), renum. (4) to be (3), cr. (4) to (11), eff. 11-7-94, am. (2), r. (3), renum. (3) to be (4) and am., cr. (4) to (11), Register, April, 1995, No. 472, eff. 5-1-95**;** corrections in (2) and (5) (a) 2. made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1996, No. 487; eff. 8-1-96**;** corrections made under s. 13.93 (2m) (b) 6., Stats., Register, December, 1997, No. 504; CR 07-019: am. (2), (7) (b) and (8), Register October 2007 No. 622, eff. 11-1-07; correction in (6) (b) 1. made under s. 13.92 (4) (b) 6., Stats., **Register February 2012 No. 674; CR 150030: am. (4) (intro.), (a), (6) (b) 1. To 3., (f), (11) (a), Register October 2015 No. 718, eff. 11-1-15.**

DWD 80.50 Computation of permanent disabilities. (1) In computing permanent partial disabilities, the number of weeks attributable to more distal disabilities shall be deducted from the number of weeks in the schedule for more proximal disabilities before applying the percentage of disability for the more proximal injury, except that:

(a) Such a deduction shall not include multiple injury factors under s. 102.53, Stats., and the dominant hand increase under s. 102.54, Stats.; and

(b) Such a deduction shall include preexisting disabilities.

(2) The number of weeks attributable to scheduled disabilities shall be deducted from 1,000 weeks before computing the number of weeks due for a non-scheduled disability resulting from the same injury. This deduction shall not include multiple injury factors under s. 102.53, Stats., and the dominant hand increase under s. 102.54, Stats.

(3) Multiple injury factors under s. 102.53, Stats., and the dominant hand increase under s. 102.54, Stats., do not apply to compensation for disfigurement under s. 102.56, Stats.

History: Cr. Register, August, 1981, No. 308, eff. 9-1-81; r. and recr. Register, September, 1982, No. 321, eff. 10-1-82; CR 07-019: am. (1) (a), (2) and (3), Register October 2007 No. 622, eff. 11-1-07.

DWD 80.51 Computation of weekly wage. Pursuant to s. 102.11, Stats. **(1)** In determining daily earnings, if the number of hours a full-time employee worked had been either decreased or increased for a period of at least 90 total days prior to the injury, then this revised schedule worked during those 90 days shall be considered to be normal full-time employment.

(2) When an employee furnishes his or her truck to the employer and is paid by the employer in gross to include operating expenses, one-third of that gross sum is considered as wages except as a showing is made to the contrary.

(3) Prisoners injured in prison industries are considered to be earning the maximum average weekly earnings under the provisions of s. 102.11, Stats., except as a showing is made to the contrary.

(4) The 24 hour minimum workweek under s. 102.11 (1) (f), Stats., does not apply to a part-time employee unless the employee is a member of a regularly scheduled class of part-time employees. In all other cases part-time employment is on the basis of normal full-time employment in such job. However, this subsection does not apply to part-time employees defined in s. 102.11 (1) (f), Stats., who restrict availability on the labor market. As to the employees so defined, those wages will be expanded to the normal part-time or full-time wages unless the employer or insurance company complies with s. DWD 80.02 (2) (d).

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82; CR 07-019: am. (4), Register October 2007 No. 622, eff. 11-1-07.

DWD 80.52 Payment of permanent disability where the degree of permanency is disputed. Where injury is conceded, but the employer or the employer's insurer disputes the extent of permanent disability, payment of permanent disability shall begin with the later of sub. (1) or (2):

(1) Within 30 days of a report that provides the permanent disability rating, in the amount of the permanency set forth in the report; or

(2) Within 30 days after the employer or insurer receives a report from an examination performed under s. 102.13 (1) (a), Stats., in the amount of the permanent disability found as a result of that medical examination, if any. If such an examination had not previously been performed, the employer or employer's insurer must give notice of a request for such an examination within 30 days of receiving a report that establishes the permanent disability under sub. (1). If a report from the examination is not available within 90 days of the request for the examination, the employer and insurer shall begin payment of the permanent disability set forth in the report under sub. (1).

History: CR 03-125: cr. Register June 2004 No. 582, eff. 7-1-04.

DWD 80.60 Exemption from duty to insure (self-insurance). (1) DEFINITIONS. In this section:

(a) "Applicant" means a business entity applying for self-insurance.

(b) "Divided-insurance" means consent to the issuance of 2 or more policies, as provided in s. 102.31 (1), Stats.

(c) "Employer" means a business entity or its parent guaranteeing payments.

(d) "Excess insurance" means catastrophic insurance for employers granted self-insurance, and is not full-insurance, self-insurance, partial-insurance or divided-insurance.

(e) "Full-insurance" means the insurance of all liability by one policy, as required in s. 102.31 (1) (a), Stats.

(f) "Partial-insurance" means self-insurance of a part of the liability and consent to the issuance of one or more policies on the remainder of the

liability, as provided in ss. 102.28 (2) (b) and 102.31 (1), Stats.

(g) "Self-insurance" means exemption from the duty to insure, as provided in s. 102.28 (2) (b), Stats.

(2) EXCESS INSURANCE. Excess insurance may be carried without further order of the department or may be required by order of the department as set forth in sub. (4) (d) 3. and 7.

(3) REQUIREMENTS FOR THE STATE AND ITS POLITICAL SUBDIVISIONS. (a) The state and its political subdivisions may self-insure without further order of the department, if they are not partially-insured or fully-insured, or to the extent they are not partially-insured by written order under s. 102.31 (1), Stats., under one or more policies, and if they agree to report faithfully all compensable injuries and agree to comply with ch. 102, Stats., and the rules of the department. However, any such employer desiring partial-insurance or divided-insurance must submit an application to the department and be given special consent as described in s. DWD 80.61.

(b) 1. Any political subdivision or taxing authority of the state electing to self-insure shall notify the department in writing of the election before undertaking self-insurance, every 3 years after the initial notice, and 30 days before withdrawing from the self-insurance program.

2. The notice of election to self-insure shall be accompanied by a resolution, adopted by the governing body and signed by the elected or appointed chief executive of the applying political subdivision or taxing authority, stating its intent and agreement by the governing body to self-insure its worker's compensation liability and an agreement to faithfully report all compensable injuries and to comply with ch. 102, Stats., and the rules of the department in accordance with s. 102.28 (2) (b) and (c), Stats.

(c) Self-insurance granted under par. (a) is subject to revocation under s. 102.28 (2) (c), Stats. Once the privilege of self-insurance is revoked, further self-insurance may be authorized only under the procedures set forth in sub. (4).

(4) REQUIREMENTS FOR OTHER EMPLOYERS. (a) Employers other than those specified in sub. (3), but including those specified in sub. (3) (c), desiring self-insurance shall submit an application on a form available from the department. A non-refundable fee, determined by the department as described in par. (ag), per employer, shall accompany the initial application. If the application is approved, the department shall permit self-insurance by written order. Every 3 years, a self-insured employer shall submit an application to renew self-insurance at least 60 days before the expiration date specified in the department's order. Each quarter, or more often if requested by the department, a self-insured employer shall submit the most current financial statements to the department. Each year, a self-insured employer shall report work-injury claims payments to the department and other information related to worker's compensation liability requested by the department. A self-insured employer shall immediately report to the department in writing any change in organizational structure that differs from the information provided in the annual report submitted to the department, including mergers, acquisitions, company name changes, consolidation, sale, or divestiture of divisions or subsidiaries. After a change in organizational structure, the department may revoke or modify the exemption from the duty to insure by providing reasonable written notice to the self-insured employer. If these changes result in the creation of a new parent or subsidiary, the department may waive or modify the requirement in par. (b) 1. to submit 5 years of audited financial statements. A fee of $200, per employer, and the assessment surcharge described in par. (am) may be billed by the department at the same time as the annual assessment under s. 102.75 (1), Stats. Self-insurance shall expire on the day specified by the department in its order. Unless the context indicates otherwise, all information submitted to the department to comply with this section shall be submitted on the latest version of a department approved form.

Note: For information regarding forms contact the worker's compensation division, bureau of insurance programs, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707.

(ag) In addition to any fee-for-service costs under par. (ax), the department shall charge each initial applicant for self-insurance a flat fee

which the department estimates is the average cost for department employees to review the application for self-insurance, including employee salary and fringe benefits, supplies services and administrative costs, and information technology charges. The department shall review and, if necessary, modify the fee at least every 2 years.

(am) In addition to any fee-for-service costs under par. (ax), each year the department shall assess each self-insured employer except those specified in sub. (3), but including those specified in sub. (3) (c), a $200 fee and a proportionate share of the department's remaining costs to administer the self-insurance program after deducting the total amount estimated to be collected from the $200 fees and the fees charged under par. (ag) for initial applications. The department shall determine the assessment amount under this paragraph in the same manner as costs and expenses are apportioned in s. 102.75 (1), Stats.

(ax) To assist the department in evaluating an initial application or a renewal application for self-insurance, the department may contract for financial, loss control or other fee-for-service expertise or it may direct the applicant to provide the necessary information. The department shall charge the applicant for self-insurance the full cost of any fee-for-service expenses which the department incurs in evaluating the application for self-insurance. If these charges are related to an application for renewal of self-insurance, the department may bill the employer at the same time as the annual assessment under s. 102.75 (1), Stats.

(b) The minimum requirements necessary for initial consideration for self-insurance are set forth in this paragraph. References in this paragraph to "board of directors" and "stockholders of the corporation" apply only to corporations but an equivalent requirement as determined by the department shall be applied to sole proprietorships, partnerships and other forms of business ownership.

1. The applicant, when submitting an initial request for self-insurance, shall submit audited financial statements (which includes the opinion of a certified public accountant) for a minimum of the latest five. Except as authorized by the department, employers self-insured under this subsection shall submit to the department audited or unaudited financial statements each quarter and audited financial statements each year.

2. If the employer is a corporation or a partnership which is a majority or wholly owned subsidiary, it shall submit to the department a guaranty of payments by the ultimate or top parent company on a department form and a certified copy of the resolution adopted by the board of directors of the parent corporation.

3. If the employer is a corporation, it shall submit a certified copy of the resolution adopted by the board of directors authorizing the execution of the initial application:

a. Applications by organizations other than corporations shall be signed by one or more persons possessing authority to execute such application.

b. Partnerships must submit a consent by all the partners that all individuals executing the application have the authority to act for the applicant partnership.

4. Corporations, limited partnerships and limited liability companies shall be registered in the office of the department of financial institutions.

5. The employer shall submit a copy of its current safety and loss control plan.

(c) The following criteria may be considered by the department in evaluating the qualifications of an applicant for the initial application or renewal of self-insurance status:

1. The financial strength and liquidity of the employer to include: profit and loss history; financial and performance ratios; characteristics and trends for the employer or the consolidated group of employers to which the employer belongs; characteristics and trends for other employers of the same or the most similar industry in which the employer or the employer's consolidated group is involved;

2. The employer's organizational structure, management background, kind of business, length of time in business, and any intended or newly implemented reorganization including but not limited to merger, consolidation, acquisition of new business, divesting or spinning off of assets or other changes;

3. The nature and extent of the employer's business operations and assets in the state of Wisconsin;

4. The employer's bond or other business ratings;

5. The number of employer's employees, payroll and hours worked in Wisconsin;

6. The employer's performance indicators under ch. 102, Stats., including, but not limited to, promptness or time taken in making first indemnity payments, promptness or time taken in submitting first reports, and injury and illness incidence and severity rates;

7. The existing or proposed claims administration, occupational health, safety, and loss control programs to be maintained by the employer. The department may require certification of the occupational safety and health program by state or independently qualified specialists;

8. The worker's compensation loss history, experience modification factor, reported losses, loss reserves and worker's compensation premium of the employer; and

9. Excess insurance, surety bond, cash deposit or pledges of the employer, guaranty by the parent company, or other guarantees or pledges acceptable to the department.

(d) The required minimum bond, minimum amount of cash, letter of credit or securities deposits, minimum acceptable excess insurance upper limit, maximum excess insurance retention, or other security satisfactory to the department, shall be determined after the application has been reviewed and analyzed by the department. The employer and the employer's surety or other agent providing security shall use the latest version of any forms required by the department. All surety bonds and excess policies shall be written on standard forms approved by the Wisconsin compensation rating bureau or the commissioner of insurance, or both. Any change in the language used in the approved standard form is not accepted unless the department approves it in writing. The following conditions shall also apply to self-insured employers:

1. Surety bonds shall be written by companies authorized to transact surety business in Wisconsin and acceptable to the department.

2. Cash or equivalent securities shall be deposited with banks or trust companies authorized to exercise trust powers in Wisconsin and acceptable to the department. These securities shall be negotiable and converted into cash at anytime by the depository at the request of the department.

3. If excess insurance is required by the department, it shall be procured from a licensed excess insurance carrier and written on the basis of rates and policy form filed with and approved by the state of Wisconsin commissioner of insurance. The policy for the required excess insurance shall be filed with and approved by the Wisconsin compensation rating bureau.

4. Each self-insured employer shall provide security of at least $500,000. The department may increase the minimum required security amount after considering the criteria in par. (c).

5. If the self-insured employer provides a surety bond, the surety company shall pay worker's compensation liabilities of the employer up to the aggregate amount of the bond without deducting any of its costs for investigating, paying, defending against, or providing other services related to the worker's compensation claims. If a self-insured employer has more than one surety bond, the surety company whose bond is in effect on the date of injury is liable for claims related to that injury.

6. If the self-insured employer provides security in any form other than a surety bond, the department shall add 30 percent to the minimum amount in subd. 4.

7. Each employer self-insured under this subsection shall obtain a specific per occurrence excess insurance policy with retention and maximum limits approved by the department and in a form approved by the Wisconsin compensation rating bureau under ch. 626, Stats. In determining the limits the department shall consider, among other things, the criteria in par. (c).

(dm) The department may call and use any security provided by an employer under par. (d) to pay that employer's worker's compensation liabilities and to administer that employer's worker's compensation claims if the department has a reasonable basis to believe that the employer is not able or will not be able to timely

pay the worker's compensation liabilities incurred during the period for which that employer was authorized to be self-insured. The department may contract with a third-party administrator or other agent to administer payments. The employer is responsible for any unpaid liabilities. Within 2 working days of receiving written notice from the department, the employer whose security was called shall provide the department with the names and addresses of all present and former employees of the employer during the most recent 3 years in which the employer was self-insured. Within 30 days of receiving written notice from the department, the employer whose security was called shall provide the department with copies of any worker's compensation, medical or employment files requested by the department or summary information related to those files in a format requested by the department.

Note: In addition to a demonstrated failure to make timely worker's compensation payments, "a reasonable basis to believe that an employer...will not be able to timely pay worker's compensation liabilities" is intended to include such things as proceedings before bankruptcy court which may have an adverse financial impact on the employer or credible reports that an employer is preparing to seek some form of shelter in bankruptcy or receivership.

(dx) A surety or bonding company shall provide the department with a written plan acceptable to the department for the review and payment of any worker's compensation liability of the self-insured employer within 15 days after the department notifies the surety or bonding company that it is calling the bond. When the department approves the plan the surety or bonding company may contract with a third-party administrator or other agent to pay worker's compensation benefits and other liabilities.

(e) Whenever the department has reason to believe that an employer currently or previously granted self-insurance for its parent or subsidiary company is liquidating and distributing its assets to its owners, or is selling or is about to sell the tangible property it owns and maintains in Wisconsin and the employer or its parent or subsidiary company is moving or is about to move its operations out of Wisconsin, without providing for the payment under the terms of the agreement in the self-insurance application or guaranty form it has executed and submitted to the department, the department may, through the attorney general, cause a petition to be filed to enjoin and restrain the employer from engaging in such action until such time as all obligations of self-insurance meet the satisfaction of the department. Whenever an employer exits self-insurance status the department may require such employer to provide all available information regarding past or outstanding worker's compensation claims or liability and may require securities sufficient to provide payment for those claims or liabilities.

(f) The department may require a self-insured employer to update the information provided in pars. (b) to (e) at any time.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82; am. (3), (4) (a), (b) (intro.) and (c) (intro.), cr. (4) (b) 11., Register, September, 1986, No. 369, eff. 10-1-86; emerg. r. (4) (b) 1., renum. (4) (b) 2. to 11. to be 1. to 10., eff. 3-22-88; am, (4) (b) (intro), r. (4) (b) 1., renum. (4) (b) 2. to 11. to be 1. to 10., Register, August, 1988, No. 392, eff. 9-1-88; am. (1), (2), (3) (b) and (4), Register, April, 1990, No. 412, eff. 5-1-90**;** am. (4) (a), cr. (4) (ag) to (ax), (f), Register, July, 1996, No. 487, eff. 8-1-96; am. (2), (3) (b), (4) (a), (am), (4) (b) 1. and 4., (4) (d) (intro.), cr. (4) (d) 4. to 7., (dm) and (dx), Register, November, 1998, No. 515, eff. 12-1-98.

DWD 80.61 Divided-insurance and partial-insurance requirements under s. 102.31 (1) and (6), for all employers, including contractors working on a wrap-up project.

(1) DEFINITIONS. In this section:

(a) "Divided-insurance" means consent to the issuance of 2 or more policies, as provided in s. 102.31 (1), Stats.

(b) "Partial-insurance" means self-insurance of a part of the liability and consent to the issuance of one or more policies on the remainder of the liability, as provided in ss. 102.28 (2) (b) and 102.31 (1), Stats.

(2) REQUIREMENTS. (a) The requirements for partial-insurance and divided-insurance by 2 or more insurance companies are as follows:

1. Submission of an application on department forms available from the department. If the application is approved, the department shall permit partial-insurance or divided-insurance by written order. In the application, the employer shall agree to assume full responsibility to

immediately make all payments of compensation require, pending a final determination as to liability between the insurance carriers under divided-insurance or between the employer and the insurance carrier under partial-insurance, if a dispute should arise as to which insurance company or whether the employer or insurance company is responsible for a particular injury or illness sustained during the time the written order is in effect.

2. If the applicant is a political subdivision of the state, it shall submit a certified statement by an officer or the attorney for the political subdivision which cites the legal authority for executing the application and agreement when the initial application is submitted.

3. If the employer is a corporation, it shall submit a certified copy of the resolution adopted by the board of directors authorizing the execution of the initial application. Applications by organizations other than corporations shall be signed by person(s) possessing authority to execute such application. Partnerships must submit a consent by all the partners that the individual(s) executing the application has the authority to act for the applicant partnership.

4. Partial-insurance or divided insurance shall not be permitted when the portion of the entity to be insured is unable to obtain coverage under voluntary markets. Otherwise,

a. The department shall permit divided-insurance to municipalities which have ownership of nursing homes in order that the nursing homes may be separately insured and develop a separate experience rate.

b. Subdivision 4. a. does not apply after December 31, 1992.

(b) Renewal applications shall be submitted to the department on a department form no later than 3 months prior to the expiration date of the department's order. Partial-insurance and divided-insurance shall expire on the date specified in the order unless continued in force by further order, as the department deems necessary.

Note: To obtain a renewal application form, contact the Department of Workforce Development, Worker's Compensation Division, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707 or call (608) 266-1340.

and medical expense as the department may

(3) DIVIDED-INSURANCE FOR DESIGNATED CARRIER WRAP-UP CONSTRUCTION PROJECTS.

(a) *Definitions.* In this subsection:

1. "Bureau" means the Wisconsin compensation rating bureau.

2. "Designated wrap-up carrier" means the designated carrier or insurance company which insures the wrap-up project under ch. 102, Stats.

3. "Job site" means the premises and vicinity upon which the operations covered under the contract with the contractor or subcontractor are to be performed.

4. "Material supplier" means vendors, suppliers, material dealers, and others whose function is solely to supply or transport material, equipment, or parts to or from the construction site.

5. "Owner" means the person, firm, corporation or municipality having lawful possession of the construction project.

6. "Regular carrier" means the insurance company which insures all operations of a contractor or subcontractor under ch. 102, Stats., except for work done on the wrap-up project.

7. "Subcontractor" means a person who contracts with a contractor and also includes any subcontractor of a subcontractor.

8. "Wrap-up project" means a construction project wherein the owner selects a carrier, and this carrier issues a separate worker's compensation policy to each contractor and subcontractor scheduled to work on the project for work which will be done on the project, and where the owner pays for each such policy.

(b) *Minimum wrap-up project requirements.* Wrap-up projects shall comply with the following:

1. The estimated project cost of completion shall be equal to at least $25 million. The estimated project cost of completion shall be the estimate of the costs of the total construction contracts to be awarded by the owner on the wrap-up project.

2. The estimated standard worker's compensation manual premium shall be equal to $250,000 or more.

3. The project shall be confined to a single location except that in connection with the building of a road, bridge, pipeline, tunnel,

waterway, or 2 or more concurrent wrap-up insurance carrier the entire job or the concurrent projects are considered as a single project location.

4. The project shall have a definite completion date involving work to be performed continuously until completion and may not be extended to include maintenance work following completion.

5. All contractors and subcontractors shall be included under the wrap-up program.

6. All material suppliers shall be included in the safety program on the job site while unloading and handling material and performing other work, but material suppliers shall be excluded from the rest of the wrap-up program.

7. The submission of all bids and the letting of all contracts shall be on an ex-insurance basis.

(c) *Minimum requirements for owner*. The owner shall comply with the following requirements on a wrap-up project:

1. The wrap-up plan and application shall be submitted on a form provided by the department. If the application is approved, the department shall permit divided-insurance on the wrap-up project.

Note: To obtain the form under this paragraph, contact the Department of Workforce Development, Worker's Compensation Division, P.O. Box 7901, Madison, Wisconsin 53707 or call (608) 266-1340.

2. The owner shall comply with all conditions and agreements in the application, including, but not limited to:

a. The reimbursement of the department's costs incurred because of the wrap-up project.

b. The selection of a licensed and qualified designated wrap-up carrier having a record of compliance with the requirements of ch. 102, Stats., which is acceptable to the department.

c. Informing each contractor and subcontractor and each contractor's and subcontractor's insurance company either directly or through the bureau, at the bureau's discretion, of each one's responsibilities and the need for attaching a proper endorsement to the regular carrier's policy to exclude coverage for the wrap-up job site.

d. The submission of each contractor's and subcontractor's application, on a form provided by the department, to the department prior to the projects involving the same owner and the same time the contractor or subcontractor begins work on the wrap-up project.

Note: To obtain the form under this paragraph, contact the Department of Workforce Development, Worker's Compensation Division, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707 or call (608) 266-1340.

e. The notification of department and bureau of any entity status change resulting from ensuing reorganization.

f. The assumption of responsibility for immediately making direct compensation payments if a dispute arises over coverage.

g. The payment of an employee's attorney's fees and lost wages resulting from a dispute.

3. If the owner is a corporation, it shall submit a certified copy of the resolution by the board of directors authorizing and directing the execution of the application and agreement.

4. If the owner is a subsidiary of a corporation, it shall submit a guaranty and agreement by the owner's ultimate or top parent company agreeing to promptly satisfy all of the requirements and obligations assumed by the owner on the wrap-up project in case of default by the owner.

(d) *Minimum requirements for designated wrap-up carrier*. 1. The designated wrap-up carrier shall submit an application on forms available from the department. If the application is approved, the department shall permit divided-insurance for each contractor and subcontractor scheduled to work on the wrap-up project.

Note: To obtain application forms, contact the Department of Workforce Development, Worker's Compensation Division, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707 or call (608) 266-1340.

2. The designated wrap-up carrier shall comply with all conditions and agreements in the application, including, but not limited to:

a. Informing each contractor's and subcontractor's insurance company either directly or through the bureau, at the bureau's discretion, of each one's responsibilities and the need for attaching a proper endorsement to the regular carrier's policy to exclude coverage for the wrap-up job site;

b. The issuance of each individual contractor's and subcontractor's wrap-up policy prior to the

time the contractor and subcontractor begin work on the job site;

c. The notification of department and bureau of any entity status change resulting from ensuing reorganization;

d. Becoming the full risk insurer for any contractor or subcontractor not having purchased a worker's compensation policy during the time the contractor or subcontractor is under contract on the wrap-up project, except as to an employer granted self-insurance; and

e. Becoming the full risk insurer for any contractor or subcontractor not insured or self-insured while working on the wrap-up project.

3. The designated wrap-up carrier shall submit a certified copy of a statement from an officer authorizing and directing the execution of the application and agreement.

(e) *Application for contractors and subcontractors.* The owner shall submit an application for divided insurance on forms available from the department for each contractor and subcontractor scheduled to work on the project.

(em) *Waiver of requirements.* The department may waive one or more requirements in pars. (b) to (e) if it determines that a waiver will not impair the construction owner's ability to ensure minimum confusion about insurance coverage and maximum safety on the construction project site.

(f) *Reimbursement for expenses incurred by department.* The department shall be reimbursed for those expenses incurred because of the designated carrier wrap-up program. Where the department specifically consents to divided-insurance or partial-insurance on a wrap-up project, the owner shall reimburse the department, within 30 days after the date of a written request by the department, a sum determined by the department not to exceed 2% of the total audited worker's compensation premium charged, with payment not to exceed 1% of the estimated worker's compensation premium upon initial request. If an additional levy is determined to be necessary, a request shall be made for a sum that results in a total charge not to exceed 2% of the total audited worker's compensation premium charged.

(g) *Inapplicability to other employers.* Subsection (3) does not apply to any group of employers other than those specified in this section on any other type of operations nor to any single contract or policy of insurance for any group or association of employers.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82; am. (2) (a) 1., (3) (b) 3. and (3) (d) 3., r. and recr. (3) (e), Register, September, 1986, No. 369, eff. 10-1-86; am. (2) (a) 2. to (c), Register, April, 1990, No. 412, eff. 5-1-90; cr. (3) (em), Register, April, 1994, No. 460, eff. 5-1-94. **CR 15-030: am (3) (c) 1., 2. a. to f. Register October 2015 No. 718, eff 11-1-15.**

DWD 80.62 Uninsured employers fund. (1) PURPOSE. The purpose of this section is to clarify the department's procedures for handling claims for compensation to injured workers under s. 102.81 (1), Stats. This section also defines the financial standards and actuarial principles which the department will use to monitor the adequacy of the cash balance in the fund to pay both known claims and claims incurred but not reported under s. 102.81 (1), Stats.

(2) DEFINITIONS. In this section:

(a) "Agent" means a third-party administrator or other person selected by the department to assist in the administration of the uninsured employers fund program.

(b) "Case reserve" means the best estimate documented in the claim-loss file of all liability to pay compensation on a claim under s. 102.81 (1), Stats.

(c) "Claim" means an injury suffered by an employee of an uninsured employer for which the uninsured employer is liable under s. 102.03, Stats., and which is reported to the department on a form approved by the department for reporting work-related injuries.

(d) "Fund" means the uninsured employers fund in s. 102.80, Stats.

(e) "Incurred but not reported reserve" or "IBNR reserve" means the best actuarial estimate of liability to pay compensation under s. 102.81 (1), Stats., for injuries which occurred on or prior to the current accounting date, for which there is no claim yet reported to the department.

(f) "Insolvent" means inadequate to fund all claims under s. 102.81 (1), Stats.

(g) "Solvent" means adequate to pay all claims under s. 102.81 (1), Stats.

(h) "Ultimate reserve" means the best actuarial claims, the expected future development of claims that have been reported, and IBNR reserve.

(i) "Uninsured employer" means an employer who is subject to ch. 102, Stats., under s. 102.04 (1), Stats., and who has not complied with the duty to insure or to obtain an exemption from the duty to insure under s. 102.28 (2) or (3), Stats.

(3) REPORTING A CLAIM. (a) In addition to the notice to an employer required under s. 102.12, Stats., an employee shall report a claim for compensation under s. 102.81, Stats., to the department on a form provided by the department within a reasonable time after the employee has reason to believe that an uninsured employer may be liable for the injury.

Note: To obtain a form to report a claim for compensation, contact the Department of Workforce Development, Worker's Compensation Division, 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707 or call (608) 266-1340.

(b) After receiving a claim under par. (a), the department shall determine whether the employer is an uninsured employer by reviewing its own records and the records maintained by the Wisconsin compensation rating bureau. Within 14 days after receiving a claim under par. (a), the department shall send the employer written notice that a claim has been reported and that the department has made an initial determination that the employer is, or is not, an uninsured employer with respect to the claimed injury. The department shall send a copy of the notice to the employee who filed the claim. If the department later modifies its initial determination regarding the employer's insurance status with respect to a claim reported under this section, it shall promptly notify the employer and the employee of the reason for the modification and the likely impact of this change on the claim, if any. The employer shall notify its insurance carrier of any modification if the department determines that the employer is an insured employer.

(c) If the department determines that the employer is an uninsured employer it shall promptly seek reimbursement as provided in s. 102.82 (1), Stats., and additional payments to the fund as provided in s. 102.82 (2), Stats. The estimate of aggregate case reserves from all department may also initiate penalty proceedings under s. 102.85, Stats. If the department determines that the employer is not an uninsured employer it shall notify the parties and close the claim. Nothing in this section shall prevent the department from taking other appropriate action on a claim including penalties and interest due under ss. 102.16 (3), 102.18 (1) (b) and (bp), 102.22 (1), 102.35 (3), 102.57 and 102.60, Stats.

(4) PAYING A CLAIM. Within 14 days after a claim is reported to the department, the department or its agent shall mail the first indemnity payment to the injured employee, deny the claim or explain to the employee who filed a claim the reason that the claim is still under review. The department or its agent shall report to the employee regarding the status of the claim at least once every 30 days from the date of the first notification that the claim is under review until the first indemnity payment is made or the claim is denied.

(5) EMPLOYEE COOPERATION. (a) An employee who makes a claim shall cooperate with the department or its agent in the investigation or payment of a claim.

(b) The department or its agent may deny compensation on a claim if an employee fails to provide reasonable assistance to the department or its agent, including recorded interviews, questionnaire responses, medical and other releases, copies of relevant payroll checks, check stubs, bank records, wage statements, tax returns or other similar documentation to identify the employer who may be liable for the injury under s. 102.03, Stats. The department or its agent may also require the employee to document any medical treatment, vocational rehabilitation services or other bills or expenses related to a claim. To verify information submitted in support of a claim for compensation the department or its agent may share information related to a claim with other governmental agencies, including those responsible for tax collection, unemployment insurance, medical assistance, vocational rehabilitation, family support or general relief. Any information obtained from a patient health care record or that may constitute a patient

health care record will be shared only to the extent authorized by ss. 146.81 to 146.84, Stats.

(c) If an employee fails to cooperate as required by par. (b), the department may suspend action upon an application filed under s. 102.17 (1), Stats., or may issue an order to dismiss the application with or without prejudice.

(6) EMPLOYER COOPERATION. An employer who is alleged to be uninsured shall cooperate with the department or its agent in the investigation of a claim by providing any records related to payroll, personnel, taxes, ownership of the business or its assets or other documents which the department or its agent request from the employer to determine the employer's liability under s. 102.03, Stats. If an employer fails to provide information requested under this subsection, the department may presume the employer is an uninsured employer.

(7) DEPARTMENT AGENTS. (a) The department may select one or more agents to assist the department in its administration of the uninsured employers program, including agents selected for any of the following:

1. To receive, review, record, investigate, pay or deny a claim.

2. To represent the legal interests of the uninsured employers fund and to make appearances on behalf of the uninsured employers fund in proceedings under ss. 102.16 to 102.29, Stats.

3. To seek reimbursement from employers under s. 102.82 (1), Stats., for payments made from the fund to or on behalf of employees or their dependents and for claims administration expenses.

4. To seek additional payments to the fund under s. 102.82 (2), Stats.

5. To prepare reports, audits or other summary information related to the program.

6. To collect overpayments from employees or their dependents or from those to whom overpayments were made on behalf of employees or their dependents where benefits were improperly paid.

(b) Except as provided in this section, the department or its agent shall have the same rights and responsibilities in administering claims under ch. 102, Stats., as an insurer authorized to do business in this state. The department or its agent is not liable for penalties and interest due under ss. 102.16 (3), 102.18 (1) (b) and (bp), 102.22 (1), 102.35 (3), 102.57 and 102.60, Stats.

(9) DETERMINING THE SOLVENCY OF THE FUND. (a) The department shall monitor the fund's net balance of assets and liabilities to determine if the fund is solvent using the following accounting principles:

1. In determining the fund's assets, the department shall not include recoveries under s. 102.29 (1), Stats., unless they are in process of payment and due within 30 days, or vouchers in the process of payment which are not fully credited to the fund's account.

2. In determining the fund's liabilities, the department shall estimate the ultimate reserves without discounting, and shall not include reinsurance recoveries that are less than 60 days overdue.

(b) If the secretary determines that ultimate liabilities to the fund on known and IBNR claims exceed 85% of the cash balance in the fund, the secretary shall consult with the council on worker's compensation. If the secretary determines that the fund's ultimate liabilities exceed the fund's ultimate assets, or that there is a reasonable likelihood that the fund's liabilities will exceed the fund's assets within 3 months, the secretary shall file the certificate of insolvency in s. 102.80 (3) (ag), Stats.

(10) TEMPORARY REDUCTION OR DELAY OF PAYMENTS FROM THE FUND. (a) If the secretary files a certificate under s. 102.80 (3) (ag), Stats., the department shall continue to pay compensation under s. 102.81 (1), Stats., on claims reported to the department prior to the date specified in that certificate after which no new claims under s. 102.81 (1), Stats., will be accepted or paid.

(b) If the cash balance in the fund is not sufficient to pay all compensation or other liabilities due in a timely manner, the department may temporarily reduce or delay payments on claims to employees, dependents of employees, health care providers, vocational rehabilitation specialists and others to whom the fund is liable. To manage the fund's cash flow, the department may adopt a uniform, pro-rata

reduction schedule or it may establish different liabilities. The department may amend its payment schedule as necessary.

(c) The department shall provide written notice to each person who does not receive timely compensation from the fund which explains the reduced or delayed payment schedule adopted by the department to resolve the cash-flow problem.

History: Cr. Register, July, 1996, No. 487, eff. 8-1-96; CR 03-125: am. (7) (a) 3. Register June 2004 No. 582, eff. 7-1-04; **CR 15-030: r. (8) Register October 2015 No. 718, eff. 11-1-15.**

DWD 80.65 Notice of cancellation or termination, or nonrenewal. Notice of cancellation, termination, or nonrenewal of a policy under ss. 102.31 (2) (a) and 102.315 (10), Stats., shall be given in writing to the Wisconsin compensation rating bureau, as defined in s. 626.02 (1), Stats., rather than the department. Whenever the Wisconsin compensation rating bureau receives notice of cancellation, termination, or nonrenewal pursuant to this section, it shall immediately notify the department of cancellation, termination, or nonrenewal.

Note: Notice of cancellation, termination, or nonrenewal given to the Wisconsin Compensation Rating Bureau can be submitted in electronic formats through facsimile machine transmission, electronic mail, certified mail or by personal service. This note may be updated without rulemaking at any time the means of notification are changed.

A person may contact the Wisconsin Compensation Rating Bureau by telephone at (262) 796-4540, by visiting the website at: http://www.wcrb.org, or by writing to the following address: Wisconsin Compensation Rating Bureau, P.O. Box 3080, Milwaukee, WI 53201-3080.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82; CR 03-125: am. Register June 2004 No. 582, eff. 7-1-04; **CR 15-030: am. Register October 2015 No. 718, eff. 11-1-15.**

DWD 80.67 Insurer name change. A worker's compensation insurer shall notify the department and the Wisconsin compensation rating bureau in writing 30 days before the effective date of a change in its name. The insurer shall comply with the name change requirements in its state of domicile and in the state of Wisconsin. On or before the effective date of an approved name change, the insurer shall notify each of its employers insured under ch. 102, Stats., that the insurer's name is

payment schedules for different types of

changed. Insurers shall notify employers by an endorsement to the employer's existing policy that states the insurer's new name. The insurer shall file a copy of the endorsement with the Wisconsin compensation rating bureau by personal service, facsimile, or certified mail at the same time that it provides notice to its employers insured under ch. 102, Stats.

Note: The State of Wisconsin Office of the Commissioner of Insurance requires an advance notice of an insurer name change or reorganization. For further information, contact OCI at (608) 266-3585 or (800) 236-8517.

History: Cr. Register, September, 1986, No. 369, eff. 10-1-86; CR 00-181: r. and recr., Register July 2001, No. 547 eff. 8-1-01.

DWD 80.68 Payment of benefits under s. 102.59, Stats. (1) Payment of benefits under s. 102.59, Stats., shall initially be made to the individual entitled to the benefits at such time as payments of primary compensation by the employer cease to be made or would have been made had there been no payment under s. 102.32 (6m), Stats., unless the preexisting disability and the disability for which primary compensation is being paid combine to result in permanent total disability.

(2) Payments received by an employee or dependent from an account in a financial institution or from an annuity policy where such account or annuity policy are established through settlement of the claim for primary compensation, shall be considered payments by the employer or insurance carrier.

(3) Payments under s. 102.59, Stats., shall be on a periodic basis but subject to s. 102.32 (6m) and (7), Stats.

Note: This rule is adopted to insure the solvency of the work injury supplemental benefit and to insure the protection of dependents as of the date of death of the employee with the preexisting disability.

History: Cr. Register, September, 1986, No. 369, eff. 10-1-86; CR 07-019: am. (1) and (3), Register October 2007 No. 622, eff. 11-1-07.

DWD 80.70 Malice or bad faith. (1) An employer who unreasonably refuses or unreasonably fails to report an alleged injury to its insurance company providing worker's compensation coverage, shall be deemed to have acted with malice or bad faith.

(2) An insurance company or self-insured employer who, without credible evidence which

demonstrates that the claim for the payments is fairly debatable, unreasonably fails to make payment of compensation or reasonable and necessary medical expenses, or after having commenced those payments, unreasonably suspends or terminates them, shall be deemed to have acted with malice or in bad faith.

History: Cr. Register, September, 1982, No. 321, eff. 10-1-82.

DWD 80.72 Health service fee dispute resolution process. (1) PURPOSE. The purpose of this section is to establish the procedures and requirements for resolving a dispute under s. 102.16 (2), Stats., between a health service provider and an insurer or self-insured employer over the reasonableness of a fee charged by the health service provider relating to the examination or treatment of an injured worker, and to specify the standards that health service fee data bases must meet for certification by the department.

(2) DEFINITIONS. In this section:

(a) "ADA" means American dental association.

(b) "Applicant" means the person requesting certification of a data base.

(c) "Certified" means approved by the department for use in determining the reasonableness of fees.

(d) "CPT code" means the American medical association's 1992 physicians' current procedural terminology.

Note: This volume is on file in the offices of the secretary of state and the Legislative Reference Bureau, and in the worker's compensation division of the department, GEF I, room 161, 201 E. Washington Ave., Madison, Wisconsin. Copies can be obtained from local textbook stores or from the American medical association, order department: OP054192, P.O. Box 10950, Chicago, IL 60601.

(e) "Data base" means a list of fees for procedures compiled and sorted by CPT code, ICD-9-CM code, ADA code, DRG code, or other similar coding which is systematically collected, assembled, and updated, and which does not include procedures charged under medicare.

(f) "DRG" means a diagnostic related group established by the federal health care financing administration.

(g) "Dispute" means a disagreement between a health service provider and an insurer or self-insured employer over the reasonableness of a fee charged by a health service provider where the insurer or self-insured employer refuses to pay part or all of the fee.

(h) "Fee" or "health service fee" means the amount charged for a procedure by a health service provider.

(i) "Formula amount" means the mean fee for a procedure plus 1.4 standard deviations from that mean as shown by data from a certified data base.

(j) "ICD-9-CM" means the commission on professional and hospital activities' international classification of diseases, 9th revision, clinical modification.

Note: This volume is on file in the offices of the secretary of state and the Legislative Reference Bureau, and in the worker's compensation division of the department, GEF I, room 161, 201 E. Washington Ave., Madison, Wisconsin. Copies can be obtained from local textbook stores, or from superintendent of documents, U.S. government printing office, Washington, D.C., 20402, (stock number 917014000001).

(k) "Procedure" or "health service procedure" means any treatment of an injured worker under s. 102.42, Stats.

(L) "Provider" or "health service provider" includes a physician, podiatrist, psychologist, optometrist, chiropractor, dentist, physician's assistant, advanced practice nurse prescriber, therapist, medical technician, or hospital.

(m) "Self-insurer" means an employer who has been granted an exemption from the duty to insure under s. 102.28 (2), Stats.

(3) JUSTIFICATION OF DISPUTED FEES. (a) In a case where liability or the extent of disability is in dispute, an insurer or self-insured employer shall provide written notice of the dispute to the health care provider within 30 days after receiving a completed bill that clearly identifies the provider's name, address and phone number; the patient–employee; the date of service; and the health service procedure, unless there is good cause for delay in providing notice. In a case where liability or the extent of disability is not in issue, and a health care provider charges a fee which an insurer or self-insurer refuses to pay because it is more than the formula amount, the insurer or self-insurer shall, except as provided in sub. (6) (b), mail or deliver written notice to the provider within 30 days after receiving a completed bill which clearly

identifies the provider's name, address and phone number; the patient-employee; the date of service; the health service procedure; and the amount charged for each procedure. The notice from the insurer or self-insurer to the provider shall specify all of the following:

1. The name of the patient-employee and the employer;

2. The date of the procedure in dispute;

3. The amount charged for the procedure;

4. The CPT code, ADA code, ICD-9-CM code, DRG code or other certified code for the procedure;

5. The formula amount for the procedure and the certified data base from which that amount was determined;

6. The amount of the fee that is in dispute beyond the formula amount;

7. The provider's obligation under par. (c), if the fee is beyond the formula amount, to provide the insurer or self-insurer with a written justification for the higher fee, at least 20 days prior to submitting the dispute to the department. The notice must clearly explain that the only justification for a fee more than the formula amount is that the service provided in this particular case is more difficult or more complicated than in the usual case; and

8. The insurer's or self-insurer's obligation under par. (d) to respond within 15 days of receiving the provider's written justification for charging a fee beyond the formula amount.

9. That pursuant to s. 102.16 (2) (b), Stats., once the notice required by this subsection is received by a provider, a health service provider may not collect the disputed fee from, or bring an action for collection of the disputed fee against, the employee who received the services for which the fee was charged.

(b) If the provider and the insurer or self-insurer agree on the facts in sub. (3) (a) 1. to 6., the provider may submit the dispute to the department at any time. If the provider believes there is a factual error in the notice provided by the insurer or self-insurer, it must raise the issue as provided in par. (c).

(c) If, after receiving notice from the insurer or self-insurer, the provider believes a fee beyond the formula amount is justified, or if it does not agree with the factual information provided in the notice under par. (a), then, at least 20 days prior to submitting a dispute to the department, the provider must submit a written justification to the insurer or self-insurer noting the factual error or explaining the extent to which the service provided in the disputed case was more difficult or more complicated than in the usual case, or both.

(d) If the provider submits a written justification under par. (c), the insurer or self-insurer has 15 days after receiving the notice to notify the provider that it accepts the provider's explanation or to explain its continuing refusal to pay the fee. If the insurer or self-insurer accepts the provider's justification, the fee must be paid in full, or in an amount mutually agreed to by the provider and insurer or self-insurer, within 30 days from the date the insurer or self-insurer received written justification under par. (c).

(e) If only a portion of the fee is in dispute, the insurer or self-insurer shall, within the 30-day notice period specified in par. (a), pay the remainder of the fee which is not in dispute.

(4) SUBMITTING DISPUTED FEES. (a) For the department to determine whether or not a fee is reasonable under s. 102.16 (2), Stats., a provider shall file a written request to the department to resolve the dispute within 6 months after an insurer or self-insurer first refuses to pay as provided in sub. (3) (a), and provide a copy of the request and all attachments to the insurer or self-insured employer.

(b) A request by a provider shall include copies of all correspondence in its possession related to the fee dispute.

(c) The department shall notify the insurer or self-insurer when a request to settle the dispute is submitted that the insurer or self-insurer has 20 days to file an answer or a default judgment will be ordered.

(d) The insurer or self-insurer shall file an answer with the department, and send a copy to the provider, within 20 days from the date of the department's notice of dispute. The answer shall include:

1. Copies of any prior correspondence relating to the fee dispute which the provider has not already filed.

2. Information from a certified data base on fees charged by other providers for comparable services or procedures which clearly demonstrates that the fee in dispute is beyond the formula amount for the service or procedure.

3. An explanation of why the service provided in the disputed case is not more difficult or complicated than in the usual case.

(e) The department shall examine the material submitted by all parties and issue its order resolving the dispute within 90 days after receiving the material submitted under par. (d). The department shall send a copy of the order to the provider, the insurer or self-insurer and the employee. If the fee dispute involves a claim for which an application for hearing is filed under s. 102.17, Stats., or an injury for which the insurer or self-insurer disputes the cause of the injury, the extent of disability, or other issues which could result in an application for hearing being filed, the department may delay resolution of the fee dispute until a hearing is held or an order is issued resolving the dispute between the injured employee and the insurer or self-insurer.

(f) The department may develop and require the use of forms to facilitate the exchange of information.

(5) DEPARTMENT INITIATIVE. The department may initiate resolution of a fee dispute when requested to do so by an injured worker, an insurer or a self-insurer. The department shall direct the parties to follow the process provided for in subs. (3) and (4), except where the department specifically determines that extraordinary circumstances justify some modification to expedite or facilitate a fair resolution of the dispute.

(6) INTEREST ON LATE PAYMENT. **(a)** Except as provided in par. (b), in addition to any amount paid or awarded in a fee dispute, where an insurer or self-insurer fails to respond as required in subs. (3) and (4) or as directed under sub. (5), the insurer or self-insurer shall pay simple interest on the payment or award to the provider at an annual rate of 12%, to be computed by the insurer or self-insurer, from the date that the insurer or self-insurer first missed a deadline for response, to the date of actual payment to the provider.

(b) If the insurer or self-insurer notifies the provider within 30 days of receiving a completed bill under sub. (3) (a), that it needs additional documentation from the provider regarding the bill or treatment, the insurer or self-insurer shall have 30 days from the date it receives the provider's response to this request for additional documentation to comply with the notice requirement in sub. (3) (a). Examples of additional documentation include requests for a narrative description of services provided or medical reports.

(c) For the purpose of calculating the extent to which any claim is overdue, the date of actual payment is the date on which a draft or other valid instrument which is equivalent to payment is postmarked in the U.S. mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(7) CERTIFICATION OF DATA BASES. (a) Before the department may certify a data base under s. 102.16 (2), Stats., and sub. (8), it shall determine that all of the following apply:

1. The fees in the data base accurately reflect the amounts charged by providers for procedures rather than the amounts paid to or collected by providers, and do not include any Medicare charges.

2. The information in the data base is compiled and sorted by CPT code, ICD-9-CM code, ADA code, DRG code or other similar coding accepted by the department.

3. The information in the data base is compiled and sorted into economically similar regions within the state, with the fee based on the location at which the service was provided.

4. The information in the data base can be presented in a way which clearly indicates the formula amount for each procedure.

5. The applicant authorizes and assists the department to audit or investigate the accuracy of any statements made in the application for certification by any reasonable method including, if the applicant did not collect or compile the data itself, providing a means for the department to audit or investigate the process used by the person who collected or compiled the data.

6. The information in the data base is up-dated and published or distributed by other methods at least every 6 months.

(b) Before the department may certify a data base under s. 102.16 (2), Stats., it shall consider all of the following:

1. The coverage of the data base, including the number of CPT codes, ICD-9-CM codes or DRGs for which there are data; the number of data entries for each code or DRG; the number of different providers contributing to a code or DRG entry; and the extent to which reliable data exist for injuries most commonly associated with worker's compensation claims;

2. The sources from which the data are collected, including the number of different providers, insurers or self-insurers;

3. The age of the data, and the frequency of the updates in the data;

4. The method by which the data are compiled, including the method by which mistakes in charges are identified and corrected prior to entry and the extent to which this occurs; and the conditions under which charges reported to the applicant may be excluded and the extent to which this occurs;

5. The extent to which the data are representative of the entire geographic area for which certification is sought;

6. The length of time the applicant has been in business and doing business in Wisconsin;

7. The length of time the data base has been in existence;

8. Whether the data base has been certified by any organization or government agency.

(8) APPLICATION FOR CERTIFICATION; DECERTIFICATION. (a) To obtain certification from the department, an applicant shall submit a complete description of the items covered in sub. (7) to the department. The department may require the submission of other information which it deems relevant.

(b) The applicant shall clearly identify any trade secrets under s. 19.36 (5), Stats. The department shall treat any information marked as trade secrets as confidential and shall use it solely for the purpose of certification and shall take appropriate steps to prevent its release.

(c) Notwithstanding par. (b), the department may create a technical advisory group consisting of individuals with special expertise from both the public and private sectors to assist the department in reviewing and evaluating an application.

(d) The department shall certify a data base for one year at a time. The department may extend the one-year certification period while an application for renewal is under review by the department.

(e) If the department determines that an applicant has misrepresented a material fact in its application or that it no longer meets the requirements in sub. (7), the department may decertify a data base after providing the applicant with notice of the basis for decertification and an opportunity to respond.

(9) APPLICABILITY. This section first applies to health service procedures provided on July 1, 1992 and shall take effect on July 1, 1992.

History: Cr. Register, June, 1992, No. 438, eff. 7-1-92; CR 03-125: am. (3) (a) (intro.) Register June 2004 No. 582, eff. 7-1-04; CR 07-019: am. (2) (i) and (L), Register October 2007 No. 622, eff. 11-1-07.

DWD 80.73 Health service necessity of treatment dispute resolution process.

(1) PURPOSE. The purpose of this section is to establish the procedures and requirements for resolving a dispute under s. 102.16 (2m), Stats., between a health service provider and an insurer or self-insurer over the necessity of treatment rendered by a provider to an injured worker.

(2) DEFINITIONS. In this section:

(a) "Dispute" means a disagreement between a provider and an insurer or self-insurer over the necessity of treatment rendered to an injured worker where the insurer or self-insurer refuses to pay part or all of the provider's bill.

(b) "Expert" means a person licensed to practice in the same health care profession as the individual health service provider whose treatment is under review, and who provides an opinion on the necessity of treatment rendered to an injured worker for an impartial health care services review organization or as a member of an independent panel established by the department.

(c) "Licensed to practice in the same health care profession" means licensed to practice as a physician, psychologist, chiropractor, podiatrist or dentist.

(d) "Provider" includes a hospital, physician, psychologist, chiropractor, podiatrist, physician's assistant, advanced practice nurse prescriber, or dentist, or another licensed medical practitioner who provides treatment ordered by a physician, psychologist, chiropractor, podiatrist, physician's assistant, advanced practice nurse prescriber, or dentist whose order of treatment is subject to review.

(e) "Review organization" or "impartial health care services review organization" means a public or private entity not owned or operated by, or regularly doing medical reviews for, any insurer, self-insurer, or provider, and which, for a fee, can provide expert opinions regarding the necessity of treatment provided to an injured worker.

(f) "Self-insurer" means an employer who has been granted an exemption from the duty to insure under s. 102.28 (2), Stats.

(g) "Treatment" means any procedure intended to cure and relieve an injured worker from the effects of an injury under s. 102.42, Stats.

(3) NOTICE TO THE PROVIDER. (a) In a case where liability or the extent of liability is in dispute, an insurer or self-insured employer shall provide written notice of the dispute to the health care provider within 60 days after receiving a bill that documents the treatment provided to the worker, unless there is good cause for delay in providing notice. An insurer or self-insurer which refuses to pay for treatment rendered to an injured worker because it disputes that the treatment is necessary shall, in a case where liability or the extent of liability is not an issue, give the provider written notice within 60 days of receiving a bill which documents the treatment provided to the worker. The notice shall specify all of the following:

1. The name of the patient-employee.

2. The name of the employer on the date of injury.

3. The date of the treatment in dispute.

4. The amount charged for the treatment and the amount in dispute.

5. The reason that the insurer or self-insurer believes the treatment was unnecessary, including the organization and credentials of any person who provides supporting medical documentation and a copy of the supporting medical documentation from that person.

6. The provider's right to initiate an independent review by the department within 9 months under sub. (6), including a description of how costs will be assessed under sub.(8).

7. The address to use in directing correspondence to the insurer or self-insurer regarding the dispute.

8. That pursuant to s. 102.16 (2m) (b), Stats., once the notice required by this subsection is received by a provider, the provider may not collect a fee for the disputed treatment from, or bring an action for collection of the fee for that disputed treatment against, the employee who received the treatment.

(b) At the request of an insurer or self-insurer, the department may extend the 60-day period in par. (a) where the insurer or self-insurer is unable to obtain the supporting medical documentation within the 60-day period, or where the department determines other extraordinary circumstances justify an extension.

(c) Except as provided in par. (b), if an insurer or self-insurer provides the notice after the 60-day period, the provider may immediately request the department to issue a default order requiring the insurer or self-insurer to pay the full amount in dispute.

(4) NOTICE TO THE INSURER OR SELF-INSURER. After receiving notice from the insurer or self-insurer under sub. (3) and, except as provided in sub. (3) (b) and (c), at least 30 days prior to submitting a dispute to the department, the provider shall explain to the insurer or self-insurer in writing why the treatment was necessary to cure and relieve the effects of the injury, including a diagnosis of the condition for which treatment was provided.

(5) RESPONSE BY THE INSURER OR SELF-INSURER. (a) Within 30 days from the date on which the provider sent or delivered notice under sub. (4), an insurer or self-insurer shall notify the provider whether or not it accepts the provider's explanation regarding necessity of treatment.

(b) If the insurer or self-insurer accepts the provider's explanation, the provider's fee must be paid in full, or in an amount mutually agreed to by the provider and insurer or self-insurer,

within the 30-day period specified in par. (a). In the case of late payment, the insurer or self-insurer shall pay simple interest on the amount mutually agreed upon at the annual rate of 12 percent, from the day after the 30-day period lapses to the date of actual payment to the provider.

(6) SUBMITTING DISPUTES TO THE DEPARTMENT. (a) For the department to determine whether or not treatment was necessary under s. 102.16 (2m), Stats., a provider shall, after the 30-day notice period in sub. (4) has elapsed, apply to the department in writing to resolve the dispute. The provider shall apply to the department within 9 months from the date it receives notice under sub. (3) from the insurer or self-insurer refusing to pay the provider's bill.

(b) The provider's application to the department shall include copies of all correspondence related to the dispute.

(c) At the time it files the application with the department, the provider shall send or deliver to the insurer or self-insurer which is refusing to pay for the treatment in dispute a copy of all materials submitted to the department.

(d) When an application to resolve a dispute is submitted, the department shall notify the insurer or self-insurer that it has 20 days to either pay the bill in full for the treatment in dispute or to file an answer under par. (e) for the department to use in the review process in sub. (7).

(e) The answer shall include copies of any prior correspondence relating to the dispute which the provider has not already filed, and any other material which responds to the provider's application. The answer shall include the name of the organization, and credentials of any individual, whose review of the case has been relied upon in reaching the decision to deny payment.

(f) The department may develop and require the use of forms to facilitate the exchange of information.

Note: To obtain a form under par. (f), contact the Department of Workforce Development, Worker's Compensation Division, 201 E. Washington Ave., P. O. Box 7901, Madison, Wisconsin 53707 or access the form online at http://dwd.wisconsin.gov.

(7) REVIEW PROCESS. (a) After the 20-day period in sub. (6) (d) for the insurer or self-insurer to answer has passed, the department shall provide a copy of all materials in its possession relating to a dispute to an impartial health care services review organization, or to an expert from a panel of experts established by the department, to obtain an expert written opinion on the necessity of treatment in dispute.

(b) In all cases where the dispute involves a Wisconsin provider, the expert reviewer shall be licensed to practice in Wisconsin.

(c) When necessary to provide a fair and informed decision, the expert may contact the provider, insurer or self-insurer for clarification of issues raised in the written materials. Where the contact is in writing, the expert shall provide all parties to the dispute with a copy of the request for clarification and a copy of any responses received. Where the contact is by phone, the expert shall arrange a conference call giving all parties an opportunity to participate simultaneously.

(d) Within 90 days of receiving the material from the department under par. (a), the review organization or panel shall provide the department with the expert's written opinion regarding the necessity of treatment, including a recommendation regarding how much of the provider's bill the insurer or self-insurer should pay, if any. At the same time that it provides an opinion to the department, the review organization or panel on which the expert serves shall send a copy of the opinion to the provider and the insurer or self-insurer which are parties to the dispute.

(e) The provider, insurer or self-insurer shall have 30 days from the date the expert's opinion is received by the department under par. (d) to present written evidence to the department that the expert's opinion is in error. Unless the department receives clear and convincing written evidence that the opinion is in error, the department shall adopt the written opinion of the expert as the department's determination on the issues covered in the written opinion.

(f) If the necessity of treatment dispute involves a claim for which an application for hearing is filed under s. 102.17, Stats., or an injury for which the insurer or self-insurer

disputes the cause of the injury, the extent of the disability, or other issues which could result in an application for hearing being filed, the department may delay resolution of the necessity of treatment dispute until a hearing is held or an order is issued resolving the dispute between the injured employee and the insurer or self-insurer.

(8) PAYMENT OF COSTS. (a) The department shall charge the insurer or self-insurer the full cost of obtaining the written opinion of the expert for the first dispute involving the necessity of treatment rendered by an individual provider, unless the department determines the provider's position in the dispute is frivolous or based on fraudulent representations.

(b) In a subsequent dispute involving the same provider, the department shall charge the full cost of obtaining the expert's opinion to the losing party.

(c) Any time prior to the department's order determining the necessity of treatment, the department shall dismiss the application if the provider and insurer or self-insurer mutually agree on the necessity of treatment and the payment of any costs incurred by the department related to obtaining the expert opinion.

(9) DEPARTMENT INITIATIVE. In addition to the provider's right to submit a dispute to the department under sub. (6), the department may initiate resolution of a dispute on necessity of treatment when requested to do so by an injured worker, an insurer or a self-insurer. The department shall notify the insurer or self-insurer of its intention to initiate the dispute resolution process and shall direct them to provide information necessary to resolve the dispute. The department shall allow up to 60 days for the parties to respond, but may extend the response period at the request of either party.

(10) EXPERT PANELS. The department may establish one or more panels of experts in one or more treating disciplines, and may set the terms and conditions for membership on any panel. In making appointments to a panel the department shall consider:

(a) An individual's training and experience, including:

1. The number of years of practice in a particular discipline;

2. The extent to which the individual currently derives his or her income from an active practice in a particular discipline; and,

3. Certification by boards or other organizations;

(b) The recommendation of organizations that regulate or promote professional standards in the discipline for which the panel is being created; and,

(c) Any other factors that the department may determine are relevant to an individual's ability to serve fairly and impartially as a member of an expert panel.

(11) APPLICABILITY. This section first applies to health services provided on January 1, 1992, and shall take effect on July 1, 1992.

History: Emerg. cr. eff. 1-1-92; cr. Register, June, 1992, No. 438, eff. 7-1-92; CR 03-125: am. (3) (a) (intro.) Register June 2004 No. 582, eff. 7-1-04; CR 07-019: am. (2) (d), Register October 2007 No. 622, eff. 11-1-07; **CR 15-030: am. (3) (a) 1. To 7., (6) (f) Register October 2015 No. 718, eff. 11-1-15.**

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Chapter DWD 81, Worker's Compensation Treatment Guidelines

DWD 81.01 Purpose and application.
DWD 81.02 Incorporation by reference.
DWD 81.03 Definitions.
DWD 81.04 General treatment guidelines; excessive treatment.
DWD 81.05 Guidelines for medical imaging
DWD 81.06 Low back pain.
DWD 81.07 Neck pain.
DWD 81.08 Thoracic back pain.
DWD 81.09 Upper extremity disorders.
DWD 81.10 Complex regional pain syndrome of the upper and lower extremities.
DWD 81.11 Inpatient hospitalization guidelines.
DWD 81.12 Guidelines for surgical procedures.
DWD 81.13 Chronic management.
DWD 81.14 Health care provider advisory committee.

DWD 81.01 Purpose and application.
(1) PURPOSE. **(a)** The purpose of this chapter is to establish guidelines for necessary and appropriate treatment of patients with compensable worker's compensation injuries under s. 102.16 (2m), Stats., and s. DWD 80.73.
(b) The guidelines contained in this chapter are factors for an impartial health care services review organization and a member from an independent panel of experts established by the department to consider in rendering opinions to resolve necessity of treatment disputes arising under s. 102.16 (2m), Stats., and s. DWD 80.73.
(c) Sections DWD 81.01 to 81.13 do not affect any determination of liability for an injury under ch. 102, Stats., and are not intended to expand or restrict a health care provider's scope of practice under any other statute.
(2) APPLICATION. All treatment shall be medically necessary as defined in s. DWD 81.03 (10). In the absence of a specific guideline any applicable general guidelines govern. A departure from a guideline that limits the duration or type of treatment may be appropriate in any of the circumstances specified in s. DWD 81.04 (5). All limitations on the duration of a specific treatment modality or type of modality begin with the first time the modality is initiated after November 1, 2007. This chapter does not apply to treatment of an injury after an insurer has denied liability for the injury, except in cases in which the guidelines apply to treatment initiated after liability has been established.
History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.02 Incorporation by reference. The ICD-9-CM diagnostic codes referenced in this chapter are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is incorporated by reference.
Note: This volume is published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is on file at the Worker's Compensation Division of the Department of Workforce Development and at the office of the Legislative Reference Bureau.
History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.03 Definitions. Unless otherwise provided, in this chapter:
(1) "Active treatment" means treatment specified in ss. DWD 81.06 (4), 81.07 (4), 81.08 (4), 81.09 (4), and 81.10 (2) that requires active patient participation in a therapeutic program to increase flexibility, strength, endurance, or awareness of proper body mechanics.
(2) "Chronic pain" means complaint of persistent pain beyond 12 weeks of appropriate treatment provided under this chapter. It is persistent with verbal and nonverbal pain behaviors that exceed the identifiable pathology and medical condition. It is pain that interferes with physical, psychological, social, or vocational functioning.
(3) "Condition" means the symptoms, physical signs, clinical findings, and functional status that characterize a person's complaint, illness, or injury related to a current claim for compensation.
(4) "Day" means calendar day.
(5) "Emergency treatment" means treatment that is required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or is immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.
(6) "Etiology" means the anatomic alteration, physiologic dysfunction, or other biological or psychological abnormality that is considered a cause of the patient's condition.
(7) "Functional status" means the ability of an individual to engage in activities of daily living and other social, recreational, and vocational activities.
(8) "Initial nonsurgical management or treatment" is initial treatment provided after an injury that includes passive treatment, active treatment, injections, and durable medical equipment under ss. DWD 81.06 (3), (4), (5), and (8), 81.07 (3), (4), (5), and (8), 81.08 (3), (4), (5), and (8), 81.09 (3), (4), (5), and (8), and

81.10 (2). Scheduled and nonscheduled medication may be a part of initial nonsurgical treatment. Initial nonsurgical management does not include surgery or chronic management modalities under s. DWD 81.13.

(9) "Medical imaging procedure" is a technique, process, or technology used to create a visual image of the body or its function. Medical imaging includes X-rays, tomography, angiography, venography, myelography, computed tomography scanning, magnetic resonance imaging scanning, ultrasound imaging, nuclear isotope imaging, positron emission tomography scanning, and thermography.

(10) "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and to cure or relieve a condition consistent with any applicable treatment guidelines in this chapter. If ss. DWD 81.04 to 81.13 do not apply, the treatment must be reasonable and necessary for the diagnosis and to cure or relieve a condition consistent with the current accepted standards of practice within the scope of the provider's license or certification.

(11) "Neurologic deficit" means a loss of function secondary to involvement of the central or peripheral nervous system. This includes motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.

(12) "Progressive neurologic deficit" means any neurologic deficit that has become worse by history or been noted by repeated examination since onset.

(13) "Passive treatment" is any treatment modality specified in ss. DWD 81.06 (3), 81.07 (3), 81.08 (3), 81.09 (3), and 81.10 (2). Passive treatment modalities include bedrest, thermal treatment, traction, acupuncture, electrical muscle stimulation, braces, manual and mechanical therapy, massage, and adjustments.

(14) "Static neurologic deficit" means any neurologic deficit that has remained the same by history or been noted by repeated examination since onset.

(15) "Therapeutic injection" is any injection modality specified in ss. DWD 81.06 (5), 81.07 (5), 81.08 (5), 81.09 (5), and 81.10 (2). Therapeutic injections include trigger point injections, sacroiliac injections, facet joint injections, facet nerve blocks, nerve root blocks, epidural injections, soft tissue injections, peripheral nerve blocks, injections for peripheral nerve entrapment, and sympathetic blocks.

(16) "Week" means calendar week.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.04 General treatment guidelines; excessive treatment.

(1) GENERAL.

(a) All treatment shall be medically necessary treatment. A health care provider shall evaluate the medical necessity of all treatment under par. (b) on an ongoing basis. This chapter does not require or permit any more frequent examinations than would normally be required for the condition being treated but may require ongoing evaluation of the patient that is medically necessary and consistent with accepted medical practice.

(b) The health care provider shall evaluate at each visit whether initial nonsurgical treatment for the low back, cervical, thoracic, and upper extremity conditions specified in ss. DWD 81.06 to 81.09 is effective according to subds. 1. to 3. No later than any applicable treatment response time in ss. DWD 81.06 to 81.09, the health care provider shall evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in all of the following:

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

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

3. The patient's functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record or successive reports of work ability of less restrictive limitations on activity.

(c) Except as otherwise provided under ss. DWD 81.06 (3) (b), 81.07 (3) (b), 81.08 (3) (b), and 81.09 (3) (b), if there is not progressive improvement in at least 2 criteria of par. (b) 1. to 3., the modality shall be discontinued or significantly modified, or the health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to an allied health professional directly providing the treatment.

(d) The health care provider shall use the least intensive setting appropriate and shall assist the patient in becoming independent in the patient's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

(2) DOCUMENTATION. A health care provider shall maintain an appropriate record of any treatment provided to a patient. An appropriate record is a legible health care service record or report that substantiates the nature and necessity of a health care service being billed and its relationship to the work injury.

(3) NONOPERATIVE TREATMENT. A health care provider shall provide a trial of nonoperative treatment before offering or performing surgical treatment unless the treatment for the condition requires immediate surgery, unless an emergency situation exists, or unless the accepted standard of initial treatment for the condition is surgery.

(4) CHEMICAL DEPENDENCY. A health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the patient's condition. In cases of incipient or actual dependency, the health care provider shall refer the patient for appropriate evaluation and treatment of the dependency.

(5) DEPARTURE FROM GUIDELINES. A health care provider's departure from a guideline that limits the duration or type of treatment in this chapter may be appropriate in any of the following circumstances:

(a) There is a documented medical complication.

(b) Previous treatment did not meet the accepted standard of practice and meet the guidelines in this chapter for the health care provider who ordered the treatment.

(c) The treatment is necessary to assist the patient in the initial return to work where the patient's work activities place stress on the part of the body affected by the work injury. The health care provider shall document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan, and treatment delivered on each visit, the patient's response to the treatment, and efforts to promote patient independence in the patient's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

(d) The treatment continues to meet 2 of the following 3 criteria, as documented in the medical record:

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

2. The patient's objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

3. The patient's functional status, especially vocational activity, is objectively improving, as evidenced by documentation in the medical record or successive reports of work ability of less restrictive limitations on activity.

(e) There is an incapacitating exacerbation of the patient's condition. Additional treatment for the incapacitating exacerbation shall comply with and may not exceed the guidelines in this chapter.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.05 Guidelines for medical imaging.

(1) GENERAL PRINCIPLES. **(a)** *Documentation.* Except for emergency evaluation of significant trauma, a health care provider shall document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition before ordering any imaging study. All medical imaging shall comply with all of the following:

(b) *Effective imaging.* A health care provider shall initially order the single most effective imaging study for diagnosing the suspected etiology of a patient's condition. No concurrent or additional imaging studies shall be ordered until the results of the first study are known and reviewed by the treating health care provider. If the first imaging study is negative, no additional imaging is necessary except for repeat and alternative imaging allowed under pars. (e) and (f).

(c) *Appropriate imaging.* Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient's condition is not necessary.

(d) *Routine imaging.* Imaging on a routine basis is not necessary unless the information from the study is necessary to develop a treatment plan.

(e) *Repeat imaging.* Repeat imaging of the same views of the same body part with the same imaging modality is not necessary except for any of the following:

1. To diagnose a suspected fracture or suspected dislocation.

2. To monitor a therapy or treatment that is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment.

3. To follow up a surgical procedure.

4. To diagnose a change in the patient's condition marked by new or altered physical findings.

5. To evaluate a new episode of injury or exacerbation that in itself warrants an imaging study.

6. When the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study.

(f) *Alternative imaging.* **1.** Persistence of a patient's subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be necessary if another etiology of the patient's condition is suspected because of the failure of the condition to improve.

2. Alternative imaging may not follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation for the suspected etiology.

3. Alternative imaging may follow up abnormal but inconclusive findings in another imaging study. An inconclusive finding may not provide an adequate basis for accurate diagnosis.

(2) SPECIFIC IMAGING PROCEDURES FOR LOW BACK PAIN. **(a)** Except for the emergency evaluation of significant trauma, a health care provider shall document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study of the low back.

(b) A health care provider may order computed tomography scanning for any of the following:

1. When cauda equina syndrome is suspected.

2. For evaluation of progressive neurologic deficit.

3. When bony lesion is suspected on the basis of other tests or imaging procedures.

(c) Except as specified in par. (b), a health care provider may not order computed tomography scanning in the first 4 weeks after an injury. Computed tomography scanning is necessary after 4 weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities.

(d) A health care provider may order magnetic resonance imaging scanning for any of the following:

1. When cauda equina syndrome is suspected.

2. For evaluation of progressive neurologic deficit.

3. When previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage.

4. Suspected discitis.

(e) Except as specified in par. (d), a health care provider may not order magnetic resonance imaging scanning in the first 4 weeks after an injury. Magnetic resonance imaging scanning is

necessary after 4 weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities.

(f) A health care provider may order myelography for any of the following:

1. Myelography may be substituted for otherwise necessary computed tomography scanning or magnetic resonance imaging scanning in accordance with pars. (b) and (d), if those imaging modalities are not locally available.

2. In addition to computed tomography scanning or magnetic resonance imaging scanning, if there are progressive neurologic deficits or changes and computed tomography scanning or magnetic resonance imaging scanning has been negative.

3. For preoperative evaluation in cases of surgical intervention, but only if computed tomography scanning or magnetic resonance imaging scanning have failed to provide a definite preoperative diagnosis.

(g) A health care provider may order computed tomography myelography for any of the following:

1. The patient's condition is predominantly sciatica, there has been previous spinal surgery, and tumor is suspected.

2. The patient's condition is predominantly sciatica, there has been previous spinal surgery, and magnetic resonance imaging scanning is equivocal.

3. When spinal stenosis is suspected and the computed tomography scanning or magnetic resonance imaging scanning is equivocal.

4. If there are progressive neurologic symptoms or changes and computed tomography scanning or magnetic resonance imaging scanning has been negative.

5. For preoperative evaluation in cases of surgical intervention, but only if computed tomography scanning or magnetic resonance imaging scanning have failed to provide a definite preoperative diagnosis.

(h) A health care provider may order intravenous enhanced computed tomography scanning only if there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor, but only if intrathecal contrast for computed tomography-myelography is contraindicated and magnetic resonance imaging scanning is not available or is also contraindicated.

(i) A health care provider may order enhanced magnetic resonance imaging scanning for any of the following:

1. There has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor.

2. Hemorrhage is suspected.

3. Tumor or vascular malformation is suspected.

4. Infection or inflammatory disease is suspected.

5. Unenhanced magnetic resonance imaging scanning was equivocal.

(j) A health care provider may order discography for any of the following:

1. All of the following are present:

a. Back pain is the predominant complaint.

b. The patient has failed to improve with initial nonsurgical management.

c. Other imaging has not established a diagnosis.

d. Lumbar fusion surgery or other surgical procedures are being considered as a therapy.

2. There has been previous spinal surgery, and pseudoarthrosis, recurrent disc herniation, annular tear, or internal disc disruption is suspected.

(k) A health care provider may order computed tomography discography when it is necessary to view the morphology of a disc.

(L) A health care provider may not order nuclear isotope imaging including technicium, indium, and gallium scans, unless tumor, stress fracture, infection, avascular necrosis, or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies, or the results of other imaging studies.

(m) A health care provider may not order thermography for the diagnosis of any of the clinical categories of low back conditions in s. DWD 81.06 (1) (b).

(n) A health care provider may order anterior-posterior and lateral X-rays of the lumbosacral spine for any of the following:

1. When there is a history of significant acute trauma as the precipitating event of the patient's condition, and fracture, dislocation, or fracture dislocation is suspected.

2. When the history, signs, symptoms, or laboratory studies indicate possible tumor, infection, or inflammatory lesion.

3. For postoperative follow-up of lumbar fusion surgery.

4. When the patient is more than 50 years of age.

5. Before beginning a course of treatment with spinal adjustment or manipulation.

6. Eight weeks after an injury if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities.

(o) A health care provider may not order anterior-posterior and lateral X-rays of the lumbosacral spine for any of the following:

1. To verify progress during initial nonsurgical treatment.

2. To evaluate a successful initial nonsurgical treatment program.

(p) A health care provider may order oblique X-rays of the lumbosacral spine for any of the following:

1. To follow up abnormalities detected on anterior-posterior or lateral X-ray.

2. For postoperative follow-up of lumbar fusion surgery.

3. To follow up spondylolysis or spondylolisthesis not adequately diagnosed by other necessary imaging procedures.

(q) A health care provider may not order oblique X-rays of the lumbosacral spine as part of a package of X-rays including anterior-posterior and lateral X-rays of the lumbosacral spine.

(r) A health care provider may not order electronic X-ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine for diagnosis of any of the low back conditions in s. DWD 81.06 (1) (b).

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.06 Low back pain. (1) DIAGNOSTIC PROCEDURES FOR THE EVALUATION OF LOW BACK PAIN.

(a) A health care provider shall determine the nature of the low back condition before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination the health care provider shall assign the patient at each visit to the appropriate clinical category under subds. 1. to 4. The health care provider shall document the diagnosis in the medical record. For the purposes of subds. 2. and 3., "radicular pain" means pain radiating distal to the knee, or pain conforming to a dermatomal distribution, and accompanied by anatomically congruent motor weakness, or reflex changes. This section does not apply to fractures of the lumbar spine, or low back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

1. Regional low back pain, includes referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and that effects the lumbosacral region, with or without referral to the buttocks or leg, or both above the knee, including ICD-9-CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51, 722.52, 722.6, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 847.2 to 847.9, 922.3, 926.1, 926.11, and 926.12.

2. Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with myelopathy,

radiculopathy, radiculitis, or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine, including ICD-9-CM codes 721.4, 721.42 721.91, 722.1, 722.10, 722.2, 722.7, 722.73, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and 724.9. In these cases, neurologic findings on history and physical examination are either absent or do not show progressive deterioration.

3. Radicular pain, with or without regional low back pain, with progressive neurologic deficit. This includes the same diagnoses as subd. 2., except this subdivision applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness, or progressive reflex changes.

4. Cauda equina syndrome, which is a syndrome characterized by anesthesia in the buttocks, genitalia, or thigh and accompanied by disturbed bowel and bladder function, including ICD-9-CM codes 344.6, 344.60, and 344.61.

(c) A health care provider may not order laboratory tests in the evaluation of a patient with regional low back pain, radicular pain, or cauda equina syndrome, except for any of the following:

1. When a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered any time a health care provider suspects any of the conditions in par. (c), if the health care provider justifies the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the lumbosacral spine shall be based on the findings of the history and physical examination and may not be ordered before a health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and shall comply with all of the guidelines in s. DWD 81.05 (1) and (2). A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(f) A health care provider may not order electromyography and nerve conduction studies for regional low back pain as defined in s. DWD 81.06 (1) (b) 1. A health care provider may order electromyography and nerve conduction studies as a diagnostic tool for radicular pain and cauda equina syndrome as defined in s. DWD 81.06 (1) (b) 2. to 4. after the first 3 weeks of radicular symptoms. Repeat electromyography and nerve conduction studies for radicular pain and cauda equina syndrome are not necessary unless a new neurologic symptom or progression of existing finding has developed that in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

(g) A health care provider may not order the use of any of the following procedures or tests for the diagnosis of any of the clinical categories in par. (b) 1. to 4.:

1. Surface electromyography or surface paraspinal electromyography.

2. Thermography.

3. Plethysmography.

4. Electronic X-ray analysis of plain radiographs.

5. Diagnostic ultrasound of the lumbar spine.

6. Somatosensory evoked potentials and motor evoked potentials.

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

(i) A health care provider may order personality or psychosocial evaluations for evaluating patients who continue to have problems despite appropriate care. A treating health care provider

may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation shall consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?

3. Are there other personality factors or disorders that are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) All of the following are guidelines for diagnostic analgesic blocks or injection studies and include facet joint injection, facet nerve injection, epidural differential spinal block, nerve block, and nerve root block:

1. These procedures are used to localize the source of pain before surgery and to diagnose conditions that fail to respond to initial nonsurgical management.

2. These injections are invasive and are not necessary when done as diagnostic procedures only, unless noninvasive procedures have failed to establish the diagnosis.

3. Selection of patients, choice of procedure, and localization of the level of injection may be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

4. These blocks and injections may also be used as therapeutic modalities and are subject to the guidelines of sub. (5).

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

1. A functional capacity assessment or evaluation is not necessary during the period of initial nonsurgical management.

2. A functional capacity assessment or evaluation is necessary in any of the following circumstances:

a. To identify the patient's activity restrictions and capabilities.

b. To resolve a question about the patient's ability to do a specific job.

3. A functional capacity evaluation may not establish baseline performance before treatment or for subsequent assessments to evaluate change during or after treatment.

4. A health care provider may direct only one completed functional capacity evaluation per injury.

(L) Consultations with other health care providers may be initiated at any time by the treating health care provider consistent with accepted medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR LOW BACK PAIN. **(a)** All medical care for low back pain appropriately assigned to a clinical category in sub. (1) (b) is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11), (12), and (13), as follows:

1. Subsection (11) governs regional low back pain.

2. Subsection (12) governs radicular pain with no or static neurologic deficits.

3. Subsection (13) governs cauda equina syndrome and radicular pain with progressive neurologic deficits.

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

(c) In general, a course of treatment for low back problems is divided into the following 3 phases:

1. First, all patients with low back problems, except patients with progressive neurologic deficit or cauda equina syndrome under sub. (1) (b) 3. or 4., shall be given initial nonsurgical management which may include active treatment modalities, passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3), (4), (5), (8), and (10). The period of initial nonsurgical treatment begins with the first active, passive, medication, durable medical equipment, or injection modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11), (12), (13), and s. DWD 81.12. A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Patients with radicular pain with progressive neurological deficit or cauda equina syndrome may require immediate surgical therapy.

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

c. Surgery shall follow the guidelines in subs. (6), (11), (12), (13), and s. DWD 81.12.

d. A decision against surgery at any particular time does not preclude a decision for surgery at a later date.

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

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

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

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

1. The patient is released to work or is permanently totally disabled and the additional passive treatment shall result in progressive improvement in, or maintenance of, the functional status that was achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.
5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.
6. Passive care is not necessary while the patient has chronic pain syndrome.
(c) *Adjustment or manipulation of joints.* For purposes of this paragraph, "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations. All of the following guidelines apply to adjustment or manipulation of joints:
1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.
(d) *Thermal treatment.* For purposes of this paragraph, "thermal treatment" includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave. All of the following guidelines apply to thermal treatment:
1. Thermal treatment given in a clinical setting:
a. Time for treatment response is 2 to 4 treatments.
b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
c. Maximum treatment duration is 12 weeks in a clinical setting but only if given in conjunction with other therapies.
2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.
(e) *Electrical muscle stimulation.* For purposes of this paragraph, "electrical muscle stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:
1. Electrical muscle stimulation given in a clinical setting:
a. Time for treatment response is 2 to 4 treatments.
b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.
2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting in order to ensure proper electrode placement and patient education. All of the following guidelines apply to home use of an electrical muscle stimulation device:
a. The time for patient education and training is one to 3 sessions.
b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.
(f) *Mechanical traction.* All of the following guidelines apply to mechanical traction:
1. Treatment given in a clinical setting:
a. Time for treatment response is 3 treatments.
b. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
c. Maximum treatment duration is 12 weeks in a clinical setting but only if used in conjunction with other therapies.
2. Home use of a mechanical traction device may be prescribed as follow-up to use of traction

in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device shall be in a supervised setting in order to ensure proper patient education. All of the following guidelines apply to home use of a mechanical traction device:

a. Time for patient education and training is one session.

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

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

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

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

3. Maximum treatment duration is 12 weeks.

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

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

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

3. Maximum treatment duration is 12 weeks.

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

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

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

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

(j) *Bedrest.* Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest shall not be prescribed for more than 7 days.

(k) *Spinal braces and other movement restricting appliances.* All of the following guidelines apply to spinal braces and other movement-restricting appliances:

1. Bracing required for longer than 2 weeks shall be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability.

2. Time for treatment response is 3 days.

3. Treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.

4. Maximum continuous duration is 3 weeks unless patient is status postfusion.

(4) ACTIVE TREATMENT MODALITIS. **(a)** Active treatment modalities shall be used as set forth in pars. (b) to (f). A health care provider's use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities so long as the maximum durations for the active treatment modalities are not exceeded.

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

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

(d) Worksite analysis and modification shall examine the patient's work station, tools, and job duties. A health care provider's recommendations may be made for the alteration

of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is 3 visits.

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

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

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

a. Maximum treatment frequency is 5 times for the first week decreasing to 3 times per week for the next 2 weeks and decreasing in frequency after the third week.

b. Maximum duration is 12 weeks.

2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. All of the following guidelines apply to unsupervised exercise:

a. Maximum treatment frequency is up to 3 visits for instruction and monitoring.

b. There is no limit on the duration or frequency of exercise at home.

(5) THERAPEUTIC INJECTIONS. **(a)** Injection modalities are necessary as set forth in pars. (b) to (d). A health care provider's use of injections may extend past the 12-week limit on passive treatment modalities so long as the maximum treatment for injections is not exceeded.

(b) For purposes of this subsection, "therapeutic injections" include injections of trigger points, facet joints, facet nerves, sacroiliac joints, sympathetic nerves, epidurals, nerve roots, and peripheral nerves. Therapeutic injections may only be given in conjunction with active treatment modalities directed to the same anatomical site.

1. All of the following guidelines apply to trigger point injections:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week to any one site if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections shall be redirected to other areas or discontinued. No more than 3 injections to different sites per patient visit may be given.

c. Maximum treatment is 4 injections to any one site.

2. All of the following guidelines apply to sacroiliac joint injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency may permit repeat injection 2 weeks after the previous injection if there is a positive response to the first injection. Only 2 injections per patient visit.

c. Maximum treatment is 2 injections to any one site.

3. All of the following guidelines apply to facet joint or nerve injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks to any one site if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.

c. Maximum treatment is 3 injections to any one site.

4. All of the following guidelines apply to nerve root blocks:

a. Time for treatment response is within one week.

b. Maximum treatment frequency may permit repeat injection 2 weeks after the previous injection if there is a positive response to the first injection. Only 3 injections to different sites per patient visit.

c. Maximum treatment is 2 injections to any one site.

5. All of the following guidelines apply to epidural injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection per patient visit.

c. Maximum treatment is 3 injections.

(c) For purposes of this paragraph, "lytic or sclerosing injections" include radio frequency denervation of the facet joints. These injections may only be given in conjunction with active treatment modalities directed to the same anatomical site. All of the following guidelines apply to lytic or sclerosing injections:

1. Time for treatment response is up to 6 weeks.

2. Maximum treatment frequency may repeat 4 times per year or once every 3 months for any site.

3. Maximum of 2 injections to any one site.

(d) Prolotherapy and botulinum toxin injections are not necessary in the treatment of low back problems.

(6) SURGERY, INCLUDING DECOMPRESSION PROCEDURES AND ARTHRODESIS. **(a)** A health care provider may only perform surgery if it meets the specific guidelines specified in subs. (11), (12), (13), and s. DWD 81.12 (1).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period, the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Eight weeks following lumbar decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system.

2. Twelve weeks following arthrodesis.

(c) Repeat surgery shall also meet the guidelines of subs. (11), (12), (13), and s. DWD 81.12 (1).

(d) The surgical therapies in subds. 1. and 2. have very limited application and require a personality or psychosocial evaluation that indicates the patient is likely to benefit from the treatment:

1. Spinal cord stimulator may be necessary for a patient who has neuropathic pain and has had a favorable response to a trial screening period.

2. Intrathecal drug delivery system may be necessary for a patient who has somatic or neuropathic pain and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of low back pain shall be provided according to the guidelines of s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. **(a)** A health care provider may direct the use of durable medical equipment in any of the following:

1. Lumbar braces, corsets, or supports are necessary within the guidelines of sub. (3) (k).

2. For patients using electrical muscle stimulation or mechanical traction devices at home, the device and any required supplies are necessary within the guidelines of sub. (3) (e) and (f).

3. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are necessary only as part of an approved chronic management program. This equipment is not necessary during initial nonsurgical care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

a. 'Indications.' The patient is deconditioned and requires reconditioning that may be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

b. 'Requirements.' The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(b) All of the following durable medical equipment is not necessary for home use for low back conditions:

1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

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

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

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

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

(e) If there is not progressive improvement in at least 2 criteria specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to another health care provider.

(10) MEDICATION MANAGEMENT. **(a)** Prescription of controlled substance medications under ch. 450, Stats., including opioids and narcotics, are indicated primarily for the treatment of severe acute pain. These medications are not recommended in the treatment of patients with persistent low back pain.

(b) Patients with radicular pain may require longer periods of treatment.

(c) A health care provider shall document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL LOW BACK PAIN. **(a)** A health care provider shall use initial nonsurgical treatment as the first phase of treatment for all patients with regional low back pain under sub. (1) (b) 1.

1. The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

2. The only therapeutic injections necessary for patients with regional low back pain are trigger point injections, facet joint injections, facet nerve injections, sacroiliac joint injections, and epidural blocks, and their use shall meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical treatment shall at all times contain active treatment modalities according to the guidelines in sub. (4).

4. Initial nonsurgical treatment shall be provided in the least intensive setting consistent with quality health care practices.

5. Except as otherwise specified in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not necessary beyond 12 weeks after any

passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is necessary in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is necessary.

1. Surgical evaluation, if necessary, may begin as soon as 8 weeks after, but shall begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery may not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique shall be chosen on the basis of the suspected etiology of the patient's condition but a health care provider shall follow the guidelines in s. DWD 81.05. Medical imaging studies that do not meet these guidelines are not necessary.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only necessary if their use is consistent with the guidelines of sub. (1) (j).

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

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks, and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

6. The only surgical procedures necessary for patients with regional low back pain are decompression of a lumbar nerve root or lumbar arthrodesis, with or without instrumentation, which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1). For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary and consistent with sub. (6) (d).

a. If surgery is necessary, it shall be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it shall be performed as expeditiously as possible consistent with sound medical practice.

b. If surgery is not necessary, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management under the guidelines in s. DWD 81.13.

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management that shall be provided under the guidelines in s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL LOW BACK PAIN, WITH NO OR STATIC NEUROLOGIC DEFICITS. **(a)** Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits under sub. (1) (b) 2., and shall be the first phase of treatment. It shall be provided within the guidelines of sub. (11) (a), with the following modifications: Epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections necessary for patients with radicular pain only. If there is a component of regional low back pain, therapeutic facet joint injections, facet nerve injections, trigger point injections, and sacroiliac injections may also be necessary.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for

surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional low back pain, with static neurologic deficits shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR CAUDA EQUINA SYNDROME AND FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL LOW BACK PAIN, WITH PROGRESSIVE NEUROLOGIC DEFICITS. **(a)** Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, with progressive neurologic deficits may require immediate or emergency surgical evaluation at any time during the course of the overall treatment. The decision to proceed with surgical evaluation is made by a health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any initial nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (11) (b), except that surgical evaluation and surgical therapy may begin at any time.

(b) If a health care provider decides to proceed with a course of initial nonsurgical care for a patient with radicular pain with progressive neurologic changes, it shall follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional low back pain, with foot drop or progressive neurologic changes at first presentation shall be provided under the guidelines of s. DWD 81.13.

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DWD 81.07 Neck pain.

(1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF NECK INJURY.

(a) A health care provider shall determine the nature of the neck condition before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination the health care provider shall assign the patient at each visit to the appropriate clinical category in subds. 1. to 4. A health care provider shall document the diagnosis in the medical record. For the purposes of subds. 2. and 3., "radicular pain" means pain radiating distal to the shoulder. This section does not apply to fractures of the cervical spine or cervical pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

1. Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and that affects the cervical region, with or without referral to the upper back or shoulder, including ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

2. Radicular pain, with or without regional neck pain, with no or static neurologic deficit includes the diagnoses of brachialgia, cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine, including ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00. In these cases neurologic findings on

history and examination are either absent or do not show progressive deterioration.

3. Radicular pain, with or without regional neck pain, with progressive neurologic deficit, includes the same diagnoses as subd. 2., except in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness, and progressive reflex changes.

4. Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

(c) A health care provider may not order laboratory tests in the evaluation of a patient with regional neck pain, or radicular pain, except for any of the following:

1. When a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, or systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered at any time a health care provider suspects any of the conditions specified in par. (c), but a health care provider shall justify the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the cervical spine shall be based on the findings of the history and physical examination and may not be ordered prior to a health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and shall comply with the guidelines in s. DWD 81.05. A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(f) Electromyography and nerve conduction studies are always inappropriate for the regional neck pain diagnoses in par. (b) 1. to 4. Electromyography and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and myelopathy diagnoses in par. (b) 2. to 4., after the first 3 weeks of radicular or myelopathy symptoms. Repeat electromyography and nerve conduction studies for radicular pain and myelopathy are not necessary unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

(g) A health care provider may not order the use of any of the following procedures or tests for the diagnosis of any of the clinical categories in par. (b) 1. to 4.:

1. Surface electromyography or surface paraspinal electromyography.

2. Thermography.

3. Plethysmography.

4. Electronic X-ray analysis of plain radiographs.

5. Diagnostic ultrasound of the spine.

6. Somatosensory evoked potentials and motor evoked potentials.

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

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

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?
3. Are there other personality factors or disorders that are interfering with recovery?
4. Is the patient chemically dependent?
5. Are there any interpersonal conflicts interfering with recovery?
6. Does the patient have a chronic pain syndrome or psychogenic pain?
7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?
(j) All of the following are guidelines for diagnostic analgesic blocks or injection studies and include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.
1. These procedures are used to localize the source of pain prior to surgery and to diagnose conditions that fail to respond to initial nonsurgical management.
2. These blocks and injections are invasive and when done as diagnostic procedures are not necessary unless noninvasive procedures have failed to establish the diagnosis.
3. Selection of patients, choice of procedure, and localization of the level of injection shall be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.
4. These blocks and injections may also be used as therapeutic modalities and are subject to the guidelines in sub. (5)
(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine a patient's physical capacities in general or to determine and report work tolerance for a specific job, task, or work activity.
1. Functional capacity assessment or evaluation is not necessary during the period of initial nonoperative care.
2. Functional capacity assessment or evaluation is necessary in any of the following circumstances:
a. To identify the patient's permanent activity restrictions and capabilities.
b. To assess the patient's ability to do a specific job.
(L) Consultations with other health care providers may be initiated at any time by a treating health care provider consistent with accepted medical practice.
(2) GENERAL TREATMENT GUIDELINES FOR NECK PAIN.
(a) All medical care for neck pain appropriately assigned to a clinical category in sub. (1) (b) is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (14) as follows:
1. Subsection (11) governs regional neck pain.
2. Subsection (12) governs radicular pain with no or static neurologic deficits.
3. Subsection (13) governs radicular pain with progressive neurologic deficits.
4. Subsection (14) governs myelopathy.
(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan shall be appropriately modified to reflect the new clinical category. A change of clinical category shall not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury.
(c) In general, a course of treatment is divided into the following 3 phases:

1. First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit or myelopathy under sub. (1) (b) 3. and 4., shall be given initial nonsurgical care that may include both active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3), (4), (5), (8), and (10). The period of initial nonsurgical management begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonoperative care is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (14), and s. DWD 81.12 (1). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Patients with radicular pain with progressive neurological deficit or myelopathy may require immediate surgical therapy.

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

c. Surgery shall follow the guidelines in subs. (6), (11) to (14), and s. DWD 81.12 (1).

d. A decision against surgery at any particular time does not preclude a decision for surgery made at a later date.

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

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

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

(b) *Additional passive treatment modalities.* A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months to be provided if all of the following apply:

1. The patient is released to work or is permanently totally disabled and the additional passive treatment shall result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is not necessary while the patient has chronic pain syndrome.

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

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

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

3. Maximum treatment duration is 12 weeks.

(d) *Thermal treatment.* For purposes of this paragraph, "thermal treatment" includes all superficial, deep heating modalities, and cooling modalities. Superficial thermal modalities

include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave. All of the following guidelines apply to thermal treatment:

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) *Electrical muscle stimulation.* For purposes of this paragraph, "electrical muscle stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:

1. Electrical muscle stimulation given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

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

a. Time for patient education and training is one to 3 sessions.

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

(f) *Mechanical traction.* All of the following guidelines apply to mechanical traction:

1. Treatment given in a clinical setting:

a. Time for treatment response is 3 treatments.

b. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks and decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks in a clinical setting, but only if used in conjunction with other therapies.

2. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device shall be in a supervised setting in order to ensure proper patient education. All of the following guidelines apply to home use of a mechanical traction device:

a. Time for patient education and training is one session.

b. A patient may use the mechanical traction device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

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

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

2. Maximum treatment frequency is up to 3 times per week for one to 3 weeks and

decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

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

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

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

3. Maximum treatment duration is 12 weeks.

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

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

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

3. Maximum treatment duration is 12 weeks.

(j) *Bedrest.* Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest shall not be prescribed for more than 7 days.

(k) *Cervical collars, spinal braces, and other movement restricting appliances.* All of the following guidelines apply to cervical collars, spinal braces, and other movement-restricting appliances:

1. Bracing required for longer than 2 weeks shall be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability.

2. Time for treatment response is 3 days.

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

4. Maximum continuous duration is up to 3 weeks unless patient is status postfusion.

(4) ACTIVE TREATMENT MODALITIES. **(a)** Active treatment modalities shall be used as set forth in pars. (b) to (f). A health care provider's use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

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

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

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

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

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

1. 'Guidelines for supervised exercise.' One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains

experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is 3 times per week for 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks.

2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. All of the following guidelines apply to unsupervised exercise:

a. Maximum treatment frequency is up to 3 visits for instruction and monitoring.

b. There is no limit on the duration or frequency of exercise at home.

(5) THERAPEUTIC INJECTIONS. **(a)** Injection modalities are necessary as set forth in pars. (b) to (d). A health care provider's use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

(b) For purposes of this paragraph, "therapeutic injections" include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections may only be given in conjunction with active treatment modalities directed to the same anatomical site.

1. All of the following guidelines apply to trigger point injections:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections shall be redirected to other areas or discontinued. Only 3 injections per patient visit.

c. Maximum treatment is 4 injections to any one site.

2. All of the following guidelines apply to facet joint injections or facet nerve blocks:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks shall be discontinued. Only 3 injections or blocks per patient visit.

c. Maximum treatment is 3 injections or blocks to any one site.

3. All of the following guidelines apply to nerve root blocks:

a. Time for treatment response is within one week.

b. Maximum treatment frequency may permit repeat injection no sooner than 2 weeks after the previous injection if there is a positive response to the first injection. No more than 3 blocks per patient visit.

c. Maximum treatment is 2 blocks to any one site.

4. All of the following guidelines apply to epidural injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only one injection per patient visit.

c. Maximum treatment is 3 injections.

(c) For purposes of this paragraph, "lytic or sclerosing injections" include radio frequency denervation of the facet joints. These injections may only be given in conjunction with active treatment modalities directed to the same anatomical site. All of the following guidelines apply to lytic or sclerosing injections:

1. Time for treatment response is within one week.

2. Maximum treatment frequency, may repeat once for any site.

3. Maximum duration is 2 injections to any one site.

(d) Prolotherapy and botulinum toxin injections are not necessary in the treatment of neck problems.

(6) SURGERY, INCLUDING DECOMPRESSION PROCEDURES AND ARTHRODESIS.

(a) A health care provider may perform surgery only if it meets the specific guidelines of subs. (11) to (14) and s. DWD 81.12 (1).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Eight weeks following decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system.

2. Twelve weeks following arthrodesis.

(c) Repeat surgery shall also meet the guidelines of subs. (11) to (14) and s. DWD 81.12 (1).

(d) The surgical therapies in subds. 1. and 2. have very limited application and require a personality or psychosocial evaluation that indicates the patient is likely to benefit from the treatment.

1. Spinal cord stimulator may be necessary for a patient who has neuropathic pain and has had a favorable response to a trial screening period.

2. Intrathecal drug delivery system may be necessary for a patient who has somatic or neuropathic pain and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of neck pain shall be provided according to the guidelines in s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. **(a)** A health care provider may direct the use of durable medical equipment only as specified in pars. (b) to (e).

(b) Cervical collars, braces or supports, and home cervical traction devices may be necessary within the guidelines of sub. (3) (f) and (k).

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

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

1. 'Indications.' The patient is deconditioned and requires reconditioning that may be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

2. 'Requirements.' The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment is not necessary for home use for neck pain conditions:

1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER.

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

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

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

(d) The patient's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical

record or documentation of work ability involving less restrictive limitations on activity.

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to another health care provider.

(10) MEDICATION MANAGEMENT. **(a)** Prescription of controlled substance medications scheduled under ch. 450, Stats., including opioids and narcotics, are indicated primarily for the treatment of severe acute pain. These medications are not recommended in the treatment of patients with persistent regional neck pain.

(b) Patients with radicular pain may require longer periods of treatment.

(c) A health care provider shall document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL NECK PAIN. **(a)** A health care provider shall use initial nonsurgical treatment for the first phase of treatment for all patients with regional neck pain under sub. (1) (b) 1.

1. The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subs. (3), (4), (5), (8), and (10), may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition.

2. The only therapeutic injections necessary for patients with regional neck pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical treatment shall at all times contain active treatment modalities according to the guidelines of sub. (4).

4. Initial nonsurgical treatment shall be provided in the least intensive setting consistent with quality health care practices.

5. Except as otherwise provided in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not necessary beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is necessary in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is necessary.

1. Surgical evaluation if necessary may begin as soon as 8 weeks after, but shall begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique shall be chosen on the basis of the suspected etiology of the patient's condition but a health care provider shall follow the guidelines of s. DWD 81.05. Medical imaging studies that do not meet these guidelines are not necessary.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only necessary if their use is consistent with the guidelines of sub. (1) (j).

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

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks, and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

6. The only surgical procedure necessary for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation, which shall meet the guidelines in sub. (6). For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with the guidelines of sub. (6) (d).

a. If surgery is necessary, it shall be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it shall be performed as expeditiously as possible, consistent with sound medical practice.

b. If surgery is not necessary or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management.

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

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL NECK PAIN, WITH NO OR STATIC NEUROLOGIC DEFICITS. **(a)** Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional neck pain, with no or static neurologic deficits under sub. (1) (b) 2., and shall be the first phase of treatment. It shall be provided within the guidelines of sub. (11) (a), with the following modifications: Epidural blocks, nerve root, and peripheral nerve blocks are the only therapeutic injections necessary for patients with radicular pain only. If there is a component of regional neck pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be necessary.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b), with the following modifications: The only surgical procedures necessary for patients with radicular pain are decompression of a cervical nerve root which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (c) and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with static neurologic changes shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL NECK PAIN, WITH PROGRESSIVE NEUROLOGIC DEFICITS. **(a)** Patients with radicular pain, with or without regional neck pain, with progressive neurologic deficits may require immediate or emergency evaluation at any time during the course of their overall treatment. A health care provider may make the decision to proceed with surgical evaluation based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (11) (b), with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures necessary for patients with radicular pain are decompression of a cervical nerve root that shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (c), or cervical arthrodesis, with or without instrumentation. For patients with failed back surgery, spinal cord stimulators or intrathecal

drug delivery systems may be necessary consistent with the guidelines of sub. (6) (d).

(b) If a health care provider decides to proceed with a course of nonsurgical care for a patient with radicular pain with progressive neurologic changes, it shall follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with progressive neurologic changes at first presentation shall be provided under the guidelines of s. DWD 81.13.

(14) SPECIFIC TREATMENT GUIDELINES FOR MYELOPATHY. **(a)** Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. A health care provider may make the decision to proceed with surgical evaluation based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (6) (b), with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures necessary for patients with myelopathy are anterior or posterior decompression of the spinal cord, or cervical arthrodesis with or without instrumentation. For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with the guidelines of sub. (6) (d).

(b) If a health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it shall follow the guidelines of sub. (12) (a).

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

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.08 Thoracic back pain.

(1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF THORACIC BACK INJURY. **(a)** A health care provider shall determine the nature of the thoracic back condition before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination, a health care provider shall assign the patient at each visit to the appropriate clinical category in subds. 1. to 3. A health care provider shall document the diagnosis in the medical record. For the purposes of subds. 2. and 3., "radicular pain" means pain radiating in a dermatomal distribution around the chest or abdomen. This section does not apply to fractures of the thoracic spine or thoracic back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

1. Regional thoracic back pain includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and that affects the thoracic region, including ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

2. Radicular pain, with or without regional thoracic back pain, includes the diagnoses of

thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to originate with irritation of a nerve root in the thoracic spine, including ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00.

3. Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

(c) A health care provider may not order laboratory tests in the evaluation of a patient with regional thoracic back pain, or radicular pain, except for any of the following:

1. When a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered at any time a health care provider suspects any of the conditions specified in par. (c), but a health care provider shall justify the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the thoracic spine shall be based on the findings of the history and physical examination and may not be ordered prior to a health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and shall comply with the guidelines in s. DWD 81.05. A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(f) A health care provider may not order electromyography and nerve conduction studies for regional thoracic back pain and radicular pain under par. (b) 1. to 3.

(g) A health care provider may not order the use of any of the following procedures or tests for the diagnosis of any of the clinical categories in par. (b) 1. to 3.:

1. Surface electromyography or surface paraspinal electromyography.

2. Thermography.

3. Plethysmography.

4. Electronic X-ray analysis of plain radiographs.

5. Diagnostic ultrasound of the spine.

6. Somatosensory evoked potentials and motor evoked potentials.

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

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

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?

3. Are there other personality factors or disorders that are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) All of the following are guidelines for diagnostic analgesic blocks or injection studies and include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block:

1. These procedures are used to localize the source of pain prior to surgery and to diagnose conditions that fail to respond to initial nonoperative care.

2. These blocks and injections are invasive and when done as diagnostic procedures only are not necessary unless noninvasive procedures have failed to establish the diagnosis.

3. Selection of patients, choice of procedure, and localization of the level of injection may be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

4. These blocks and injections may also be used as therapeutic modalities and are subject to the guidelines in sub. (5).

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

1. A functional capacity assessment or evaluation is not necessary during the period of initial nonoperative care.

2. Functional capacity assessment or evaluation is necessary in any of the following circumstances:

a. To identify the patient's permanent activity restrictions and capabilities.

b. To assess the patient's ability to do a specific job.

(L) Consultations with other health care providers may be initiated at any time by a treating health care provider consistent with standard medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR THORACIC BACK PAIN. **(a)** All medical care for thoracic back pain, appropriately assigned to a category of sub. (1) (b) 1. to 3. is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11), (12), and (13) as follows:

1. Subsection (11) governs regional thoracic back pain.

2. Subsection (12) governs radicular pain.

3. Subsection (13) governs myelopathy.

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

(c) In general, a course of treatment is divided into the following 3 phases:

1. First, all patients with thoracic back problems, except patients with myelopathy under sub. (1) (b) 3., shall be given initial nonoperative care that may include active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3), (4), (5), (8), and (10). The period of initial nonsurgical treatment begins with the first clinical passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11), (12), (13), and s. DWD 81.12 (1). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Patients with myelopathy may require immediate surgical therapy.

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

c. Surgery shall follow the guidelines in subs. (6), (11), (12), (13), and s. DWD 81.12 (1).

d. A decision against surgery at any particular time does not preclude a decision for surgery made at a later date in light of new clinical information.

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

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

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

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

1. The patient is released to work or is permanently totally disabled and the additional passive treatment shall result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is not necessary while the patient has chronic pain syndrome.

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

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

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

3. Maximum treatment duration is 12 weeks.

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

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the

maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) *Electrical muscle stimulation.* For purposes of this paragraph "electrical muscle stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:

1. Electrical muscle stimulation given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

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

a. Maximum time for patient education and training is up to 3 sessions.

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

(f) *Mechanical traction.* All of the following guidelines apply to mechanical traction:

1. Treatment given in a clinical setting:

a. Time for treatment response is 3 treatments.

b. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks in a clinical setting but only if used in conjunction with other therapies.

2. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device shall be in a supervised setting in order to ensure proper patient education. All of the following guidelines apply to home use of a mechanical traction device:

a. Maximum time for patient education and training is one session.

b. A patient may use the mechanical traction device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

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

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

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

3. Maximum treatment duration is 12 weeks.

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

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

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

3. Maximum treatment duration is 12 weeks.

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

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

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

3. Maximum treatment duration is 12 weeks.

(j) *Bedrest.* Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest may not be prescribed for more than 7 days.

(k) *Spinal braces and other movement restricting appliances.* Spinal braces and other movement-restricting appliances required for longer than 2 weeks shall be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability. All of the following guidelines apply to spinal braces and other movement-restricting appliances:

1. Time for treatment response is 3 days.

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

3. Maximum continuous duration is 3 weeks unless patient is status postfusion.

(4) ACTIVE TREATMENT MODALITIES. **(a)** Active treatment modalities shall be used as set forth in pars. (b) to (f). A health care provider's use of active treatment modalities may extend past the 12-week limit on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

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

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

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

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

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

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

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

b. Maximum duration is 12 weeks.

2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. All of

the following guidelines apply to unsupervised exercise:

a. Maximum treatment frequency is one to 3 visits for instruction and monitoring.

b. There is no limit on the duration and frequency of exercise at home.

(5) THERAPEUTIC INJECTIONS. **(a)** Injection modalities are necessary as set forth in pars. (b) to (d). A health care provider's use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

(b) For purposes of this subsection, "therapeutic injections" include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections may only be given in conjunction with active treatment modalities directed to the same anatomical site.

1. All of the following guidelines apply to trigger point injections:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections shall be redirected to other areas or discontinued. Only 3 injections per patient visit.

c. Maximum treatment is 4 injections to any one site.

2. All of the following guidelines apply to facet joint injections and facet nerve blocks:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks shall be discontinued. Only 3 injections or blocks per patient visit.

c. Maximum treatment is 3 injections or blocks to any one site.

3. All of the following guidelines apply to nerve root blocks:

a. Time for treatment response is within one week.

b. Maximum treatment frequency may permit repeat injection 2 weeks after the previous injection if there is a positive response to the first block. Only 3 injections per patient visit.

c. Maximum treatment is 2 blocks to any one site.

4. All of the following guidelines apply to epidural injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only one injection per patient visit.

c. Maximum treatment is 3 injections.

(c) For purposes of this paragraph, "lytic or sclerosing injections" include radio frequency denervation of the facet joints. These injections may only be given in conjunction with active treatment modalities directed to the same anatomical site. All of the following guidelines apply to lytic or sclerosing injections:

1. Time for treatment response is within one week.

2. Optimum treatment frequency may repeat once for any site.

3. Maximum duration is 2 injections to any one site.

(d) Prolotherapy and botulinum toxin injections are not necessary in the treatment of thoracic back problems.

(6) SURGERY INCLUDING DECOMPRESSION PROCEDURES. **(a)** A health care provider may perform surgery only if it meets the specific guidelines of subs. (11), (12), (13), and s. DWD 81.12 (1).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Eight weeks following decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system.

2. Twelve weeks following arthrodesis.

(c) Repeat surgery shall also meet the guidelines of subs. (11), (12), (13), and s. DWD 81.12 (1).

(d) The surgical therapies in subds. 1. and 2. have very limited application and require a personality or psychosocial evaluation that indicates the patient is likely to benefit from the treatment.

1. Spinal cord stimulator may be necessary for a patient who has neuropathic pain and has had a favorable response to a trial screening period.

2. Intrathecal drug delivery system may be necessary for a patient who has somatic or neuropathic pain and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of thoracic back pain shall be provided according to the guidelines of s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. **(a)** A health care provider may direct the use of durable medical equipment only in certain specific situations as specified in pars. (b) to (e).

(b) Braces or supports may be necessary within the guidelines of sub. (3) (k).

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

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

1. 'Indications.' The patient is deconditioned and requires reconditioning that may be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

2. 'Requirements.' The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment is not necessary for home use for thoracic back pain conditions:

1. Whirlpools, Jacuzzis, hot tubs, or special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, or loungers.

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

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

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

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

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to another health care provider.

(10) MEDICATION MANAGEMENT. **(a)** Prescription of controlled substance medications under ch. 450, Stats., including opioids and narcotics, are indicated primarily for

the treatment of severe acute pain. These medications are not recommended in the treatment of patients with persistent thoracic back pain.

(b) Patients with radicular pain may require longer periods of treatment.

(c) A health care provider shall document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL THORACIC BACK PAIN. **(a)** A health care provider shall use initial nonsurgical treatment for the first phase of treatment for all patients with regional thoracic back pain under sub. (1) (b) 1.

1. The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

2. The only therapeutic injections necessary for patients with regional thoracic back pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use shall meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical management shall at all times contain active treatment modalities according to the guidelines of sub. (4).

4. Initial nonsurgical treatment shall be provided in the least intensive setting consistent with quality health care practices.

5. Except as provided in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not necessary beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and objective physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is necessary in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is necessary.

1. Surgical evaluation, if necessary, may begin as soon as 8 weeks after, but shall begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgical therapy does not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique shall be chosen on the basis of the suspected etiology of the patient's condition, but a health care provider shall follow the guidelines in s. DWD 81.05. Medical imaging studies that do not meet these guidelines are not necessary.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only necessary if their use is consistent with the guidelines of sub. (1) (j).

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

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks, and injections, if performed, and the patient's ongoing subjective complaints and objective physical findings.

6. The only surgical procedure necessary for patients with regional thoracic back pain only is thoracic arthrodesis with or without instrumentation, which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (d). For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

a. If surgery is necessary, it shall be offered to the patient as soon as possible. If the patient agrees to the proposed surgery it shall be performed as expeditiously as possible consistent with sound medical practice.

b. If surgery is not necessary or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management.

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

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN. **(a)** Initial nonsurgical treatment is appropriate for all patients with radicular pain under sub. (1) (b) 2., and shall be the first phase of treatment. It shall be provided within the guidelines of sub. (11) (a), with the following modifications: Epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections necessary for patients with radicular pain only. If there is a component of regional thoracic back pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be necessary.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b), with the following modifications: The only surgical procedures necessary for patients with radicular pain are decompression or arthrodesis. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional thoracic back pain shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR MYELOPATHY. **(a)** Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The health care provider may decide to proceed with surgical evaluation based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be within the guidelines of sub. (11) (b), with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures necessary for patients with myelopathy are decompression and arthrodesis. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

(b) If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it shall follow the guidelines of sub. (12) (a).

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

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DWD 81.09 Upper extremity disorders.

(1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF UPPER EXTREMITY DISORDERS. **(a)** A health care provider shall determine the nature of an upper extremity disorder before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical

examination. Based on the history and physical examination a health care provider shall at each visit assign the patient to the appropriate clinical category according to subds. 1. to 6. A health care provider shall document the diagnosis in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This section does not apply to upper extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, fractures, lacerations, amputations, or sprains or strains with complete tissue disruption.

1. 'Epicondylitis.' This clinical category includes medial epicondylitis and lateral epicondylitis, including ICD-9-CM codes 726.31 and 726.32.

2. 'Tendonitis of the forearm, wrist, and hand.' This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the upper extremity at or distal to the elbow due to mechanical injury or irritation, including the diagnoses of tendonitis, tenosynovitis, tendovaginitis, peritendinitis, extensor tendinitis, de Quervain's syndrome, intersection syndrome, flexor tendinitis, and trigger digit, including ICD-9-CM codes 726.4, 726.5, 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04, 727.05, and 727.2.

3. 'Nerve entrapment syndromes.' This clinical category encompasses any compression or entrapment of the radial, ulnar or median nerves, or any of their branches, including carpal tunnel syndrome, pronator syndrome, anterior interosseous syndrome, cubital tunnel syndrome, Guyon's canal syndrome, radial tunnel syndrome, posterior interosseous syndrome, and Wartenburg's syndrome, including ICD-9-CM codes 354, 354.0, 354.1, 354.2, 354.3, 354.8, and 354.9.

4. 'Muscle pain syndromes.' This clinical category encompasses any painful condition of any of the muscles of the upper extremity, including the muscles responsible for movement of the shoulder and scapula, characterized by pain and stiffness, including the diagnoses of chronic nontraumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome, myofascial pain syndrome, myofasciitis, nonspecific myalgia, fibrositis, fibromyalgia, and fibromyositis, including ICD-9-CM codes 723.3, 729.0, 729.1, 729.5, 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and 842.

5. 'Shoulder impingement syndromes, including tendonitis, bursitis, and related conditions.' This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the shoulder due to mechanical injury or irritation, including the diagnoses of impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendinitis, including ICD-9-CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, 840.6, 840.8, and 840.9.

6. 'Traumatic sprains or strains of the upper extremity.' This clinical category encompasses an instantaneous or acute injury that occurred as a result of a single precipitating event to the ligaments or the muscles of the upper extremity including ICD-9-CM codes 840 to 842.19. Injuries to muscles as a result of repetitive use, or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes under subd. 4. Injuries with complete tissue disruption are not subject to this section.

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

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

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

(e) Electromyography and nerve conduction studies are only necessary for nerve entrapment disorders and recurrent nerve entrapment after surgery.

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

1. Surface electromyography.

2. Thermography.

3. Somatosensory evoked potentials and motor evoked potentials.

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

1. Vibrometry.

2. Neurometry.

3. Semmes-Weinstein monofilament testing.

4. Algometry.

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

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

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?

3. Are there other personality factors or disorders that are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

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

1. Selection of patients, choice of procedure, and localization of the site of injection shall be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

2. These blocks and injections may also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5).

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

1. Functional capacity assessment or evaluation is not necessary during the first 12 weeks of initial nonsurgical treatment.

2. Functional capacity assessment or evaluation is necessary after the first 12 weeks of care in any of the following circumstances:
a. To identify the patient's activity restrictions and capabilities.
b. To assess the patient's ability to return to do a specific job.
3. A functional capacity evaluation is not necessary to establish baseline performance before treatment or for subsequent assessments to evaluate change during or after treatment.
4. Only one completed functional capacity evaluation is necessary per injury.
(L) Consultations with other health care providers may be initiated at any time by a treating health care provider consistent with accepted medical practice.
(2) GENERAL TREATMENT GUIDELINES FOR UPPER EXTREMITY DISORDERS. **(a)** All medical care for upper extremity disorders, appropriately assigned to a category of sub. (1) (b) 1. to 6., is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (16) as follows:
1. Subsection (11) governs epicondylitis.
2.Subsection (12) governs tendonitis of the forearm, wrist, and hand.
3.Subsection (13) governs upper extremity nerve entrapment syndromes.
4.Subsection (14) governs upper extremity muscle pain syndromes.
5.Subsection (15) governs shoulder impingement syndromes.
6. Subsection (16) governs traumatic sprains and strains of the upper extremity.
(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan shall be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.
(c) When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality shall be applied simultaneously, if possible, to all necessary areas.
(d) In general, a course of treatment shall be divided into the following 3 phases:
1. First, all patients with an upper extremity disorder shall be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subs. (3), (4), (5), (8), and (10), appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).
2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (16), and s. DWD 81.12 (2). A treating health care provider may do the evaluation or may refer the patient to another health care provider.
a. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.
b. Surgery shall follow the guidelines in subs. (6), (11) to (16), and s. DWD 81.12 (2).
c. A decision against surgery at any particular time does not preclude a decision for surgery made at a later date.

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

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

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

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

1. The patient is released to work or is permanently totally disabled and the additional passive treatment may result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is not necessary while the patient has chronic pain syndrome.

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

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

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

3. Maximum treatment duration is 12 weeks.

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

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) *Electrical muscle stimulation.* For purposes of this paragraph, "electrical muscle stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

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

a. Time for patient education and training is one to 3 sessions.

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

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

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

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

3. Maximum treatment duration is 12 weeks.

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

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

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

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

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

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

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

3. Maximum treatment duration is 12 weeks.

(i) *Splints, braces, and other movement-restricting appliances.* Bracing required for longer than 2 weeks shall be accompanied by active motion exercises to avoid stiffness and prolonged disability. All of the following guidelines apply to splints, braces, and other movement-restricting appliances:

1. Time for treatment response is 10 days.

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

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

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

(4) ACTIVE TREATMENT MODALITIES. **(a)** A health care provider shall use active treatment modalities as set forth in pars. (b) to (f). A health care provider's use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded.

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

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

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

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

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

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

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

b. Maximum duration is 12 weeks.

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

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

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

1. Time for treatment response is within 30 minutes.

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

3. Maximum treatment is 4 injections to any one site over the course of treatment.

(c) For purposes of this paragraph, "soft tissue injections" include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion. All of the following guidelines apply to soft tissue injections:

1. Time for treatment response is within one week.

2. Maximum treatment frequency is once per month to any one site if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.

3. Maximum treatment is 3 injections to any one site over the course of treatment.

(d) All of the following guidelines apply to injections for median nerve entrapment at the carpal tunnel:

1. Time for treatment response is within one week.

2. Maximum treatment frequency may permit repeat injection in one month if there is a positive response to the first injection. Only 3 injections to different sites per patient visit.

3. Maximum treatment is 2 injections to any one site over the course of treatment.

(6) SURGERY. **(a)** A health care provider may perform surgery if it meets applicable guidelines in subs. (11) to (16) and s. DWD 81.12 (2).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Sixteen weeks for rotator cuff repair, acromioclavicular ligament repair, or any surgery for a clinical category in this section that requires joint reconstruction.

2. Eight weeks for all other surgery for clinical categories in this section.

(c) Repeat surgery shall also meet the guidelines of subs. (11) to (16) and s. DWD 81.12 (2).

(7) CHRONIC MANAGEMENT. Chronic management of upper extremity disorders shall be provided according to the guidelines in s. DWD 81.13.

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

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

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

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

1. 'Indications.' The patient is deconditioned and requires reconditioning that can be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

2. 'Requirements.' The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment is not necessary for home use for the upper extremity disorders specified in subs. (11) to (16):

1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER.

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

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

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

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

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall

reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to an allied health professional directly providing the treatment but remains the ultimate responsibility of the treating health care provider.

(10) MEDICATION MANAGEMENT. **(a)** Prescription of controlled substance medications scheduled under ch. 450, Stats., including opioids and narcotics, are necessary primarily for the treatment of severe acute pain. Therefore, these medications are not generally recommended in the treatment of patients with upper extremity disorders.

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

(11) SPECIFIC TREATMENT GUIDELINES FOR EPICONDYLITIS. **(a)** A health care provider shall use initial nonsurgical management for all patients with epicondylitis and this shall be the first phase of treatment.

1. The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first week of treatment, initial nonsurgical care shall at all times include active treatment modalities under sub. (4).

2. Initial nonsurgical management shall be provided in the least intensive setting consistent with quality health care practices.

3. Except as provided in sub. (3), the use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period in excess of 12 weeks is not necessary.

4. Use of home-based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

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

1. Surgical evaluation, if necessary, shall begin no later than 12 months after beginning initial nonsurgical management.

2. Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the guidelines of sub. (1), if not already obtained during the initial evaluation. Repeat testing is not necessary unless there has been an objective change in the patient's condition that in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

3. Plain films may be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general guidelines in s. DWD 81.05 (1). Other medical imaging studies are not necessary.

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

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

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

7. If surgery is not necessary or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(c) If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's

condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management under s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR TENDINITIS OF FOREARM, WRIST, AND HAND. **(a)** Except as provided in par. (b) 3., a health care provider shall use initial nonsurgical management for all patients with tendonitis and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11) (a).

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

1. For patients with a specific diagnosis of de Quervain's syndrome, surgical evaluation and surgical therapy, if necessary, may begin after only 2 months of initial nonsurgical management.

2. For patients with a specific diagnosis of trigger finger or trigger thumb, surgical evaluation and potential surgical therapy may begin after only one month of initial nonsurgical management.

3. For patients with a locked finger or thumb, surgery may be necessary immediately without any preceding nonsurgical management.

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

(13) SPECIFIC TREATMENT GUIDELINES FOR NERVE ENTRAPMENT SYNDROMES. **(a)** A health care provider shall use initial nonsurgical management for all patients with nerve entrapment syndromes, except as specified in par. (b) 2., and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11) (a), with the following modifications: Nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression, such as abnormal two-point discrimination, motor weakness, or muscle atrophy, or for patients with symptoms of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be necessary.

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

1. Surgical evaluation may begin and surgical therapy may be provided, if necessary, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is necessary under par. (a).

2. Surgery is necessary if an electromyography confirms the diagnosis or if there has been temporary resolution of symptoms lasting at least 7 days with local injection.

3. If there is neither a confirming electromyography nor appropriate response to local injection or if surgery has been previously performed at the same site, surgery is not necessary.

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

(14) SPECIFIC TREATMENT GUIDELINES FOR MUSCLE PAIN SYNDROMES.

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

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

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

(15) SPECIFIC TREATMENT GUIDELINES FOR SHOULDER IMPINGEMENT SYNDROMES.

(a) A health care provider shall use initial nonsurgical management for all patients with shoulder impingement syndromes without clinical evidence of rotator cuff tear, and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11) (a), except for the following:

1. Continued nonsurgical management may be inappropriate, and early surgical evaluation may be necessary, for patients with any of the following:

a. Clinical findings of rotator cuff tear.

b. Acute rupture of the proximal biceps tendon.

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

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

1. Surgical evaluation shall begin no later than 6 months after beginning initial nonsurgical management.

2. Diagnostic injection, arthrography, computed tomography-arthrography, or magnetic resonance imaging scanning may be necessary as part of the surgical evaluation.

3. The only surgical procedures necessary for patients with shoulder impingement syndromes and related conditions are rotator cuff repair, acromioplasty, excision of distal clavicle, excision of bursa, removal of adhesion, or repair of proximal biceps tendon, all of which shall meet the guidelines of s. DWD 81.12 (2).

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

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

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

(b) Surgery is not necessary for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

(c) If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management

for patients with traumatic sprains and strains shall be provided under the guidelines of s. DWD 81.13.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.10 Complex regional pain syndrome of the upper and lower extremities.

(1) SCOPE.

(a) Complex regional pain syndrome of the upper and lower extremities encompasses any condition of the upper or lower extremity characterized by findings in all of the following categories:

1. One or more findings reported by the patient in 3 or more of the following categories:

a. Positive sensory abnormalities, which include spontaneous pain, mechanical hyperalgesia, thermal hyperalgesia, and deep somatic hyperalgesia.

b. Vascular abnormalities, which include vasodilation, vasoconstriction, skin temperature asymmetries, and skin color changes.

c. Swelling or sweating abnormalities.

d. Motor and trophic changes, which include motor weakness, tremor, abnormal movements, coordination deficits, nail changes, hair changes, skin atrophy, joint stiffness, and soft tissue changes.

2. One or more findings observed by the health care provider in 2 or more of the following categories:

a. Positive sensory abnormalities, which include spontaneous pain, mechanical hyperalgesia, thermal hyperalgesia, and deep somatic hyperalgesia.

b. Vascular abnormalities, which include vasodilation, vasoconstriction, skin temperature asymmetries, and skin color changes.

c. Edema or sweating abnormalities, which include swelling, hyperhidrosis, and hypohidrosis.

d. Motor and trophic changes, which include motor weakness, tremor, abnormal movements, coordination deficits, nail changes, hair changes, skin atrophy, joint stiffness, and soft tissue changes.

(b) Complex regional pain syndrome of the upper and lower extremities includes the diagnoses of complex regional pain syndrome, reflex sympathetic dystrophy, causalgia, Sudek's atrophy, algoneurodystrophy, shoulder-hand syndrome, including ICD-9-CM codes 337.9, 354.4, and 733.7.

(c) Complex regional pain syndrome occurs as a complication of another preceding injury. The treatment guidelines of this section refer to the treatment of the body part affected by the complex regional pain syndrome. The treatment for any condition not affected by complex regional pain syndrome continues to be subject to whatever treatment guidelines otherwise apply. Any treatment under this section for complex regional pain syndrome may be in addition to treatment received for the original condition.

(d) Thermography may be used in the diagnosis of complex regional pain syndrome and is considered an adjunct to physical examination.

(e) For a patient with continued clinical signs and symptoms of complex regional pain syndrome, further diagnostic testing may be appropriate.

(2) INITIAL NONSURGICAL INVOLVEMENT.

(a) A health care provider shall use initial nonsurgical management for all patients with complex regional pain syndrome and this shall be the first phase of treatment. Any course or program of initial nonsurgical management is limited to the modalities specified in pars. (b) to (i).

(b) The only therapeutic injection modalities necessary for complex regional pain syndrome are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

1. Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or sympatholytics shall be used if complex regional pain syndrome has continued for 4 weeks and the patient remains disabled as a result of the complex regional pain syndrome. All of the following guidelines apply to therapeutic injection modalities:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency permits a repeat injection at a site if there was a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.

c. Maximum treatment duration may be continued as long as injections control symptoms and facilitate objective functional gains if the period of improvement is progressively longer with each injection.

2. Epidural block may only be performed in patients who had an incomplete improvement with sympathetic block or intravenous infusion of steroids or sympatholytics.

(c) Only the passive treatment modalities set forth in pars. (d) to (g) are necessary. These passive treatment modalities in a clinical setting or requiring attendance by a health care provider are not necessary beyond 12 weeks from the first modality initiated for treatment of complex regional pain syndrome.

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

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies specified in this subsection.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without professional assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) For purposes of this paragraph, "desensitizing procedures" includes stroking or friction massage, stress loading, and contrast baths. All of the following guidelines apply to desensitizing procedures:

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

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

3. Maximum treatment duration in a clinical setting is 12 weeks. Home use of desensitizing procedures may be prescribed at any time during the course of treatment.

(f) For purposes of this paragraph, "electrical stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical stimulation treatment:

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

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

a. Time for patient education and training is one to 3 sessions.

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

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

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.
(h) Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management shall include exercise. Exercise is essential for a return to normal activity and shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall be specifically aimed at the involved musculature. Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care.
1. 'Guidelines for supervised exercise.' One goal of a supervised exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:
a. Maximum treatment frequency is up to 5 times per week for 3 weeks and shall decrease in frequency until the end of the maximum treatment duration period in subd. 1. b.
b. Maximum duration is 12 weeks.
2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting and may supplement or follow the period of supervised exercise. Maximum duration is unlimited.
(i) Oral medications may be necessary in accordance with accepted medical practice.
(3) SURGERY. **(a)** Surgical sympathectomy may only be performed on a patient who had a sustained but incomplete improvement with sympathetic blocks by injection.
(b) There shall be appropriate psychological assessment prior to implantation of a spinal cord stimulator or intrathecal drug delivery system to determine whether the patient is a suitable candidate for this type of treatment.
(4) CHRONIC MANAGEMENT. If the patient continues with symptoms and objective physical findings after surgery, or the patient refuses surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with complex regional pain syndrome shall be provided under the guidelines of s. DWD 81.13.
History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.11 Inpatient hospitalization guidelines.
(1) GENERAL PRINCIPLES.
(a) For purposes of this chapter, hospitalization is characterized as inpatient if the patient spends at least one night in a hospital, except for a patient in outpatient short stay status recovering after surgery for less than 24 hours or a patient in observation status.
(b) Unless a patient's condition requires special care, only ward or semiprivate accommodations are necessary. The admitting health care provider shall document the patient's special care needs.
(c) Admission before the day of surgery is necessary only if it is medically necessary to stabilize the patient before surgery. Admission before the day of surgery to perform any part of a preoperative work-up that could have been completed as an outpatient is not necessary.
(d) Inpatient hospitalization solely for physical therapy, bedrest, or administration of injectable drugs is necessary only if the treatment is otherwise necessary and the patient's condition makes the patient unable to perform the activities of daily life and participate in the patient's own treatment and self-care.
(e) Discharge from the hospital shall be at the earliest possible date consistent with proper health care.
(2) SPECIFIC GUIDELINES FOR HOSPITAL ADMISSION OF PATIENTS WITH LOW BACK PAIN.
(a) A health care provider shall direct hospitalization for low back pain in the circumstances in pars. (b) to (e).
(b) When the patient experiences incapacitating pain as evidenced by inability to mobilize for

activities of daily living, for example unable to ambulate to the bathroom, and, in addition, the intensity of service during admission meets any of the following:

1. Physical therapy is necessary at least twice daily for assistance with mobility. Heat, cold, ultrasound, and massage therapy alone do not meet this criterion.

2. Muscle relaxants or narcotic analgesics are necessary intramuscularly or intravenously for a minimum of 3 injections in 24 hours. Need for parenteral analgesics is determined by any of the following:

a. An inability to take oral medications or diet by mouth.

b. An inability to achieve relief with aggressive oral analgesics.

(c) For surgery that is otherwise necessary according to s. DWD 81.12 (1) and is appropriately scheduled as an inpatient procedure.

(d) For evaluation and treatment of cauda equina syndrome according to s. DWD 81.06 (13).

(e) For evaluation and treatment of foot drop or progressive neurologic deficit according to s. DWD 81.06 (13).

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.12 Guidelines for surgical procedures.

(1) SPINAL SURGERY.

(a) *General.* In addition to this section, initial nonsurgical, surgical and chronic management guidelines are also in s. DWD 81.06, relating to low back pain; s. DWD 81.07, relating to neck pain; and s. DWD 81.08, relating to thoracic back pain.

(b) *Surgical decompression of lumbar nerve root or roots.* Surgical decompression of a lumbar nerve root or roots includes all of the following lumbar procedures: laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. The procedure at each nerve root is subject independently to the requirements of subds. 1. and 2.

1. A health care provider may perform surgical decompression of a lumbar nerve root for any of the following diagnoses:

a. Intractable and incapacitating regional low back pain with positive nerve root tension signs and an imaging study showing displacement of lumbar intervertebral disc that impinges significantly on a nerve root or the thecal sac, ICD-9-CM code 722.10.

b. Sciatica, ICD-9-CM code 724.3.

c. Lumbosacral radiculopathy or radiculitis, ICD-9-CM code 724.4.

2. Any of the following conditions in this subdivision and any of the conditions in subd. 3. shall be satisfied to indicate that the surgery is reasonably required. For the response to nonsurgical care, the patient's condition includes one of the following:

a. Failure to improve with a minimum of 8 weeks of initial nonsurgical care.

b. Cauda equina syndrome, ICD-9-CM code 344.6, 344.60, or 344.61.

c. Progressive neurological deficits.

3. The patient exhibits one of the clinical findings of subd. 3. a. in combination with the test results of subd. 3. b. or, in the case of diagnosis in subd. 1. a., a decompression of the lumbar nerve root is the appropriate treatment for the patient's condition.

a. Subjective sensory symptoms in a dermatomal distribution that may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, including foot drop or quadriceps weakness, reflex changes, or positive electromyography.

b. Medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(c) *Surgical decompression of a cervical nerve root.* Surgical decompression of a cervical nerve root or roots includes all of the following cervical procedures: laminectomy, laminotomy, discectomy, foraminotomy with, or without, fusion. For decompression of multiple nerve roots, the procedure at each nerve root is subject to the guidelines of subds. 1. and 2.

1. A health care provider may perform surgical decompression of a cervical nerve root for any of the following diagnoses:

a. Displacement of cervical intervertebral disc, ICD-9-CM code 722.0, excluding fracture.

b. Cervical radiculopathy or radiculitis, ICD-9-CM code 723.4, excluding fracture.

2. Any of the requirements in this subdivision and any of the requirements in subd. 3. shall be satisfied to indicate that surgery is reasonably required. For the response to nonsurgical care, the patient's condition includes any of the following:

a. Failure to improve with a minimum of 8 weeks of initial nonsurgical care.

b. Cervical compressive myelopathy.

c. Progressive neurologic deficits.

3. The patient exhibits one of the clinical findings of subd. 3. a. in combination with the test results of subd. 3. b.

a. Subjective sensory symptoms in a dermatomal distribution that may include radiating pain, burning, numbness, tingling or paresthesia, or objective clinical findings of nerve root specific motor deficit, reflex changes, or positive electromyography.

b. Medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(d) *Lumbar arthrodesis with or without instrumentation.* A health care provider may perform surgery for a lumbar arthrodesis when any of the following diagnoses are present to indicate that the surgery is reasonably required:

1. Unstable lumbar vertebral fracture, ICD-9-CM codes 805.4, 805.5, 806.4, and 806.5.

2. For a second or third surgery only, documented reextrusion or redisplacement of lumbar intervertebral disc, ICD-9-CM code 722.10, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain, ICD-9-CM code 724.4. Documentation under this subdivision shall include a magnetic resonance imaging scan or computed tomography scan or a myelogram.

3. Traumatic spinal deformity including a history of compression or wedge fracture or fractures, ICD-9-CM code 733.1, and demonstrated acquired kyphosis or scoliosis, ICD-9-CM codes 737.1, 737.10, 737.30, 737.41, and 737.43.

4. Incapacitating low back pain, ICD-9-CM code 724.2, for longer than 3 months, and any of the following conditions involving lumbar segments L-3 and below is present:

a. For the first surgery only, degenerative disc disease, ICD-9-CM code 722.4, 722.5, 722.6, or 722.7, with postoperative documentation of instability created or found at the time of surgery, or positive discogram at one or 2 levels.

b. Pseudoarthrosis, ICD-9-CM code 733.82.

c. For the second or third surgery only, previously operated disc.

d. Spondylolisthesis.

5. A health care provider may not perform a lumbar arthrodesis as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.

(2) UPPER EXTREMITY SURGERY.

(a) *General.* Initial nonsurgical, surgical, and chronic management guidelines for upper extremity disorders are set forth in s. DWD 81.09 (1) to (16).

(b) Rotator cuff repair. A health care provider may perform rotator cuff surgery for any of the following diagnoses:

1. Rotator cuff syndrome of the shoulder, ICD-9-CM code 726.1, and allied disorders, including unspecified disorders of shoulder bursae and tendons, ICD-9-CM code 726.10; calcifying tendinitis of shoulder, ICD-9-CM code 726.11; bicipital tenosynovitis, ICD-9-CM code 726.12; and other specified disorders, ICD-9-CM code 726.19.

2. Tear of rotator cuff, ICD-9-CM code 727.61.

(c) *Criteria and indications for rotator cuff repair.* In addition to one of the diagnoses in par. (b), both of the following conditions shall be satisfied to indicate that surgery for rotator cuff repair is necessary:

1. The patient's condition failed to improve in response to nonsurgical care with adequate initial nonsurgical treatment.

2. The patient's clinical findings exhibit any of the following:

a. Severe shoulder pain and inability to elevate the shoulder.

b. Weak or absent abduction and tenderness over rotator cuff or pain relief obtained with an

injection of anesthetic for diagnostic or therapeutic trial.

c. Positive findings in arthrogram, magnetic resonance imaging scan, or ultrasound, or positive findings on previous arthroscopy, if performed.

(d) *Acromioplasty diagnosis.* A health care provider may perform acromioplasty for the diagnosis of acromial impingement syndrome, ICD-9-CM codes 726.0 to 726.2. In addition to the diagnosis in this paragraph, both of the following conditions shall be satisfied to indicate that surgery is necessary:

1. The patient's condition has failed to improve in response to nonsurgical care after adequate initial nonsurgical care.

2. The patient's clinical findings exhibit pain with active elevation from 90 to 130 degrees, pain at night, and a positive impingement test.

(e) *Repair of acromioclavicular or costoclavicular ligaments.* A health care provider may perform surgical repair of acromioclavicular or costoclavicular ligaments for the diagnosis of acromioclavicular separation, ICD-9-CM codes 831.04 to 831.14.

1. In addition to the diagnosis in this paragraph, the guidelines in subds. 2. and 3. shall be satisfied for repair of acromioclavicular or costoclavicular ligaments.

2. The patient's condition or response to nonsurgical care includes any of the following:

a. Failure to improve after at least a one-week trial period in a support brace.

b. Separation cannot be reduced and held in a brace.

c. Grade III separation has occurred.

3. The patient's clinical findings exhibit localized pain at the acromioclavicular joint and prominent distal clavicle and radiographic evidence of separation at the acromioclavicular joint.

(f) *Excision of distal clavicle diagnosis.* A health care provider may perform excision of the distal clavicle for any of the following diagnoses specified in subd. 1. to 3.:

1. Acromioclavicular separation, ICD-9-CM codes 831.01 to 831.14.

2. Osteoarthrosis of the acromioclavicular joint, ICD-9-CM codes 715.11, 715.21, and 715.31.

3. Shoulder impingement syndrome.

(g) *Criteria and indications for excision of distal clavicle.* In addition to one of the diagnosis in par. (f), all of the following conditions shall be satisfied for excision of distal clavicle:

1. The patient's condition failed to improve in response to nonsurgical care with adequate initial nonsurgical care.

2. The patient's clinical findings exhibit any of the following:

a. Pain at the acromioclavicular joint, with aggravation of pain with motion of shoulder or carrying weight.

b. Confirmation that separation of the acromioclavicular joint is unresolved and prominent distal clavicle, or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial.

c. Separation at the acromioclavicular joint with weight-bearing films or severe degenerative joint disease at the acromioclavicular joint noted on X-rays.

(h) *Repair of shoulder dislocation or subluxation, any procedure.*

1. A health care provider may perform surgical repair of a shoulder dislocation for any of the following diagnoses:

a. Recurrent dislocations, ICD-9-CM code 718.31.

b. Recurrent subluxations.

c. Persistent instability following traumatic dislocation.

2. In addition to one of the diagnoses in this paragraph, all of the following clinical findings shall exist for repair of a shoulder dislocation:

a. The patient exhibits a history of multiple dislocations or subluxations that inhibit activities of daily living.

b. X-ray findings are consistent with multiple dislocations or subluxations.

(i) *Repair of proximal biceps tendon.* **1.** A health care provider may perform surgical repair of a proximal biceps tendon for the diagnosis of proximal rupture of the biceps, ICD-9-CM code 727.62 or 840.8.

2. In addition to the diagnosis in subd. 1., both of the following conditions shall be satisfied for repair of proximal biceps tendon:

a. The procedure may be done alone or in conjunction with another necessary repair of the rotator cuff.

b. The patient's clinical findings exhibit pain that does not resolve with attempt to use arm and palpation of "bulge" in upper aspect of arm.

(j) *Epicondylitis.* Specific guidelines for surgery for epicondylitis are included in s. DWD 81.09 (11).

(k) *Tendinitis.* Specific guidelines for surgery for tendinitis are included in s. DWD 81.09 (12).

(L) *Nerve entrapment syndromes.* Specific guidelines for nerve entrapment syndromes are included in s. DWD 81.09 (13).

(m) *Muscle pain syndromes.* Surgery is not necessary for muscle pain syndromes.

(n) *Traumatic sprains and strains.* Surgery is not necessary for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

(3) LOWER EXTREMITY SURGERY.

(a) *Anterior cruciate ligament reconstruction.*

1. A health care provider may perform surgical repair of the anterior cruciate ligament, including arthroscopic repair, for any of the following diagnoses:

a. Old disruption of anterior cruciate ligament, ICD-9-CM code 717.83.

b. Sprain of cruciate ligament of knee, ICD-9-CM code 844.2.

2. In addition to one of the diagnoses in this paragraph, all of the conditions in subd. 2. a. to c. shall be satisfied for anterior cruciate ligament reconstruction. Pain alone is not an indication.

a. The patient gives a history of instability of the knee described as "buckling or giving way" with significant effusion at time of injury, or description of injury indicates a rotary twisting or hyperextension occurred.

b. There are objective clinical findings of positive Lachman's sign, positive pivot shift, or positive anterior drawer.

c. There are positive diagnostic findings with arthrogram, magnetic resonance imaging scan, or arthroscopy, and there is no evidence of severe compartmental arthritis.

(b) *Patellar tendon realignment.* **1.** A health care provider may perform patellar tendon realignment for the diagnosis of dislocation of patellar, open, ICD-9-CM code 836.3; or closed, ICD-9-CM code 836.4; or chronic residuals of dislocation.

2. In addition to the diagnosis in this paragraph, all of the following conditions shall be satisfied for a patellar tendon realignment:

a. The patient gives a history of rest pain as well as pain with patellofemoral movement, and recurrent effusion, or recurrent dislocation.

b. There are objective clinical findings of patellar apprehension, synovitis, lateral tracking, or Q angle greater than 15 degrees.

(c) *Knee joint replacement.* **1.** A health care provider may perform a knee joint replacement for degeneration of articular cartilage or meniscus of knee, ICD-9-CM codes 717.1 to 717.4.

2. In addition to the diagnosis in this paragraph, all of the following conditions shall be satisfied for a knee joint replacement:

a. The patient exhibits limited range of motion, night pain in the joint, or pain with weight-bearing, and no significant relief of pain with an adequate course of initial nonsurgical care.

b. The patient's diagnostic findings confirm there is significant loss or erosion of cartilage to the bone, and positive findings of advanced arthritis, and joint destruction with standing films, magnetic resonance imaging scan, or arthroscopy.

(d) *Fusion; ankle, tarsal, metatarsal.* **1.** A health care provider may perform an ankle, tarsal, or metatarsal fusion for either of the following diagnoses:

a. Malunion or nonunion of fracture of ankle, tarsal, or metatarsal, ICD-9-CM code 733.81 or 733.82.

b. Traumatic arthritis, arthropathy, ICD-9-CM code 716.17.

2. In addition to one of the diagnoses in this paragraph, the following conditions shall be satisfied for an ankle, tarsal, or metatarsal fusion. For initial nonsurgical care the patient shall have failed to improve with an adequate course of initial nonsurgical care that included any of the following:

a. Immobilization, which may include casting, bracing, shoe modification, or other orthotics.

b. Anti-inflammatory medications.

3. The patient's clinical findings exhibit both of the following and subd. 4.:

a. The patient gives a history of pain which is aggravated by activity and weight-bearing, and relieved by xylocaine injection.
b. There are objective findings on physical examination of malalignment or specific joint line tenderness, and decreased range of motion.
4. The patient's diagnostic findings include medical imaging studies confirming the presence of any of the following:
a. Loss of articular cartilage and joint space narrowing.
b. Bone deformity with hypertrophic spurring and sclerosis.
c. Nonunion or malunion of a fracture.
(e) *Lateral ligament ankle reconstruction.* **1.** A health care provider may perform ankle reconstruction surgery involving the lateral ligaments for any of the following diagnoses:
a. Chronic ankle instability, ICD-9-CM code 718.87.
b. Grade III sprain, ICD-9-CM codes 845.0 to 845.09.
2. In addition to one of the diagnoses in subd. 1., all of the clinical findings in subd. 3. shall be satisfied for a lateral ligament ankle reconstruction. For initial nonsurgical care, the patient shall have received an adequate course of initial nonsurgical care, including one of the following:
a. Immobilization with support, cast, or ankle brace.
b. A physical rehabilitation program that follows immobilization with support, cast, or ankle brace.
3. The patient's clinical findings shall include all of the following:
a. The patient gives a history of ankle instability and swelling.
b. There is a positive anterior drawer sign on examination.
c. There are positive stress X-rays identifying motion at ankle or subtalar joint with at least a 15 degree lateral opening at the ankle joint, or demonstrable subtalar movement, and negative to minimal arthritic joint changes on X-ray, or ligamentous injury is shown on magnetic resonance imaging scan.
4. Prosthetic ligaments are not necessary for the treatment of lateral ligament ankle reconstruction.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.13 Chronic management.
(1) SCOPE. This section applies to chronic management of all types of physical injuries, even if the injury is not specifically governed by this chapter. If a patient continues with symptoms and physical findings after all appropriate initial nonsurgical and surgical treatment has been rendered, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. The purpose of chronic management is twofold: the patient should be made independent of health care providers in the ongoing care of a chronic condition; and the patient shall be returned to the highest functional status reasonably possible.
(a) Personality or psychological evaluation may be necessary for patients who are candidates for chronic management. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, a health care provider performing the evaluation shall consider all of the following:
1. Is symptom magnification occurring?
2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?
3. Are there other personality factors or disorders that are interfering with recovery?
4. Is the patient chemically dependent?
5. Are there any interpersonal conflicts interfering with recovery?
6. Does the patient have a chronic pain syndrome or psychogenic pain?
7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?
(b) Any of the chronic management modalities of sub. (2) may be used singly or in combination as part of a program of chronic management.

(c) No further passive treatment modalities or therapeutic injections are necessary, except as otherwise provided in ss. DWD 81.06 (3) (b), 81.07 (3) (b), 81.08 (3) (b), and 81.09 (3) (b).

(d) No further diagnostic evaluation is necessary unless there is the development of symptoms or physical findings that would in themselves warrant diagnostic evaluation.

(e) A program of chronic management shall include appropriate means by which use of scheduled medications can be discontinued or severely limited.

(2) CHRONIC MANAGEMENT MODALITIES. **(a)** *Home-based exercise programs.* Home-based exercise programs consist of aerobic conditioning, stretching, and flexibility exercises, and strengthening exercises done by the patient on a regular basis at home without the need for supervision or attendance by a health care provider. Maximum effectiveness may require the use of certain durable medical equipment that may be prescribed within any applicable treatment guidelines in ss. DWD 81.06 to 81.10.

1. 'Indications.' Exercise is necessary on a long-term basis to maintain function.

2. 'Guidelines.' The patient shall receive specific instruction and training in the exercise program. Repetitions, durations, and frequencies of exercises shall be specified.

3. 'Treatment.' Treatment period is one to 3 visits for instruction and monitoring.

(b) *Health clubs.* **1.** 'Indications.' The patient is deconditioned and requires a structured environment to perform prescribed exercises. A health care provider shall document the reasons why reconditioning may not be accomplished with a home-based program of exercise.

2. 'Guidelines.' The program shall have specific prescribed exercises stated in objective terms, for example "30 minutes riding stationary bicycle three times per week." There shall be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There shall be a prescribed frequency of attendance and the patient shall maintain adequate documentation of attendance. There shall be a prescribed duration of attendance.

3. 'Treatment.' Treatment period is 13 weeks. Additional periods of treatment at a health club are not necessary unless there is documentation of attendance and progression in activities during the preceding period of treatment. If the employer has an appropriate exercise facility on its premises the insurer may mandate use of that facility instead of providing a health club membership.

(c) *Computerized exercise programs.* Computerized exercise programs utilize computer-controlled exercise equipment that allows for the isolation of specific muscle groups and the performance of graded exercise designed to increase strength, tone, flexibility, and range of motion. In combination with computerized range of motion or strength measuring tests, these programs allow for quantitative measurement of effort and progress.

1. 'Indications.' The patient is deconditioned and requires a structured environment to accomplish rehabilitation goals. A health care provider shall document the reasons why reconditioning may not be accomplished with a home-based program of exercise.

2. 'Guidelines.' The program shall have specific goals stated in objective terms, for example "improve strength of back extensors 50%." There shall be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals may be achieved in the prescribed time. There shall be a prescribed frequency and duration of attendance.

3. 'Treatment.' Treatment period is 6 weeks. Additional periods of treatment are not necessary unless there is documentation of attendance and progression in activities during the preceding period of treatment.

(d) *Work conditioning and work hardening programs.* Work conditioning and work hardening programs are intensive, highly structured, job oriented, individualized treatment plans based on an assessment of the patient's work setting or job demands, and designed to maximize the patient's return to work. These programs shall include real or simulated work activities. Work conditioning is designed to restore an individual's neuromusculoskeletal strength, endurance, movement, flexibility, motor control, and cardiopulmonary function.

Work conditioning uses physical conditioning and functional activities related to the individual's work. Services may be provided by one discipline of health care provider. Work hardening is designed to restore an individual's physical, behavioral, and vocational functions within an interdisciplinary model. Work hardening addresses the issues of productivity, safety, physical tolerances, and work behaviors. An interdisciplinary team includes professionals qualified to evaluate and treat behavioral, vocational, physical, and functional needs of the individual.

1. 'Indications.' The patient is disabled from usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. A health care provider shall document the reasons why work hardening cannot be accomplished through a structured return to work program. Work conditioning is necessary when only physical and functional needs are identified. Work hardening is necessary when, in addition to physical and functional needs, behavioral, and vocational needs are also identified that are not otherwise being addressed.

2. 'Guidelines.' The program shall have specific goals stated in terms of work activities, for example "able to type for 30 minutes." There shall be an individualized program of activities and the activities shall be chosen to simulate required work activities or to enable the patient to participate in simulated work activities. There shall be a specific timetable of progression in those activities, designed so that the goals may be achieved in the prescribed time. There shall be a set frequency and hours of attendance and the program shall maintain adequate documentation of attendance. There shall be a set duration of attendance. Activity restrictions shall be identified at completion of the program.

3. 'Treatment.' The treatment period for a work conditioning or work hardening program is 6 weeks. Additional periods of treatment are not necessary unless there is documentation of attendance and progression in activities during the preceding period of treatment or unless there has been a change in the patient's targeted return to work job that necessitates a redesign of the program.

(e) *Chronic pain management programs.* A chronic pain management program consists of a multidisciplinary team who provides coordinated, goal-oriented services to reduce pain, disability, improve functional status, promote return to work, and decrease dependence on the health system of persons with chronic pain syndrome. A pain management program shall provide physical rehabilitation, education on pain, relaxation training, psychosocial counseling, medical evaluation, and, if necessary, chemical dependency evaluation. The program of treatment shall be individualized and based on an organized evaluative process for screening and selecting patients. Treatment may be provided in an inpatient setting, outpatient setting, or both as appropriate.

1. 'Indications.' The patient is diagnosed as having a chronic pain syndrome.

2. 'Guidelines.' An admission evaluation shall be performed by a health care provider. The evaluation shall confirm the diagnosis of chronic pain syndrome and a willingness and ability of the patient to benefit from a pain management program. There shall be a specific set of prescribed activities and treatments and a specific timetable of progression in those activities. There shall be a set frequency and hours of attendance and the program shall maintain adequate documentation of attendance. There shall be a set duration of attendance.

3. 'Treatment.' Treatment period is for initial treatment, a maximum of 20 eight-hour days, though fewer or shorter days may be used, and a maximum duration of 4 weeks no matter how many or how long the days prescribed. For aftercare, a maximum of 12 sessions is allowed. Only one completed pain management program is necessary for an injury.

(f) *Individual or group psychological or psychiatric counseling.*

1. 'Indications.' A personality or psychosocial evaluation has revealed one or more of the problems listed in sub. (1) (a) that interfere with recovery from the physical injury, but the patient does not need or is not a candidate for a pain management program.

2. 'Guidelines.' There shall be a specific set of goals based on the initial personality or psychosocial evaluation and a timetable for

achieving those goals within the prescribed number of treatment or therapy sessions. There shall be a prescribed frequency of attendance and a treating health care provider shall maintain adequate documentation of attendance. There shall be a prescribed duration of treatment.

3. 'Treatment.' Treatment period is a maximum of 12 sessions. Only one completed program of individual or group psychological or psychiatric counseling is necessary for an injury.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.14 Health care provider advisory committee. (1) The department shall establish a health care services provider committee to advise the department and the council on worker's compensation on modification of the treatment standards under this chapter. The administrator of the worker's compensation division shall serve as chairperson. The committee shall consist of 14 members, including 6 medical doctors of different specialties, 2 chiropractors, 2 hospital representatives, one registered nurse, one physical therapist, and 2 at-large members, all of whom are licensed in and practicing in Wisconsin and provide treatment under s. 102.42, Stats. The appointments to the committee shall be made from a consensus list of 24 names submitted by the Wisconsin Medical Society, Wisconsin Chiropractic Association, and the Wisconsin Hospital Association, except for the 2 at-large members, who shall be selected by the department.

(2) In modifying this chapter, the committee shall consider the following:

(a) Clarifying the description of the guidelines under this chapter.

(b) Updating the guidelines at least every 4 years to include new modalities of treatment, procedures, and treatment options for classes of injuries included in the guidelines.

(c) Expanding the guidelines to cover new types and classes of injuries.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

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Chapter HA 4, Procedure and Practice for Worker's Compensation and Related Cases

HA 4.01	Application of rules.
HA 4.02	Definitions.
HA 4.03	Application of department rules.
HA 4.04	Procedure on claim.
HA 4.05	Appearance by attorney or agent.
HA 4.06	Service and filing.
HA 4.07	Amendments.
HA 4.08	Witness attendance; extension of time and postponement.
HA 4.09	Stipulations.
HA 4.10	Depositions.
HA 4.11	Rules of practice; selection of hearing site.
HA 4.12	Audio recording of formal hearings.
HA 4.13	Transcripts.
HA 4.14	Reports by practitioners and expert witnesses.
HA 4.15	Use of reports as evidence.
HA 4.16	Procedure and claims under ch. 40, Stats.
HA 4.17	Witness fees and travel reimbursement.
HA 4.18	Mediation conferences.

Note: Chapter HA 4 (title) was created and ss. HA 4.04, 4.07, 4.08, 4.10, 4.11, 4.12, 4.13, 4.15, 4.16, and 4.17 were renumbered from ss. DWD 80.05, 80.08, 80.09, 80.11, 80.12, 80.13, 80.14, 80.22, 80.31, and 80.44 by the legislative reference bureau under s. 13.92 (4) (b) 1. and 2. and pursuant to 2015 Wisconsin Act 55, section 9151 (2) (g) in Register May 2018 No. 749.

HA 4.01 Application of rules. (1) AUTHORITY. This chapter is promulgated under the authority of ss. 15.03, 102.15, 102.17 (1) (d) 3., and 227.11 (2) (b), Stats.

(2) SCOPE AND APPLICATION. This chapter applies to the procedure of the division with respect to worker's compensation hearings under ch. 102, Stats., and to hearings under ss. 40.65 (2), 59.88 (3), 62.624 (2), 106.25, 303.07 (7), and 303.21, Stats., and s. 66.191, 1981 Stats.

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19.

HA 4.02 Definitions. In this chapter:

(1) "Administrative law judge" means a hearing examiner employed by the office of worker's compensation hearings to conduct hearings under s. 102.18 (2) (b) and (c), Stats.

(2) "Applicant" means a party filing an application for relief.

(3) "Department" means the department of workforce development.

(4) "Division" means the division of hearings and appeals.

(5) "Office of worker's compensation hearings" is one of several subunits authorized by the division administrator and is the subunit that administers adjudicatory functions related to worker's compensation claims.

(6) "Respondent" means a party adverse to an application for relief.

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19; correction in (1) made under s. 13.92 (4) (b) 7., Stats., Register July 2019 No. 763.

HA 4.03 Application of department rules. (1) Section DWD 80.025 applies to the procedure for inspection and copying of worker's compensation records in the custody of the division.

(2) (a) Except as provided in par. (b), the provisions of s. DWD 80.03 apply with respect to the division when the division acts on a compromise under s. l02.16 (1) (c), Stats., to the same extent those provisions apply to the department when acting on a compromise under s. 102.16 (1) (b), Stats.

(b) All written compromise agreements submitted to the division shall contain the following statement:

The employee has the right to petition the department of administration, division of hearings and appeals to set aside or modify this compromise agreement within one year of its approval by the division. The division may set aside or modify the compromise agreement. The right to request the division to set aside or modify the compromise agreement does not guarantee that the compromise will in fact be reopened.

(3) Substantive rules of the department that implement, interpret, or make specific legislation enforced or administered by the department within the meaning of s. 227.01 (13), Stats., have the force and effect of law in proceedings before the division under this chapter.

Note: Substantive rules of the department dealing with worker's compensation have the force and effect of law in worker's compensation and related proceedings before the division. These include, without limitation, the factors listed in s. DWD 80.34 in determining loss of earning capacity, the factors listed in s. DWD 80.39 in determining whether to order full or partial payment of unaccrued compensation to an employee or his or her dependents under s. 102.32 (6m), Stats., the provisions of s. DWD 80.43 in determining the amount of attorney fees and costs under s. 102.26 (3), Stats., and the factors set out in s. DWD 80.49 (9) (b) in determining whether an offer of employment is suitable under s. DWD 80.49 (8) (c) and (9) (b).

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19.

HA 4.04 Procedure on claim. (1) In cases of disputes in matters coming under the jurisdiction of ch. 102, Stats., or s. 40.65, 59.88 (3), 62.624 (2), 106.25, 303.07 (7), or 303.21, Stats., and s. 66.191, 1981 Stats., any party to the dispute may apply to the department for relief.

(2) In all such cases under sub. (1), the applicant shall file his or her application with the department, along with sufficient copies of the application for service on the respondents. The department shall thereupon serve the respondents with a copy of the application and the respondents shall file an answer to the application with the division within 20 days after the service and likewise serve a copy of the answer on the applicant. If no answer is mailed by the respondent within 20 days of service of the application by the department, the division may issue an order by default, without hearing, in accordance with the application, as provided by s. 102.18 (1) (a), Stats.

Note: See s. 102.17, Stats.

(3) After an application for hearing is served, the division shall manage its caseload by appropriate action including any of the following:

(a) Determining whether any answer received is complete, identifies the correct date of injury, and identifies the correct parties for that date of injury.

(b) Filing documents or other material received or issued in connection with the claim.

(c) Controlling its calendar and scheduling matters for hearing.

(d) Notifying the parties of the time and place of hearing, at least 10 days prior to the hearing.

(e) Conducting hearings and making findings, orders, and awards that are lawful and just under the circumstances.

(4) After an application for hearing is served, the division, when appropriate, may take other action to manage its caseload, including any of the following:

(a) In cases of vision loss and hearing loss, obtaining a computation of permanent disability indemnity.

(b) Impleading other employers or insurance carriers.

(c) Securing the participation of the uninsured employers fund or the work injury supplemental benefit fund.

(d) Dismissing parties improperly served with the application.

(e) Dismissing the application if defective or upon request of a party.

(f) Scheduling and conducting prehearing conferences.

(g) Adjourning or postponing prehearing conferences and hearings scheduled under par. (f) and sub. (3) (c).

(h) Within 21 days of issuance, setting aside, reversing, or modifying findings, orders or awards as provided in s. 102.18 (3), Stats.

(5) For injuries for which an employer is required to give notice under s. DWD 80.02 (1) (a), a self−insured employer or insurance company shall, when submitting a stipulation or compromise to the division, and at the time of hearing, submit a current form WKC–13 indicating all worker's compensation payments to date and the periods of time for which these payments were made. This subsection does not apply if the information has been submitted via electronic, magnetic or other reporting media under s. DWD 80.02 (3m).

History: 1−2−56; am., Register, April, 1975, No. 232, eff. 5−1−75; am. Register, September, 1982, No. 321, eff. 10−1−82; am. (1), Register, September, 1986, No. 369, eff. 10−1−86; CR 02−094: am. (1) Register November 2002 No. 563, eff. 12−1−02; renumbered from DWD 80.05 under s. 13.92 (4) (b) 1., correction under s. 13.92 (4) (b) 6., Stats., Register May 2018 No. 749; **CR 18−059: am. (1), (2), cr. (3), (4), (5) Register July 2019 No. 763, eff. 8−1−19, correction in (1) made under s. 35.17., Stats., Register July 2019 No. 763.**

HA 4.05 Appearance by attorney or agent. Any party may appear before the division in person or by an attorney or agent.

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19.

HA 4.06 Service and filing. (1) SERVICE. Service of materials, unless otherwise directed by the division or by law, may be made by mail and proof of mailing shall be prima facie proof of service. The time within which service shall be made shall be the same as in courts of record unless otherwise specified by rule or order of the division.

(2) FILING DATE. Regardless of how served, materials submitted to the division are considered filed on the date they are received by the division.

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19.

HA 4.07 Amendments. Amendment may be made to the application or answer by letter mailed to the division prior to the date the notice of hearing is mailed. Copies of the letter shall be sent directly to the other parties. The letter shall state reasons for the amendment.

History: 1−2−56; am. Register, April, 1975, No. 232, eff. 5−1−75; r. and recr. Register, September, 1982, No. 321, eff. 10−1−82.; renumbered from DWD 80.08 (1) under s. 13.92 (4) (b) 1., correction under s. 13.92 (4) (b) 6., Stats., Register May 2018 No. 749; **CR 18−059: am. Register July 2019 No. 763, eff. 8−1−19**.

HA 4.08 Witness attendance; extension of time and postponement. (1) Upon receipt of the notice of hearing, it is the responsibility of each party to contact any witnesses necessary for that party's case and to make arrangements to have them attend the hearing.

(2) Requests for postponements or continuances shall be considered by the division only if such requests are received within a reasonable time before the date of the hearing.

(3) The division shall grant postponements and continuances only because of extraordinary circumstances. Neither the scheduling problems nor the convenience of the parties shall be considered extraordinary circumstances.

(4) A postponement, continuance, or extension of time may not be granted upon the mutual agreement of the parties without the consent of the division.

History: 1−2−56; am. Register, April, 1975, No. 232, eff. 5−1−75; r. and recr. Register, September, 1982, No. 321, eff. 10−1−82; renumbered from DWD 80.09 under s. 13.92 (4) (b) 1., correction in (2), (3), (4) under s. 13.92 (4) (b) 6., Stats., Register May 2018 No. 749; **CR 18−059: am. (2), (3), (4) Register July 2019 No. 763, eff. 8−1−19**.

HA 4.09 Stipulations. Parties to a controversy may stipulate the facts in writing, and the division may make its order or award upon the written stipulation. Stipulations must set forth in detail the manner of computing the compensation due and must be accompanied by a report from a physician stating the extent of the disability.

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19.

HA 4.10 Depositions. Depositions may be taken and used in any hearing only in accordance with s. 102.17 (1) (f), Stats. These depositions shall be taken in the same manner as in courts of record. Depositions for the purpose of discovery before the hearing are specifically prohibited.

History: 1−2−56; am. Register, April, 1975, No. 232, eff. 5−1−75; am. Register, September, 1982, No. 321, eff. 10−1−82; renumbered from DWD 80.11 under s. 13.92 (4) (b) 1., Register May 2018 No. 749.

HA 4.11 Rules of practice; selection of hearing site. (1) (a) The rules of practice before the division shall be such as to secure the facts in as direct and simple a manner as possible.

(b) The administrative law judge may limit testimony to only those matters which are disputed.

(c) The administrative law judge may not allow into the record, either on direct or cross–examination, redundant, irrelevant or repetitive testimony. Hearsay testimony with probative value may be admitted at the discretion of the administrative law judge.

(2) The division may select places for a hearing after considering the geographical location and volume of claims in an area. A list of sites will be furnished upon request to interested parties by the division. From this list, a hearing site shall be selected at the discretion of the division. The division, in determining the site of the hearing, shall consider all of the following:

(a) The applicant's location choice.

(b) The location of the office of the treating practitioner or practitioner appointed under s. 102.13 (3) or 102.17, Stats.

(c) The location where the injury occurred.

History: Cr. Register, August, 1976, No. 248, eff. 9−1−76; r. and recr. Register, September, 1982, No. 321, eff. 10−1−82; renumbered from DWD 80.12 under s. 13.92 (4) (b) 1., correction in (1) (intro.), (2) (intro.), (b) under s. 13.92 (4) (b) 6., Stats., correction in (2) (b) under s. 35.17, Stats., Register May 2018 No. 749; **CR 18−059: am. (1) (a), (b), (c), (2) (intro.), (a), (b) Register July 2019 No. 763, eff. 8−1−19**.

HA 4.12 Audio recording of formal hearings. (1) (a) A party to a claim may audio record the proceedings of a formal hearing in a non−disruptive and non−obstructive manner.

(b) Witnesses, participants, and other attendees, who are not parties to the case, are not permitted to audio record the proceedings of a formal hearing.

(2) A party shall provide verbal notice of audio recording to the presiding administrative law judge and all other parties in attendance at the proceedings of a formal hearing before audio recording of the hearing begins.

(3) The presiding administrative law judge shall determine if a party's audio recording disrupts or obstructs the hearing.

(4) The presiding administrative law judge may set conditions for audio recording of a formal hearing to avoid disruption or obstruction of the hearing.

(5) A party's recording of the proceedings does not constitute the official record of the proceedings.

History: CR 15−031: cr. Register October 2015 No. 718, eff. 11−1−15; renumbered from DWD 80.13 under s. 13.92 (4) (b) 1., Register May 2018 No. 749.

HA 4.13 Transcripts. Transcripts of testimony taken or proceedings had before the division shall be furnished to the applicant or respondent or their attorneys in accordance with all of the following provisions:

(1) After the commencement of an action to review an order of the labor and industry review commission in circuit court, a copy of the hearing record will be furnished to the plaintiff or other parties upon payment to the division of the reporter's fees set forth in s. 757.57 (5), Stats., and not as set forth in s. 757.57 (2), Stats.

(2) Transcripts of the hearing may not be provided until after commencement of an action in circuit court.

(3) Upon proper showing of financial inability to pay for copies of such testimony or proceedings, the division may furnish copies of the same on such terms as may be agreed upon.

History: 1−2−56; am. (1) (a), (b), Register, October, 1965, No. 118, eff. 11−1−65; am. Register, November, 1970, No. 179, eff. 12−1−70; am. (1) (a), Register, April, 1971, No. 184, eff. 5−1−71; r. and recr. (1) (a) and (b), Register, September, 1982, No. 321, eff. 10−1−82; (title), (intro.), (1) to (3) renumbered from DWD 80.14 (title), (1) (intro.), (a) to (c) under s. 13.92 (4) (b) 1., correction in (intro.), (1), (3) under s. 13.92 (4) (b) 6., Stats., Register May 2018 No. 749; **CR 18−059: am. (intro.), (1), (3) Register July 2019 No. 763, eff. 8−1−19**.

HA 4.14 Reports by practitioners and expert witnesses. (1) Upon the request of the division, any party to a claim pending before the division under ch. 102, Stats., shall furnish to the division and to all parties copies of all reports by practitioners and expert witnesses in their possession or procurable by them.

(2) In cases involving nonscheduled injuries under s. 102.44 (2) or (3), Stats., any party to a claim pending before the division under ch. 102, Stats., shall, upon the request of the division, furnish to the division and to all parties any reports in the party's possession or reasonably available to that party relating to the loss of earning capacity as set forth in s. DWD 80.34.

(3) Any party who does not comply with the request of the division under sub. (1) or (2) shall be barred from presenting the reports or the testimony contained in the reports at the hearing.

(4) No testimony or reports from expert witnesses on the issue of loss of earning capacity may be received unless the party offering the evidence has notified the division and the other parties of interest of the party's intent to provide the testimony or reports and the names of expert witnesses involved as required under s. 102.17 (7), Stats.

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19.

HA 4.15 Use of reports as evidence. (1) In this section, "report" means a report by a practitioner or a report by an expert witness on the issue of loss of earning capacity, as described in s. HA 4.14.

(2) Matters stated in a report that would not be competent or material evidence if given as oral testimony are not competent or material as prima facie evidence if objection is made, except as corroborated by competent and material oral testimony.

Note: See s. 102.17 (1) (d), Stats.

(3) Use of reports shall be permitted in any case in which claim for compensation is made, provided the reporting practitioner or other expert is available for cross examination.

(4) Reports shall be submitted to the division on a prescribed form and shall be certified. An applicant shall be informed of the provisions of s. 102.17 (1) (d), Stats., and ss. DWD 80.21 and HA 4.14, and also that a form for reporting will be supplied to the applicant upon request.

(5) The division may require additional or supplementary reports. Upon failure of the applicant to submit such reports within the time specified prior to hearing, all reports previously filed may, in the discretion of the division, be excluded as evidence.

(6) Reports shall be filed with the application or as soon thereafter as possible. Reports not filed with the division 15 days prior to the date of hearing shall not be acceptable as evidence except upon good cause for failure so to file, established to the satisfaction of the division.

(7) Simultaneously with the filing of a report with the division, a party shall serve copies upon all other parties. Service upon the designated representative of a party shall be deemed service upon the party. Service upon the insurance carrier for an employer shall be deemed service upon the employer. However, if a party does not have a representative, the division may elect to make service upon other parties.

History: 1−2−56; am. (intro.), (4), (7) Register, October, 1965, No. 118, eff. 11−1−65; am. Register, April, 1975,

No. 232, eff. 5−1−75; am. (3) and r. and recr. (6), Register, September, 1982, No. 321, eff. 10−1−82; am. (intro.), Register, September, 1986, No. 369, eff. 10−1−86; reprinted to restore dropped copy in (1), Register September 2005 No. 597; renumbered from DWD 80.22 under s. 13.92 (4) (b) 1., correction in (3) to (6) under s. 13.92 (4) (b) 6., Stats., Register May 2018 No. 749; **CR 18−059: renum. (1) to (6) to (2) to (7) and am., cr. (1); Register July 2019 No. 763, eff. 8−1−19**.

HA 4.16 Procedure and claims under ch. 40, Stats.

The division shall observe the same rules and procedures and may use the same forms in processing and determining claims made under s. 40.65, Stats., as are used under ch. 102, Stats.

History: Cr. Register, October, 1965, No. 118, eff. 11−1−65; am. Register, April, 1975, No. 232, eff. 5−1−75; am. Register, September, 1986, No. 369, eff. 10−1−86; renumbered from DWD 80.31 under s. 13.92 (4) (b) 1., correction under s. 13.92 (4) (b) 6., Stats., Register May 2018 No. 749; **CR 18−059: am. Register July 2019 No. 763, eff. 8−1−19**.

HA 4.17 Witness fees and travel reimbursement.

The fees and travel reimbursement of witnesses and interpreters for attending a hearing before an administrative law judge shall be the statewide rate currently paid under s. 814.67 (1) (b), Stats., notwithstanding any local county variations.

History: Cr. Register, September, 1982, No. 321, eff. 10−1−82; correction made under s. 13.93 (2m) (b) 7., Stats., Register November 2002 No. 563; renumbered from DWD 80.44 under s. 13.92 (4) (b) 1., correction under s. 13.92 (4) (b) 6., Stats., Register May 2018 No. 749; **CR 18−059: am. Register July 2019 No. 763, eff. 8−1−19**.

HA 4.18 Mediation conferences. (1) DEFINITIONS. In this section:

(a) "Administrative law judge mediator" means an administrative law judge whose duties include conducting mediation conferences.

(c) "Mediation conference" means a voluntary, informal, off−record conference among an administrative law judge mediator and the parties, their representatives, or both, to explore settlement options in an effort to achieve a negotiated, conciliatory resolution of disputed claims without a formal hearing on the merits of a case.

(d) "Request to schedule a mediation conference form" means a form prescribed by the division that sets out the claims at issue in a requested mediation conference, identifies the conceded and disputed benefits, and describes the parties' respective positions.

(2) MEDIATION PROCESS. (a) 1. The purpose of a mediation conference is to resolve all disputed matters or issues in cases in which the issues are sufficiently well−developed.

2. A mediation conference should not be used to address minor disputes or effect piecemeal resolution of disputed claims.

(b) A mediation conference shall be scheduled only after all of the following have occurred:

1. An application for hearing has been served.

2. The applicant has submitted a request to schedule a mediation conference form.

3. The respondent has confirmed in writing that it concurs with the request for a settlement mediation.

4. The respondent has confirmed that the insurance company has, or will have by the date of the scheduled mediation conference, authority to resolve the claim based on a good faith evaluation of the known facts and evidence of record.

(c) A party may request a particular administrative law judge mediator to serve in a particular case. The division shall assign an administrative law judge mediator to conduct mediation conferences based on division needs and resources after considering a party's request.

(d) In conducting a mediation conference, an administrative law judge mediator may do all of the following:

1. Engage in ex parte communication with the parties or their representatives.

2. Adopt his or her own procedures regarding the submission of documents and evidence to be used in preparing for a mediation conference.

(e) A settlement achieved through a mediation conference must be approved by both the administrative law judge mediator and the chief administrative law judge or his or her designee. A settlement agreement achieved through mediation outside the office of worker's compensation hearings' mediation process must be reviewed and approved by an administrative law judge as provided in s. HA 4.03 (2).

(3) CONFIDENTIALITY. (a) 1. Subject to subd. 2. and par. (d), all communications or statements, oral or written, that take place within the context of a mediation conference and are not otherwise discoverable, are confidential and

not subject to disclosure. Such communications or statements shall not be disclosed by any administrative law judge mediator, party, attorney attendee, or division employee, and may not be used as evidence for any purpose, including impeachment, at hearing or any other legal or administrative proceeding.

2. This paragraph does not apply to an executed compromise agreement derived from a mediation conference or any order approving any such mediated settlement.

(b) Subject to par. (d), neither the administrative law judge mediator nor any third−party observer present at a mediation conference with the permission of the parties may be subpoenaed or otherwise required to testify in any proceeding concerning a mediation or settlement negotiations. Absent waiver of confidentiality by the offended party, the notes, records, and recollections of the administrative law judge mediator, as well as well as any evidentiary compilation of records or documents utilized by the administrative law judge mediator in preparing for the mediation conference, shall be kept separate and apart from the division litigation file, are not subject to discovery, and shall not be used as evidence in any proceedings. If so called or subpoenaed, the person or entity called or subpoenaed may refuse to testify or produce the requested documents. Should any party attempt to compel such testimony or production of documents, such party shall be liable for, and shall indemnify the division and the administrative law judge mediator against, any liabilities, costs, or expenses, including reasonable attorney fees, that may be incurred in resisting such compulsion.

(c) Upon request, the presiding administrative law judge mediator may issue a protective order to keep private spoken or written information that might otherwise become part of the official record in a contested case. Such an order does not preclude release or sharing of information already known or discovered outside the mediation process.

(d) This subsection does not apply to any of the following:

1. Threats of violence to the administrative law judge mediator or others.

2. Security personnel or law enforcement officials.

3. Party or attorney misconduct.

4. Legal or disciplinary complaints brought against an administrative law judge mediator or attorney arising out of and during the occurrence of an event that transpires in the course of a mediation.

History: CR 18−059: cr. Register July 2019 No. 763, eff. 8−1−19; correction in (1) (b) to (d) made under s. 13.92 (4) (b) 1., Stats., Register July 2019 No. 763; corrections in (2) (b) 4. and (3) (b) made under s. 35.17, Stats., Register July 2019 No. 763.

ADMINISTRATIVE CODE

Chapter LIRC 1, General

LIRC 1.01 General.
LIRC 1.015 Definitions.
LIRC 1.02 Petitions for review; appeal period.
LIRC 1.025 Petitions for review; filing.
LIRC 1.026 Cross-petitions.
LIRC 1.027 Answers.
LIRC 1.03 Withdrawals.
LIRC 1.04 Record used for review.
LIRC 1.045 Obtaining copy of record.
LIRC 1.05 Hearings.
LIRC 1.06 Oral argument.
LIRC 1.07 Briefs.

LIRC 1.01 General. The labor and industry review commission has jurisdiction for review of cases arising under ss. 40.65 (2), 66.191, 1981 Stats., ss. 102.18 (3) and (4), 106.52 (4), 106.56 (4), 108.09 (6), 108.10 (2) and (3), 111.39 (5) (a), 303.07 (7) and 303.21, Stats.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; am. Register, August, 1982, No. 320, eff. 9-1-82; am. Register, January, 1985, No. 349, eff. 2-1-85; am. Register, May, 1997, No. 497, eff. 6-1-97; correction made under s. 13.93 (2m) (b) 7., Stats., Register September 2001 No. 549; CR 05-092: am. Register July 2006 No. 607, eff. 8-1-06.

LIRC 1.015 Definitions.

(1) In chs. LIRC 1 to 4, "commission" means the Wisconsin labor and industry review commission.

(2) In chs. LIRC 1 to 4, "department" means the Wisconsin department of workforce development.

History: CR 05-092: cr. Register July 2006 No. 607, eff. 8-1-06.

LIRC 1.02 Petitions for review; appeal period. All petitions for commission review shall be filed within 21 days from the date of mailing of the findings and decision or order, except that the petition may be filed on the next business day if the 21st day falls on any of the following:

(1) January 1.

(1m) The third Monday in January.

(1r) The third Monday in February.

(3) The last Monday in May.

(4) July 4.

(5) The first Monday in September.

(5m) The second Monday in October.

(5r) November 11.

(6) The fourth Thursday in November.

(7) December 24, 25 or 31.

(8) The Monday following if January 1, July 4 or December 25 falls on Sunday.

(9) Any other day on which mail is not delivered by the postal authorities.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; am. Register, August, 1982, No. 320, eff. 9-1-82; am. (intro.), (3), (5), (6) and (8), cr. (1m), (1r), (5m) and (5r), Register, January, 1985, No. 349, eff. 2-1-85; am. (intro.) and (1m), Register, May, 1988, No. 389, eff. 6-1-88; am. Register, May, 1997, No. 497, eff. 6-1-97; CR 05-092: am. (intro.) Register July 2006 No. 607, eff. 8-1-06.

LIRC 1.025 Petitions for review; filing.

(1) Petitions for review may be filed by mail or personal delivery. A petition for review filed by mail or personal delivery is deemed filed only when it is actually received by the commission or by the division of the department to which the petition is mailed, except that petitions for review in unemployment insurance cases under s. 108.09 or 108.10, Stats., which are filed by mail or personal delivery are deemed filed when received or postmarked as provided for in s. LIRC 2.015.

(2) Except as provided for in subs. (3) and (4), petitions for review may not be filed by e-mail or by any other method of electronic data transmission.

(3) Petitions for review may be filed by facsimile transmission. A petition for review transmitted by facsimile is not deemed filed unless and until the petition is received and printed at the recipient facsimile machine of the commission or of the division of the department to which the petition is being transmitted. The party transmitting a petition by facsimile is solely responsible for ensuring its timely receipt. The commission is not responsible for errors or failures in transmission. Except in the case of a petition for review in fair employment and public accommodations cases under s. 106.52 or 111.39 (5), Stats., where a facsimile transmission filed after the regular business hours of the equal rights division shall be considered filed on the next business day, a petition for review transmitted by facsimile is deemed filed on the date of transmission recorded and printed by the facsimile machine on the petition. If the commission's or department's records indicate receipt of the facsimile at a date later than that shown, then the later date shall control.

(4) Except in the case of petitions for review in fair employment and public accommodations cases under s. 106.52 or 111.39 (5), Stats., petitions for review may be filed electronically through the internet website of the commission, at the page found at http://dwd.wisconsin.gov/lirc/petition.htm.

Successful filing of a petition for review electronically through the internet website of the commission will result in a display on the petitioner's internet browser of a message

confirming that the petition has been successfully filed. A petition for review transmitted electronically through the website of the commission is not deemed filed unless and until the confirmation message is displayed. The commission is not responsible for errors in transmission that result in failure of a petition to be successfully filed electronically through the website of the commission. A petition for review filed electronically through the internet website of the commission is deemed filed on the date of filing stated on the commission's electronic record of the filing.

(5) Petitions for review may not be filed by telephone.

History: Cr. Register, May, 1997, No. 497, eff. 6-1-97; CR 05-092: r. and recr. Register July 2006 No. 607, eff. 8-1-06; **CR 09-014: am. (3) and (4) Register September 2009 No. 645, eff. 10-1-09**.

LIRC 1.026 Cross-petitions. Any party may file a petition for review, whether or not any other party has already filed a petition for review. The filing of a petition for review by one party does not extend the time within which any other party may file a petition for review. All petitions for review, including cross-petitions, are subject to the requirements of s. LIRC 1.02 concerning timeliness.

History: Cr. Register, May, 1997, No. 497, eff. 6-1-97.

LIRC 1.027 Answers. A party opposing a petition for commission review may file an answer with the commission within 21 days from the party's receipt of a copy of the petition. A party filing an answer with the commission shall furnish a copy to the opposing party.

History: Cr. Register, May, 1997, No. 497, eff. 6-1-97.

LIRC 1.03 Withdrawals. Requests to withdraw petitions shall be in writing. The commission may deny a request by any party to withdraw a petition if the commission has already reviewed and decided the case, but not yet issued its decision, or if the commission considers that withdrawal is not in the best interests of proper administration of the program involved. Denials of withdrawals shall be in writing, but may be included in the findings and decision of the commission.

History: Cr. Register, January, 1985, No. 349, eff. 2-1-85; am. Register, May, 1988, No. 389, eff. 6-1-88.

LIRC 1.04 Record used for review. Review by the commission shall be based on the record of the case including the evidence previously submitted at hearing before the department. The record of the hearing may be in the form of a written synopsis or a transcript, and may include an audio recording of the hearing. The form of the record of the hearing which the commission uses in its review shall be determined as follows:

(1) Except as provided in subs. (2) through (5), the commission shall base its review on a written synopsis of the testimony taken at the hearing. The synopsis shall be prepared by the department, by the commission, or by an outside contractor, from an audio recording of the hearing or from notes taken at the hearing by the administrative law judge. In those cases any party may obtain a copy of the synopsis as provided for in s. LIRC 1.045.

(2) The commission shall base its review on a transcript of the hearing rather than a synopsis if a transcript was prepared and was used by the administrative law judge in deciding the case. In such cases any party may obtain a copy of the transcript as provided for in s. LIRC 1.045.

(3) Except in unemployment insurance cases, the commission shall base its review on a transcript of the hearing rather than a synopsis if a party timely requests the commission in writing to conduct its review on the basis of a transcript, the party certifies in such request that it has ordered preparation of a transcript at the party's own expense, and the party thereafter files a copy of the transcript with the commission and serves a copy of the transcript on all other parties. To be timely under this subsection, a request must be made no later than 14 days after the requesting party's receipt from the commission of written confirmation that a petition for commission review has been filed.

(4) The commission shall base its review on a transcript of the hearing rather than a synopsis if a party shows to the commission that the synopsis is not sufficiently complete and accurate to fairly reflect the relevant and material testimony and other evidence taken. In those cases the commission shall direct the preparation of a transcript at its own expense and provide a copy of the transcript to each party without charge.

(5) On its own motion, the commission may base its review on a transcript of the hearing in addition to a synopsis. In those cases the commission shall direct the preparation of a transcript at its own expense and provide a copy of the transcript to each party without charge.

(6) A transcript used pursuant to subs. (2) to (5) shall be prepared by an independent court reporter or transcriptionist and shall include a certification by the court reporter or transcriptionist that the transcript is an original, verbatim transcript of the proceedings.

(7) On its own motion, the commission may base its review on an audio recording of the hearing in addition to a synopsis or transcript.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; renum. from LIRC 1.03 and am., Register, January, 1982, No. 349, eff. 2-1-85; am. Register, May, 1988, No. 389, No. 6-1-88; r. and recr. Register, May, 1997, No. 497, eff. 6-1-97; CR 05-092: r. and recr. Register July 2006 No. 607, eff. 8-1-06.

LIRC 1.045 Obtaining copy of record. A party in a case before the commission may request the commission to provide a copy of the synopsis or transcript of the testimony, exhibits received at the hearing, or other documents in the administrative record. The commission shall furnish the copies upon request but may charge a fee for photocopying of 20 cents per page. Upon proper showing of financial inability to pay for photocopying, the commission may waive the fee.

History: Cr. Register, May, 1997, No. 497, eff. 6-1-97; CR 05-092: am. Register July 2006 No. 607, eff. 8-1-06.

LIRC 1.05 Hearings. If the record in a case is inadequate for the commission to arrive at a decision, the commission shall remand the case to the department of workforce development to take additional evidence on behalf of the commission.

Note: The commission does not conduct hearings as part of its review.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; renum. from LIRC 1.04, Register, January, 1985, No. 349, eff. 2-1-85; r. and recr. Register, May, 1997, No. 497, eff. 6-1-97.

LIRC 1.06 Oral argument. The commission may grant a written request for oral argument if it determines that an issue would be more clearly presented by oral argument.

Note: The commission does not consider oral argument to be necessary because review is on the basis of the record, the parties have the right to file briefs, and oral argument delays disposition of the petition.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; renum. from LIRC 1.05, Register, January, 1985, No. 349, eff. 2-1-85; r. and recr. Register, May, 1997, No. 497, eff. 6-1-97.

LIRC 1.07 Briefs. Either party may request the commission to establish a briefing schedule. Requests to file briefs may be made in the petition for review, in an answer, or in writing after the petition and answer. The commission may deny a request to file a brief which is not made in a petition or answer if the commission has already reviewed the case but not yet issued its decision at the time the request is made. Each party may file with the commission briefs or memoranda within the time limits of the briefing schedule established by the commission. Requests for extensions of time for filing briefs shall be made in writing. Extensions may be approved in writing upon good cause shown. A party filing a brief or memorandum with the commission shall furnish a copy to the opposing party.

History: Cr. Register, January, 1985, No. 349, eff. 2-1-85; am. Register, May, 1997, No. 497, eff. 6-1-97.

ADMINISTRATIVE CODE

Chapter LIRC 3, Worker's Compensation

LIRC 3.01 Petitions for review; where filed.
LIRC 3.03 Other petitions.
LIRC 3.04 Compromise settlements.
LIRC 3.05 Actions for judicial review.

LIRC 3.01 Petitions for review; where filed. A petition for commission review of the findings or order of a department administrative law judge under s. 102.18, Stats., shall be filed with any of the following:

(1) The worker's compensation division of the department, at any of the following locations:

(a) 201 East Washington Avenue, P.O. Box 7901, Madison, Wisconsin 53707 (FAX: 608-267-0394).

(b) 819 North Sixth Street, Milwaukee, Wisconsin 53203 (FAX: 414-227-4012).

(c) 1500 North Casaloma Drive, Suite 310, Appleton, Wisconsin 54915 (FAX: 920-832-5355).

(2) The commission, at its office at 3319 West Beltline Highway, P.O. Box 8126, Madison, Wisconsin 53708 (FAX: 608-267-4409).

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; am. (1) (intro.) and (a), r. (2), Register August, 1982, No. 320, eff. 9-1-82; am. Register, January, 1985, No. 349, eff. 2-1-85; am. Register, May, 1988, No. 389, eff. 6-1-88; am. Register, May, 1997, No. 497, eff. 6-1-97; CR 05-092: r. and recr. Register July 2006 No. 607, eff. 8-1-06.

LIRC 3.03 Other petitions. The provisions of s. 102.18, Stats., shall apply to all petitions to the commission under ss. 40.65 (2), 303.07 (7) and 303.21, Stats.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; am. Register, August, 1982, No. 320, eff. 9-1-82; renum. from LIRC 3.05 and am. Register, January, 1985, No. 349, eff. 2-1-85; renum. from LIRC 3.04 and am., Register, May, 1997, No. 497, eff. 6-1-97.

LIRC 3.04 Compromise settlements. Compromise settlements of worker's compensation claims are governed by s. 102.16, Stats., and s. DWD 80.03. Under s. 102.18 (4) (d), Stats., if a compromise is reached while a case is pending commission review, the compromise shall be submitted to the commission, and the commission shall remand the case to the worker's compensation division of the department for consideration of the compromise. If the compromise is not approved, the party who filed the petition for commission review may reinstate its petition by notifying the commission. Under s. 102.24 (2), Stats., if a compromise is reached while a case is pending court review of a commission order, remand shall be to the commission and the commission shall then remand the case to the department for consideration of the compromise.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; renum. from LIRC 3.06, Register, January, 1985, No. 349, eff. 2-1-85; am. Register, May, 1988, No. 389, eff. 6-1-88; renum. from LIRC 3.05 and am., Register, May, 1997, No. 497, eff. 6-1-97; correction made under s. 13.93 (2m) (b) 7., Stats., Register, May, 1997, No. 497; CR 05-092: am. Register July 2006 No. 607, eff. 8-1-06.

LIRC 3.05 Actions for judicial review. Judicial review of any commission decision shall be commenced in the manner and upon the grounds specified in s. 102.23, Stats., and not under ch. 227, Stats., or s. 801.02, Stats. Either party may commence a legal action for review of the commission decision in circuit court. The action must be commenced within 30 days from the date of the decision. Such action is commenced only by filing a summons and complaint with the circuit court and serving an authenticated copy of the summons and the complaint upon the commission, all within 30 days. Service must be made upon a commissioner of the labor and industry review commission or an agent authorized by the commission to accept service only at the commission's office in Madison. Such service shall be deemed complete service on all parties but there shall be left with the person so served as many copies of the summons and complaint as there are defendants. Service made by mail is effective only if the pleadings are actually received by the commission within the appeal period. The complaint shall state the grounds upon which review is sought. The action shall be commenced against the commission, and the party in whose favor the order or award was made shall also be made a defendant. The proceedings shall be in the circuit court of the county where the plaintiff resides, except that, if the plaintiff is a state agency, the proceedings shall be in the circuit court of the county where the defendant resides. If the plaintiff is a nonresident of Wisconsin, the proceedings shall be in the circuit court for the county where the claim arose. The proceedings may be brought in any circuit court if all parties stipulate and that court agrees. The appealing party shall arrange for preparation of the necessary legal documents.

History: Cr. Register, March, 1981, No. 303, eff. 4-1-81; renum. from LIRC 3.07 and am., Register, January, 1985, No. 349, eff. 2-1-85; r. and recr. Register, May, 1988, No. 389, eff. 6-1-88; renum. from LIRC 3.06, Register, May, 1997, No. 497, eff. 6-1-97; **CR 09-014: am. Register September 2009 No. 645, eff. 10-1-09.**

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Subject Index

A

Adoption
As to family farm, 102.07(5)(c)
As to death benefit, 102.49(2) and (3)
As to dependency, 102.51(2)(a)
Administrative expenses, 102.75; DWD 80.38
Assessment for administrative costs, 102.75(2); DWD 80.38
DOJ position on fraud, 20.445 (1)(ra), not in this publication
Administrative law judges [ALJ]
Direct employee to attend IME, 102.13(4)
Direct tape recording of hearing in case of emergency, 102.15(3)
Conduct prehearing conference, 102.17(1)(b)
Grant license to appear at a single hearing, DWD 80.20(1)(a)
Limit testimony, HA 4.11(1)(b) and (c)
Interest due on order of ALJ or decision of commission, 102.22(3)
90 days to issue orders after hearing, 102.18(1)(b)
Order payment for future retraining, 102.18(1)(b)2
Order payment for future treatment, 102.18(1)(b)
Order employee to attend exam if toxic or hazardous exposure claimed, 102.565(3)
Party has 21 days to appeal order of ALJ, 102.18(3)
Shall be attorneys, 102.18(2)
Tie-breaker examiner, 102.18(1)(c)
10 percent late payment penalty, 102.22(2)
Unless appealed, a party shall pay award of ALJ within 21 days, 102.18 (1)(e)
Witness fees for attending hearing before examiner, HA 4.17
Advance Payments
Factors considered when granting, DWD 80.39
5 percent interest credit allowed, 102.32(6m)
In compromise $10,000, DWD 80.03(1)(d)
Lump sum settlements, 102.32; DWD 80.03(1)(d); DWD 80.39
In best interest of employee or dependents, 102.32(6m)
Not in cases of PTD, 102.32(7)
3 per calendar year allowed, 102.32(6m)
Adverse examinations, See Independent medical examinations
Advisory committees – Medical
Necessity of treatment disputes, 102.16(2m)(g); DWD 81.14
Review PPD ratings, 102.44(4m)
Advisory councils
WC Advisory Council
Appropriations for, 20.445(1)(ha)
Duties of, 102.14(2)
Duties concerning the uninsured employers Fund and 102.80(3)(a), and (ag); DWD 80.62(9)(b)
Exception for open meetings, 19.85(1)(eg)
Minimum disability ratings considered by subcommittee, DWD 80.32 note
Shall certify administrative expenses to the department, 102.75(1)
Self-Insurers Council
Created by, 15.227(11)
Advises department on revocation of self-insured status of employer, 102.28(2)(c)
Agents
Conditions for license to appear, DWD 80.20
Fiscal agents, 102.07(20); 102.29(12)
Suspension of license, 102.17(1)(c)
Alcohol
Decreased compensation for use, 102.58
Aliens
Dependents, 102.19
Ambulance service provider, 102.07(7)
Amendments to application or answer, HA 4.07
Amputation, 102.52; Rule DWD 80.32
Between joints, 102.55(1)
Dominant hand, 102.54
Fingertips, DWD 80.33
Paralysis, equivalent to, 102.55(2)
Report required, DWD 80.02(2)(g)3.
Annual wage, See Wage
Annuity
Guarantee of future compensation payments, 102.32(2)
Structured settlements, DWD 80.03(1)(f)
Answer to application for adjustment of claim, See Hearings
20 days to file answer, HA 4.04
Amendments not allowed after notice of hearing mailed, HA 4.07

Appeals
Extension of time to begin action, 102.23
From decision of circuit court, 102.25(1)
From health cost dispute order, 102.16(2)(f); 102.16(2m)(e)
From order of ALJ, review by commission, 102.18(3) – (6); LIRC 1; LIRC 3
From order of commission, review by circuit court, appeals courts, 102.23 – 102.26
Remand of record to commission, 102.24
Review of compromise agreement, 102.16
Service of papers in court appearance, 102.23(1)
Summons and complaint, 102.23
Supreme Court, Appeal to and remand from, 102.25(1)
Appearance before department, See Agents
Appliances, artificial members
Included in definition of injury, 102.01(2)(c)
Employer shall provide, 102.42(1)
Liability for repair and replacement, 102.42(5)
Liability of supplemental benefit fund for barred claims, 102.66
Written notice of amputation requiring appliance, DWD 80.02(2)(g)3.
Training in use of, 102.42(1)
Temporary disability payable while training in use of, 102.43(5)
Application
For hearing, 102.17(1); HA 4.04; HA 4.07
For license to appear, 102.17(1)(c);DWD 80.20
For members of religious sects, 102.28(3)(d)
Within 2 years from date of injury, 102.12
Apportionment
Of liability between parties, 102.175(1) and (2)
Of permanent disability, 102.175(3)
Artificial members, See Appliances
Arising out of employment, 102.03(1)(c)1
Assessments
Insolvent employers, 102.28(7)
Supplemental benefit reimbursement 102.75(1)(g)
Assignment of benefits
Exception for child support and certain government payments, 102.27(2); 767.265(1)
For creditors forbidden, 102.27(1)
Assignment of claim
Not affected by making lawful claim against third party, 102.29
Attorney general
Actions involving self-insured employers, DWD 80.60(4)(e)
May bring action for review, 102.23(4)
Represent state and commission, 102.64
Represent state in action involving insolvent employer, 102.28(7)
Represent state in death benefit of law enforcement, firefighters and others, 102.475(3)
Attorneys
Department may retain to represent uninsured employer's fund, 102.81(2)
Factors used by department in setting fee, DWD 80.43 generally
Fees, 102.26
Fees not allowed on medical expenses, DWD 80.43(2)
500-week limit in case of permanent total disability, DWD 80.43(3)
On reimbursement of group insurance, 102.30(7)
Parties may appear at hearing by attorney, 102.17(1)(c)
Third-party suit, 102.29
Audio recordings of hearings, HA 4.12
Autopsy, 102.13(5)
Auxiliary police, 102.07(7)
Average annual earnings, 102.11(2)
Death benefits, 102.46
Disfigurement, 102.56
Awards/Orders
Against counties, cities, villages, towns and school districts, 102.21
Certified, 102.20; 102.21
Collection of award, 102.20; 102.28
Final orders may be reopened within year, 102.18(4)
Interest upon, if unpaid, 102.22(2)
Interlocutory or final, 102.18(1)(b)
Judgment upon, 102.20
Not subject to debts, 102.27(1)
Payable to claimant, in person, 102.26(3)
Range of 5 percent of medical opinions, 102.18(1)(d)
Reasons for reversal, 102.23
Reopening, 102.44(6)(b)
Reservation in award, automatic, 102.18(4)
Setting aside, one year, 102.18(4)(c)
Where ALJs disagree, 102.18(1)(c)

Within 90 days of close of record, 102.18(1)(b)
Orders, general, Rules as to, 102.39
Orders of the department, 102.18
Within 90 days after close of hearing record, 102.18(1)(b)

B

Bad Faith
Basis for claim in writing, 102.17(1)(a)3
Defined, DWD 80.70
Exception for uninsured employer's fund, 102.81(1)
Non payments of interlocutory order 102.18(1)(b)
Penalty for, 102.18(1)(bp)
Bankruptcy
Preference of claims, 102.28(1)
Insolvent self-insured employers, 102.28(7), (8)
Court ordered liquidation of insurance company, 102.31(2)(b)
Insurer's secondary liability for insolvent employer, 102.62
Assessment for insolvent self-insurer, DWD 80.40
Insurance service organization for insolvent self-insurer, 102.28(7)(c)
Barred claims, 102.66; See also Statute of Limitations
Benefits, See Compensation
Blindness, See Vision Loss
Bonds
From contractors, 102.07(1)
To guarantee future compensation payments, 102.28(2)(b); 102.32(4); DWD 80.60(4)(d)
Brand name drugs, 102.425(2)(c)
Burial expense, See Death Benefits

C

Calendar weeks, 102.11(1)(d)
Car pooling, van pool, 102.03(1)(c)3
Casual employment, 102.07(4)(b)
Certified Data Base, 102.16(2)(d);DWD 80.72 (7) and (8)
Certified Reports, See Reports
Child support
Assignment of benefits, 102.27(2); 767.265(1)
Children and Minors
Children:
Adoption of, 102.49(2)
Child and spousal support program, 102.17(1)(cg)3. and (cm); 102.33(2)(b)5.
Compromise, 102.64(1)
Death benefits, 102.49; DWD 80.48
Extent of dependency, 102.49; 102.51(1), (4) and (6)
Guardian, 102.45; 102.49(6)
Parental support:
Loss of, 102.29 annotation
Room and board payments not counted, DWD 80.46
Mentally or physically incapacitated, 102.49(1); 102.51(1)
Employment of Minors:
Double compensation, 102.60(1)
Exception for uninsured employers fund, 102.81(1)
Increased compensation when illegally employed, 102.60
Payment of compensation to, 102.45
Permanent disability and death rate, 102.11(1)(g)
Power to contract, 102.07(4)
Preservation of rights, 102.17(6)
Treble compensation, unlawful employment of minors, 102.60
Exception for uninsured employer fund, 102.81(1)
Waiver of benefits by, 102.28(3)(a)
Chiropractor, See Physicians
Choice of practitioner, 102.42(2) and (3)
Christian Science treatment, 102.42(1), (4), and (6)
Citations procedures, 102.87
Civil defense employees, 166.03(8) (Not printed in this booklet)
Claims for compensation
Enforced against employer or insurance carrier, 102.30(4)
Not waived by making lawful claim against third party, 102.29
Notice of, to employer, 102.12
Preference of, 102.28(1)
Closure orders, 102.28(4)
Violations of, 102.85(3)
Coemployee assault, 102.02(3)
Collective bargaining agreements, 102.03(2); 102.11(1)(d); 102.35(3); 102.43(8)
Commission, See Labor and Industry Review Commission

Community service work, 102.07(13) and (14)
Compensation
Conditions necessary to recover, 102.03
Definition, 102.01(2)
Exclusive remedy, when, 102.03(2)
Incidental, 102.17(8); 102.42
For employees of uninsured employers, 102.81
Monthly payments, 102.32(6)
Preference of claims and awards for, 102.28(1)
Present worth of, 102.32 (1m) and (6m)
Reduction for sick or accident benefits, 102.30(2) and (3)
Reimbursement between carriers, 102.175(2); 102.18(1)(bw)
Scheduled, 102.52
Sick leave, 102.30(3); 102.43(6)
Supplemental, 102.44(1)
Employees institutions, See Inmates
Weekly, 102.43; 102.44
Compromise settlements
Affect on claims of dependents, 102.51(5); 102.16(1)
Advancement of $10,000 unaccrued benefits allowed, DWD 80.03(1)(d)
After appeal has been taken to courts, 102.24(2)
Children's benefits, 102.64
Estimates of disability used, DWD 80.03(3)(b)
In lieu of hearing, 102.18(1)
Issues not deemed affected by, 102.18(4)(a)
Review of, 102.16(1)
Rules of department regarding, DWD 80.03
Second Injury, 102.59(1m)
Stipulation, 102.16(1)
In lieu of hearing, 102.18(1)
Written facts and compensation due, DWD 80.10
Structured Settlements, DWD 80.10
State Fund, 102.64(1) and (2)
Compulsory vacation, 102.43(8)
Conditions of liability, 102.03
Confidential records, 102.33
Construction projects, 102.31(7); DWD 80.61(3) [Wrap up insurance]
Contractors
Liability of, 102.06
May be required to give bond, 102.07(1)
Principal employer liable for compensation to employees of, 102.06
Contracts for insurance, 102.31
Construction projects, 102.31(7)
Conviction of a crime, 102.43(9)(d)
Copying of records
Confidential records of department may not be copied, 102.33
Fees for copying department records, DWD 80.025
Provider may charge for copying medical records, 102.13(2)(b)
Corporate officers
Liability of, 102.28(5); 102.83(8)
Non-election of benefits, 102.076
Councils, See Advisory Councils
Counties, See Municipalities
Court review, See Appeals
COVID-19, 102.03(6); 102.565(6)
Crime conviction of an employee, 102.43(9)(d)
Crutches, See Appliances

D

Databases, reasonableness of fees, 102.16(2)
Department certified databases, 102.16(2)(c), DWD 80.72 (7) and (8)
1.2 standard deviation from mean, 102.16(2)(d)
Date of injury
Defined, 102.01(2)(g)
Controls right and amount to compensation, 102.03(4)
For hearing loss, 102.555(3) and (4)
Deafness, See Hearing Loss
Death benefits, 102.46-102.49
Advancements of, 102.32(6)
Additional for children, 102.49; DWD 80.46
Burial expense, 102.47; 102.50
For death of child, 102.49(6)
Compromise, 102.64(1)
Dependents:
Alien dependents represented by consular officers, 102.19
Alien proof of dependency, 102.51(2) (b) and (c)
Anticipation of support, 102.48(2)
Date of death to control, 102.51(4)
Division among dependents, 102.51(6)
Posthumous child, 102.51(4)
Partial, 102.48
Rights to review of compromise, 102.16(1)
Total, 102.51

Who are not, 102.51(2)
Divorced spouse, 102.51(2)
Method of payment on monthly basis, 102.32(6)
Firefighter, Police officer, etc., 106.25; 102.475; 40.65
Power of department to distribute, 102.51(3)(6)
Reassignment when spouse remarries, DWD 80.48
Redistribution of death benefits, 102.49(3); 102.51(6); DWD 80.48
Unestranged parents, 102.48(1); contribution to support of, DWD 80.46
Decreased compensation, 102.58
For failure to use safety devices, 102.58
For alcohol use, 102.58
For controlled substance use, 102.58
Deduction from wage prohibitions, 102.16(3) and (4)
Default judgments, 102.18(1)(a); HA 4.04(2)
Dentists, See Physicians
Opinion on treatment not disability, 102.17(1)(d)
Dependents, See Death Benefits
Of incompetent or incarcerated employee, 102.195
Depositions, HA 4.08
Deposits to guarantee future compensation payments, 102.28(2)(b); 102.32(4); DWD 80.60(4)(d)
Deviation, 102.03(1)(f)
Direct deposit of compensation allowed, 102.26(3)(b)
Discharge of liability, 102.32
Discovery, See Hearings
Discrimination against employee claiming benefits prohibited, 102.35(2)
Disease, Occupational
Injury defined, 102.01(2).
Date of injury defined, 102.01(2)(g); 102.555(4)
Mistake, 102.18(5)
Review of findings, 102.18(6)
Disfigurement, 102.56
Compensation for not to exceed average annual earnings, 102.11(2)
Multiple injury factor does not apply, DWD 80.50(3)
Dispensing fees, 102.425
Distributors of magazines or newspapers, 102.31(1)(c); 102.60(7)
Diving teams, 102.03(1)(c); 102.07(a); 102.475
Doctors. See Physicians
Domestic Partners, 102.475(6); 102.49; 102.51(2); 102.64(1)
Domestic Servants, status under act, 102.05(2); 102.07(4)(a)
Dominant hand injuries, 102.54
Double compensation, See Children and Minors
Drug equivalents, 102.425
Drug treatment, 102.58
Drug use, 102.43(9)(c)
Duty disability, 40.65
Communicable disease, 891.45(2); 891.453
Duty to insure, 102.28(2)(a)

E

Earnings, See Wages
Average weekly earnings, 102.11(1)(d)
Average weekly earnings in case of seasonal employment, 102.11(1)(b)
Daily earnings, 102.11(1)(a)
For loss of wage, 102.11(3)
Generally, 102.11; DWD 80.51
Part-time employees, 102.11(1)(a); 102.11(1)(f); 102.43(6)(b); DWD 80.51(4)
Part-time labor organization services, 102.11(1)(d)
Persons without fixed earnings, 102.11(1)(c)
Things of value as part of earnings, 102.11(1)(e)
Educational programs, see Vocational Rehabilitation
Election of coverage/withdrawal
By corporate office, 102.076
By employer, 102.05(2)
By real estate firm, 102.078
By school for students, 102.077
By sole proprietor, partner or member of a limited liability company, 102.075
Electronic records, 102.13(2)(b)
Emergency government, 102.475; 166.03(8)(d) (Not in this publication)
Emergency responders, 102.03(1)(c)2
Emergency treatment, 102.42(1)
Emotional stress and strain, 102.01(2)(c)
Employee
Defined, 102.07
Discharge of, 102.31(5), 102.35(3)

Domestic servant, 102.07(4)(a)
Farm, 102.04 (1) (c) and (3); 102.07 (5)
Independent contractor, 102.07(8)
On the job training, 102.07(19)
Publicly employed, right to compensation in all cases, 102.07(1)(10)
Real estate, 102.17(8)(bm)
Religious sect, 102.07(4m); 102.07(5)(d)
Shall not contribute to cost of compensation, 102.16(3) and (4)
Statutory, 102.07(8)
Student, 102.07(12)
Employer
Defined, 102.04
Election by, 102.05(2)
Enforced safety rule, 102.57
Failure to rehire employee, 102.35(3)
Farming, 102.04(1)(c); 102.07(5)
Keep records of accidents, 102.37
Liability for compensation, 102.03; 102.30(4)
Liability to employees of contractors and subcontractors, 102.06
Must insure liability unless exempted, 102.28(2)
Not to shift any part of compensation cost to employee, 102.16(3) and (4)
Reports required, 102.28(6); DWD 80.02
Territorial limitation, 102.04(1)(b)1
Withdrawal from coverage, 102.05(1), (2) and (3); 102.28(2)(a)
Evidence, See Hearings
Exclusive Liability, 102.07(12m); 102.18(1)(bp); 102.29(6m)(b)2.
Ex parte department action to inspect premises or take testimony, 102.17(1)(e)
Examination by physician, chiropractor, psychologist, podiatrist, dentist or vocational expert
See Independent Medical Exam,
See Vocational Experts for Loss of Earning Capacity
Examination of records of insurance companies, 102.31(3)
Examiners, see Administrative Law Judges
Excess payment, 102.63
Exclusive remedy, 102.03(2)
Exceptions, 102.03(2)
As to bad faith, 102.18(1)(bp)
As to unreasonable refusal to rehire, 102.35(3)
Expenses
Administrative, 102.75
Burial, 102.50; 102.17(4); 102.47(2); 102.48(3); 102.66
Lodging, 102.17(8)
Meals, 102.17(8)
To attend IME, 102.13(1)(b)
Travel, 102.17(8)
Expert opinions, 102.16(2m)
Extra-territoriality, 102.03(5)
Eye glasses, See Appliances
Eye injury, See Vision Loss
Final report, 102.13(2)(c); DWD 80.02(2)(e)4

F

Facsimile machine transmission, 102.31(2)
Family farm, 102.07(5)(c)
Farming, 102.04
Defined, 102.04(1)(c); 102.04(3)
Exchange of employees, 102.07(5)
Family farm corporations, 102.07(5)
Fifteen day rule to file
Itemized medical expenses, 102.17(8)
Medical and vocational reports, 102.17(1)(d)
Fifteen percent rule for loss of earning capacity, 102.44(6)
Final medical reports, 102.13(2)(c)
Eye injury, DWD 80.02(2)(e)4
Finance charges, 102.22(1)
Findings, See Awards
Fingertip amputations, DWD 80.33
Firefighters and Police Officers
Duty disability and death benefits, 40.65
When responding to a call outside their jurisdiction, 102.03(1)(c)2
While engaged in pursuit and capture, 102.07(2)
Municipalities may pay salary during disability, 102.07(3)
Death benefits, 102.475
Cancer presumption, 891.455
Heart or respiratory impairment or disease presumption, 891.45
See Volunteers
Fiscal agents, 102.07(20); 102.29(12)
Fitness programs, 102.03(1)(c)3.
Five hundred week attorney fee limit, See Attorneys
Five percent rule on medical opinions, 102.18(1)(d)
Food stamp employment, 102.29(8r)

Forfeiture. See penalties
Forms
Provided or approved by department, 102.28(3)(d); 102.33; 102.37; 102.38; DWD 80.27
WKC-12, First report of injury, DWD 80.02
WKC-13, Supplementary report, DWD 80.02
WKC-13A, Wage less than maximum, DWD 80.02
WKC-16-B, Practitioner's report, 102.17(1)(d); HA 4.15(6)
Forty-five day notice of vocational testimony, 102.17(7)(b)
Self-Insurance, DWD 80.60(4)
Fraud
DOJ assistance, 102.125(2)
Reporting, 102.125(1)
Fraudulent claims, 102.125
Fractures, See X-rays
Franchisor, 102.04(2r)
Funeral expenses, See Death Benefits

G

Garnishment of benefits, not allowed, 102.27(1)
Except for child support, 102.27(2); 767.265(1)
Good cause for late filing
Itemized medical expenses, 102.17(8)
Vocational witnesses, 102.17(7)(c)
Good faith treatment, 102.42(1m)
Growing out of and incidental to employment, 102.03(1)(c)

H

Hazardous substance exposures, 102.565
Healing period, 102.13(3), 102.43(9)
Adult community service, 102.07(13)
Artificial members, 102.42(5)
Incarceration, 102.43(9)(d)
Juvenile community service, 102.07(13)
Hearing Loss
Barred claims, 102.66
Hearing aid, 102.01(2)
As treatment, DWD 80.25(6)
Impairment table, DWD 80.25
Occupational deafness, 102.555
Schedule, 102.52(17) and (18)
Tinnitus, 102.555(10): DWD 80.25(7)
Hearings
Amendments to application and answer, HA 4.07
Answer to application for hearing, HA 4.04(2)
Application for, 102.17(1)(a); HA 4.04(2)
Service of application, 102.17(1)(a), HA 4.04(2), DWD 80.07
Waiver of service by general or special appearance, 102.30(4)
Contempt, 102.17
Depositions, 102.17(1)(f); HA 4.10
Discovery, 102.17(1)(b), (e) and (f)
Evidence:
Credible and substantial judicial review standard, 102.23(6)
Medical reports, 102.17(1)(d); HA 4.15
Newly discovered, grounds to set aside order, 102.18(4)
Prima facie, 102.17(1)(d)
Reports not evidence, WKC-12 and WKC-13, 102.40
Employee statement 102.123
Fifteen day rule to file itemized medical expenses, 102.17(8)
Medical and vocational reports, 102.17(1)(d)
Impleading parties, 102.17(1)
Multiple hearings, 102.17(1)(a)
Notice of, at least 10 days, 102.17(1)(a)
On department's own-motion, 102.17(2)
On disputed claims, 102.16(1); 102.17
Parties are applicant and respondent, DWD 80.06
Postponements, HA 4.08(2) – (4)
Prehearing conference, 102.17(1)(b)
Procedures generally, HA 4.04-4.11
Selection of hearing location, HA 4.11(2)
Subpoena, 102.17(1)(f); 102.17(2m) and (2s)
Tape recorded in case of emergency, 102.15(3)
Testimony, 102.15; 102.17(1)(e), HA 4.11(1)
Transcripts, 102.15(2); HA 4.13
Use of out-of-state examiners, 107.17(1)(a)
Witnesses:
Attendance, HA 4.08(1)
Department has power to compel attendance of, 102.17(3)
Fees, HA 4.17
Physicians may be compelled to testify, 102.13(1)(d); 102.17(1)(d)
Hernia, 102.13(2)(c)

Holiday break during retraining, 102.43(7)(c)

I

Illegal withholding, footnote 138
Illegally employed minor, 102.60
Incidental compensation, 102.17(8); 102.42
Incompetent employees, 102.195
Increased compensation
Increase for violation of safety order, 102.57
Safe place statute, 101.11
Safety reports as evidence, 102.17(1)(h)
SB-10, 102.17(1)(h)
Secondary liability of carrier, 102.62
Exception for uninsured employer's fund, 102.81(1)
For employment of minors, See Children and Minors
Independent contractor, 102.07(8)
Independent medical examination
By physicians, chiropractors, psychologists, dentists, podiatrists, 102.13(1)
Conditions for scheduling IME, 102.13(1)(b)
Copy of IME report to employee, 102.13(1)(b)
Employee's right to expenses for attendance at IME, 102.13(1)(b)
Translators, 102.13(1)(b)
For exposure to toxic or hazardous substance claims, 102.565(2)
Forfeiture of benefits for refusal to submit, 102.565(3)
Forfeiture of benefits if refuses to submit to exam after ordered, 102.13(1)(c)
Injured employee must submit to, 102.13
100 mile rule exception, 102.13(4)
Suspension of proceedings if refuses to submit to exam, 102.13(1)(c)
Tie-breaker ordered by department, 102.13(3)
Tie-breaker ordered by department after hearing, 102.17(1)(g)
Injury
Date of, 102.01(2); 102.555(4)
Definition, 102.01
Deviation, 102.03(1)(f)
Notice of, 102.12
On employer parking lot, 102.03(1)(c)
On employer premises, 102.03(1)(c)
Self-inflicted, 102.03(1)(d)
While traveling, 102.03(1)(f)
Inmates
Compensation for, 56.21; 102.195; 102.07(16); 303.21; 303.215; DWD 80.51(3)
Institutionalized employees, 102.195
Of state institutions, compensation for, 303.21; 303.215
On work release programs, 102.07(16)
Transitional work programs for inmates, 102.07(16)
TTD, 102.43(9)(d)
Insolvency of Uninsured Employers Fund, 102.80(3)(ag) and (c); DWD 80.62(9)
Inspection of premises, 102.17(1)(e)
Inspection of records, 102.31(3); 102.33(2); DWD 80.025
Insurance (See also Self-Insurance)
Alternative benefits. See Religious Sects
Cancellation or termination of policy, 102.31(2) and (2)(a); DWD 80.65
Common control by carrier in third party action, 102.29(4)
Compliance and enforcement, 102.28(2)-(6); 102.82-102.89
Continuing liability, bond discharge, 102.28(2)(b); 102.32; DWD 80.60(4)(d)
Coverage construed to be full, 102.31(1)(b)
Divided or partial coverage, 102.31(1); DWD 80.61
Duty to insure, 102.28(2)
Exemption from duty to insure, See Self-Insurance
Election to withdraw from coverage, 102.05
Farming, 102.05(3)
Excess insurance, 102.28(2)(d); DWD 80.60(2); DWD 80.60(4)(d)3.
Fraud or misrepresentation by agent, 102.82(2)(ar)
Failure to insure, 102.28(4)(b); 102.82; 102.85; 102.87-102.89
Full coverage, 102.31(1)(b)
Group insurance, reimbursement, 102.30(7)
Group insurer, not a party, 102.30(7)(b)
Governmental units, 102.28(2)(bm); DWD 80.60(3)
Injunction for failure to insure, 102.28(4)
Leasing company, 102.315
Liability for compensation not reduced by, 102.30(1)
Mutual companies provided for, 102.30(1)
Notice of policy cancellation, 102.31(2); DWD 80.65
Of liability, 102.28(2) and (6)

Of employer, 102.28(2)
Partial or divided coverage, 102.31(1); DWD 80.61
PEO, 102.315; 102.31(2)(a); DWD 80.65
Policy regulations, 102.31
Premiums sole liability of employer, 102.16(3) and (4)
Rates and rating methods, 626.12
Records and reports, 102.33; 102.38
Removed, in case of failure to insure, 102.28(5)
Unauthorized insurer, 102.28(2)(d)
Wrap-up insurance, construction projects, 102.31(7); DWD 80.61(3)
Insurance carrier
Appearance of, waiver of service of copy of application and notice of hearing, 102.30(4)
Department examination of records, 102.31(3)
Injured employee may recover compensation from, 102.30(4)
Mailing address of insurer, 102.31(3)
Name change, DWD 80.67
Name of carrier required, DWD 80.02(3)(c)
Notice when insures third party, 102.29(4)
Party in interest in compensation claims, 102.17
Recovery against, not affected by failure of insured to observe policy requirements, 102.30(6)
Reimbursement for supplemental benefits, 102.44(1)
Reports to department, 102.31(4)
Response to department correspondence, 102.31(3)
Secondary liability, 102.62
Interest
Court, 102.22(2)
LIRC, 102.22(3)
Surcharges, 102.35(1)
Upon advancements, 102.32(6m)
Upon payment to state treasurer, 102.49(5)
Upon uninsured employer payments, 102.82(2)(b)
Upon unpaid awards, and in cases of inexcusable delay, 102.22
Interest Credit, 102.32
Interlocutory awards, See Awards
Internet, www.dwd.wisconsin.gov/wc/
Itemized statement of medical expense, See Medical Expense

J

Joint liability of employer and contractor, 102.06
Joint ventures, 102.04(1)(d); 102.28(2)
Jurisdiction
Concerning health cost disputes, 102.16(2)
Of department to administer ch. 102, 102.14(1)
Of out-of-state injury, 102.03(5)
Juveniles, see Children and Minors

L

Labor and Industry Review Commission (See also Appeals)
Defined, 102.01(2)(af)
Petition for review by, 102.18(3)
Findings of fact by commission conclusive in absence of fraud, 102.23(1)
Further consideration within 28 days of decision, 102.18(4)(b)
One year jurisdiction for mistake or new evidence, 102.18(4)(c)
Remand of compromise to department, 102.18(4)(d)
Judicial review of commission decisions, 102.23; 102.25
Court remand of record to the commission, 102.24
Labor organization wages, 102.11(1)(d)
Late payment, 102.22
Leasing Companies, 102.315; 102.29(6m); also see Temporary Help Agencies
Leave of absence for state employees, 102.07(17(g)
Legislators, See State of Wisconsin
Levies for delinquent payments, See Uninsured Employers
Liability for compensation
Apportionment of, 102.175
Conditions of, 102.03
Dispute between carriers, 102.175(2)
Individual, joint and several, 102.28(5); 102.83(8)
Individual of partnership, 102.31(1)(d)
Joint of employer and contractor, 102.06
Primary and secondary, 102.62
Release from, 102.32
Sole on part of employer, 102.18(1)(bp); 102.31(1)(c), 102.35(3)

License to appear, See Agents
Limitations, See Statute of Limitations
Limited liability companies
Certain defense barred, 102.51(7)
Election of coverage, 102.07(15); 102.075
Joint, several liability, 102.31(1)(dL)
Status as employee/employer, 102.04(2)
Loaned employee, 102.29(7)
Local government unit, 102.01(2)(d)
Loss of earning capacity
Unscheduled disabilities, 102.17(1)(d); 102.44(2) and (3)
Factors to be considered, DWD 80.34
Fifteen percent rule, 102.44(6)
Loss of hearing, See Hearing Loss
Lump sum settlements, See Advancements

M

Magazine distributors, 102.31(1)(c)(2)
Maintenance, see Vocational Rehabilitation
Malice or bad faith, See Bad Faith
Malpractice by medical provider, recovery of damages, 102.29(3)
Maximum limitation, 102.44
Medical examination, See Independent Medical Exams
Medical expense, 102.42
Itemized statement required 15 days before hearing, good cause exception, 102.17(8)
Form WKC-3, Medical Treatment Expense: Supplies and Medications, (Not found in this booklet)
Necessity of,
Health cost dispute process, 102.16(2m)
Reasonableness of, health cost dispute process, 102.16(2); DWD 80.72
Reimbursement to non-industrial insurer, 102.30(7)
Medical Provider, includes physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, and podiatrist, 102.13; 102.17, 102.42
Medical reports
Authorizations for release not required, 102.13(1)
Certified reports filed 15 days before hearing, good cause exception, 102.17(1)(d)
Copying charge, 102.13(2)(b)
Final medical report, 102.13(2); DWD 80.02 (2)(e)4
Finance charges, 102.22(1)
Mileage expense for treatment, 102.42(1)
Unreasonable travel to obtain treatment, 102.42(2)(b)
Reasonably related records, 102.13(2)
Use of physician reports as evidence, HA 4.15
Reporting doctor available for cross-examination, HA 4.15(2)
Medical treatment
Artificial members, 102.42(5)
Choice of practitioner, 102.42(2)
Second choice of treating practitioner, 102.42(2)(a)
Christian Science treatment, 102.42(1) and (4)
Cure and relieve from effects of injury, 102.42(1)
Disability aggravated by employee's refusal, 102.42(6)
Emergency treatment, 102.42(1)
Employer to provide, 102.42(1)
End of healing, 102.42(1)
Occupational disease before nature of disease known, 102.42(1)
Out-of-state practitioner, 102.42(2)(a)
Patient privilege waived, 102.13(2)
Prospective treatment may be awarded, 102.18(1)(b)
Refusal to submit, 102.42(6)
Mental injury, 102.01(2)(c); 102.175; 102.195
City duty disability, 59.88(2)
County duty disability, 62.624(1)
Mileage, See Appendix for rates; also see Expense, Travel
Minors, see Children and Minors
Misconduct, 102.43(9)(c)
Unemployment insurance, 108.04(5)
Mistaken finding of accident rather than disease, 102.18(5)
Monthly payments, 102.32(6)
Multiple injuries, 102.53; 102.54; DWD 80.50
Municipality
See local government unit 102.01(3)(d)
Municipalities/local governmental units
Defined, 102.01
Awards against, 102.21
Claims against, 102.03(1)(c)5; 102.07(10)
Payment of awards, 102.21
School Districts, 102.07(12m)
Subject to act, 102.04(1); 102.07(1)

N

National Guard, See State of Wisconsin
Necessity of treatment, See Medical Expense
Newly discovered evidence, See Labor and Industry Review Commission
Newspaper carriers and distributors, 102.31(1)(c)2; 102.60(7)
Noise, See Hearing Loss
Non-disabling conditions, 102.565; 102.31(5)
Non election, corporate officers, 102.076
Non-industrial insurance reimbursement, 102.30(7)
Nonprescription drugs, 102.425
Nonprofit organizations, 102.07(11m)
Non-renewal, 102.31
Nonresident alien, 102.51(2)
Non-traumatic neurosis, 102.01(2)(c)
Notice relating to
- Amputation requiring artificial member, DWD 80.02(2)(g)
- Autopsy, 102.13(5)
- Benefit payments stopped or denied, written 7 days notice, DWD 80.02(2)(g)
- Christian Science treatment, 102.42(1), (4), (5)
- Compromises, from Dept of Justice to Dept. of Administration, 102.64(1)
- Corporate officers, 102.076(2)
- County medical and living expenses, 102.27(2)(b)
- Election to insure:
  - Domestic servants, 102.07(4)
  - Employees not in the trade, business, profession or occupation of employer, 102.07(4)
  - Volunteers specified by rule, 102.07(11)
  - Expert witnesses, 102.17(7)(b), See Vocational Experts
  - Election to withdraw insurance coverage, 102.05
  - Final medical exam, DWD 80.02(2)(j)
  - Hearings, 102.17(1)(a)
  - Injury, 102.12; DWD 80.02
  - Insurer same for employer and third party, 102.29(4) and (5); DWD 80.23
  - Sole proprietors, partners, members of limited liability companies, 102.075
  - Self-insurance, 102.28(2)(b), DWD 80.60(3); 80.60(4)(a) and (dm); DWD 80.61(3)(c)2.e
  - Third-party claims, 102.29(1)
  - Vocational rehabilitation, DWD 80.42; 80.49(7)(a), (b) and (e)
  - Withdrawal from insurance coverage, 102.05(1) and (3)

O

Occupational disease
- Barred claim for, 102.17(4); 102.66
- Compensation for, 102.01(2); 102.17(4); 102.66
- Date of injury, 102.01(2)(g); 102.555(4)
- Deafness, 102.555, DWD 80.25 (See also Hearing Loss)
- Medical Treatment for, 102.42(1)
- Mistake in finding accident, 102.18(5)
- No final award, 102.18(1)(b)
- Non-disabling conditions, toxic or hazardous substances, 102.565
- Statute of limitations, 102.17(4)
- Tuberculosis, 102.42(6)

Occupational hearing loss, 102.555; See also Hearing Loss
Officers and directors, liability of, 102.28(5)
Officials, as employees, 102.07(1)
One hundred mile rule, 102.13(4), See Independent Medical Examination
Open records, 102.33; DWD 80.025
Oppressive physical examinations, 626.12(3)
Orders, 102.01(2)(dm)
Other benefits not affected, 102.30(2)
Other suitable employment as affecting loss of wage, 102.11(3); 102.43(6)
Out of state treatment, 102.42(2)(a)
Own motion hearings, 102.17(2)

P

PPD See permanent partial disability.
PTD See permanent total disability.
Paralysis, 102.55(2)
Parking lot, 102.03(1)(c)2
Parties, impleaded, See Hearings
Parties to a violation, See Penalties
Partnerships
- Individual liability of partners, 102.31(1)(d)
- May elect coverage, 102.07(15), 102.075
- Members counted as employees, 102.04(2)

Part-time employees, See Earnings
Partial insurance, See Insurance

Paternity, 102.17(1)(cm)
Patient privilege waived, 102.13(2)
Payment delayed, See Delayed Payments
Payment of compensation directly to claimant, 102.26
Direct deposits of compensation allowed, 102.26(3)(b)3
Payment of awards by municipalities, 102.21
Payment to dependents, See Death Benefits, See Dependents
Peace officers, 102.07; 102.475
Penalties.
Contempt for failure to appear or testify at hearing, 102.17(3)
Exceptions for uninsured employers fund, 102.81(1)
Inexcusable delayed payments, 102.22
Failure to file insurance policy, 102.31(1)(e) footnote
Failure to insure, 102.82; 102.85; 102.88
Failure to keep records or make reports, 102.35
Finance charges for delay, 102.22(1)
For collecting from employee to pay compensation, 102.16(3) and (4)
For unreasonable refusal to rehire injured employee, 102.35(2) and (3)
For presenting fraudulent claim; 102.125; 943.395
Forfeiture for uninsured employers, 102.85
Parties to a violation, 102.89
Repeat violations of ch. 102, rules or orders, 102.88
Uninsured employers fund, 102.82; 102.85; 102.88
Pension funds, 102.07(3)
Permanent partial disability
Advances, 102.32(6m); DWD 80.39
Application of schedules, 102.55
Computations, DWD 80.50
Dominant hand increase, 102.54
Five percent variance, 102.18(1)(d)
Future Payments, 102.32(1)-(5)
Limited number of weeks, 102.44(3)
Loss of hearing, 102.52(17) and (18); 102.555; DWD 80.25
Loss of use as a percentage, 102.55(3)
Loss of vision, 102.52(15) and (16); DWD 80.26
Method of payment monthly, 102.32(6)
30/90 day payment rule, 102.32(6); DWD 80.52
Multiple injuries, 102.53
Paralysis, 102.55(2)
Payment upon death, 102.47(2)
Rate of compensation, 102.03(4); 102.11(1)
Schedule, 102.52
Social Security offset, 102.44(5)
Unscheduled, 102.44(3) and (6)
Permanent total disability
Advancements, 102.32(7)
Death benefit, 102.46; 102.47(1)
Duration, 102.44(2)
Rate of compensation, 102.03(4); 102.11(1); 102.44(2)
Social Security Offset, 102.44(5)
Statutory, 102.44(2)
Supplemental benefits, 102.44(1)
Unscheduled, 102.44(2)
Petition for review, See Appeals
Pharmacy Fees, 102.16(1m); 102.18(1)(bg)3; 102.425
Disputes, 102.425(4a) and (b)
Physical examination,
Oppressive exam, 626.12(3)
Physical fitness programs, 102.03(1)(c)3
Physicians, chiropractors, psychologists, dentists, physician assistants, advanced practice nurse prescribers, or podiatrists
Choice of, 102.42(2)
Injured must submit to IME, 102.13(1)
Malpractice by, 102.29(3)
Out-of-state, testimony by, 102.13(1); 102.17(1)(d)
Out-of-state, treatment by, 102.42(2)
Privilege waived, 102.13(1)
Reasonableness of bills may be reviewed, 102.16(2); DWD 80.72
Reports to be supplied, DWD 80.21
Testimony and reports, 102.13(1); 102.17(1)
Treatment, 102.42(2)
Work restrictions set by, DWD 80.49(8)
Podiatrists. See Physicians
Police officers, See Firefighters and Police Officers
Postage, 102.13(2)(b)
Post mortem examinations, See Autopsy
Posthumous child, See Death Benefits
Postponements of hearings, See Hearings
Pre-existing disability, See Second Injuries
Preference of claims, 102.28(1)
Preference of required employer payments,

102.84
Prehearing conference, 102.17(1)(b)
Premises, 102.03(1)(c)
Premium payments from employees not allowed, 102.16 (3) and (4)
Prescription drug monitoring, ch. 961 (Not in this publication.)
Present worth of unpaid compensation,
How determined, 102.32(3)(6)
Presumptions
Dependency, 102.52(1)
Disability, 102.44(2)
Firefighters, 102.11(1)(a)4.; 891.45
Flight attendants, 102.11(1)(a)4
Maximum wage under age 27, 102.11(1)(g)
Prima facie evidence
Certified reports/records, 102.17(1)(d)
Safety reports, 102.17(1)(h)
Primary liability of employer, 102.62
Prisoners, See Inmates
Private school, 102.077
Privilege
No doctor-patient privilege, 102.13(2)(a)
Professional employer organizations, see Leasing Companies
Prohibited acts
Insurer may not refuse to reply to department correspondence, 102.31(3)
Employee may not contribute to compensation cost, 102.16(3) and (4)
Employee may not waive right to compensation, 102.16(5)
Promptness of payment, 102.22; DWD 80.02(3)
Prosecution for fraud, 102.125
Prosthetic devices, See Appliances
Proprietor, 102.07(15); 102.075
Provision of alternative benefits. See Religious sects
Psychologists. See Physicians
Public assistance, reimbursement for, 102.27(2)
Public employees, 102.03(1)(c)5
Are covered, 102.07(1)
Benefits for death, disability, forced retirement, 40.65
Injured in riot or insurrection, 106.25
Publishers,
May carry insurance of agency, 102.31(1)(c)
Of minor, 102.60(7)

Q

Qualified loss management program, 626.125 (Not printed in this booklet.)
Quasi-public corporations, 102.01(2)(d); 102.04(1)(a)

R

Random searches of department records, 102.33(2); DWD 80.025(2)
Rating bureau
Definitions, 102.01(2)(gm); DWD 80.61(3)
Filing of insurance policy with, 102.31(1)(e)
Records of, 102.31(8); 102.33(2)(c)
To receive notice of cancellation or termination of insurance, 102.31(2); DWD 80.65
To provide information to the department, 102.31(8)
Reasonable and necessary medical expense, See Medical Expense
Reasonable costs of records, 102.13(2)(b)
Recorded Statement of Employee, 102.123
Records
Of employers, 102.37
Of department, 102.33; DWD 80.025
Of hospitals, as evidence, 102.17(1)(d)
Of payments, 102.38
Red Book, 102.425(3)(a)1
Red Cross, 102.17(17g)
Referrals for treatment, 102.42(2)(a)
Refunds by state, 102.63
Refusal to rehire, 102.31(1)(c); 102.35(3)
Exclusive liability of employer, 102.35(3)
Exception for uninsured employer's fund, 102.81(1)
Regarding self-insurer, 102.31(5)
Refusal to submit to medical examination, 102.13(1)(c)
Refusal to submit to medical treatment, 102.42(6)
Rehiring of employee, see Refusal to Rehire
Reimbursement
For public assistance, 102.27(2)
Group insurance, 102.30(7)
Of compensation, 102.175(2); 102.18(1)(bw)
Of premiums, 102.16 (3) and (4)
Of supplemental benefits, 102.44(1)
Release from liability for future compensation payments, 102.32

Religious sects
Application for exemption, 102.28(3)(d)
Definition, 102.01(2)(eg)
Exemption from duty to insure, 102.28(2)(b); 102.28(3)(a)
Failure to provide acceptable standard of living, 102.28(3)(c)
Minors when members of religious sects, 102.28(3)
Number of employees, 102.07(4m); 102.07(5)(d)
Provision of alternative benefits, 102.28(3)
Waiver of right to compensation, 102.16(5); 102.28(3)(a)
Remanded record to commission, See Appeals
Renewed period of temporary disability, 102.43(7)
Reports
Alien dependent interim reports, 102.19
Certified reports:
Data bases for health-service fees, 102.16(2); DWD 80.72
Medical reports, 102.17(1)(d); HA 4.15
Safety reports, 102.17(1)(h)
Vocational reports, 102.17(1)(d); 102.17(7)(a)-(c); DWD 80.21; HA 4.15
Employee reports:
Permanent work restrictions to employer, DWD 80.49(8)
Social security disability payments, 102.44(5)(c)
Uninsured employer fund, DWD 80.62(3)(a)
Employer reports:
Compensable injuries to insurer, DWD 80.02(1)
Death, DWD 80.02(1)
Employee name, address, age, wages, time and cause of accident; nature and extent of injury, 102.37
Fraud reports, 102.125
Number of employees, nature of work, insurer name, policy number, expiration date, 102.28(6)
Forms provided or approved by the department, 102.33; DWD 80.02 end note; 80.27
Insurance company reports:
Answer to application, HA 4.04
Compensable injuries, DWD 80.02(2), (2m) and (3)
Fraud, 102.125
Payment records, 102.37; DWD 80.02
Policy cancellation notices, DWD 80.65
Social security offset reduction, 102.44(5)(c)
TTD more than 13 weeks, DWD 80.42
Itemized medical expenses 15 days before hearing, 102.17(8)
Examinations ordered by Department, 102.13(3); 102.17(1)(g) and (e); 102.565(2)
Eye examinations, DWD 80.26(6)
Notice and copies to parties and Department, DWD 80.21; HA 4.15
Not evidence, 102.17(7)(b); 102.40
Self-insured employer reports:
Answer to application, HA 4.04
Compensable injuries, 102.28(2)(b) and (6); DWD 80.02(2) and (3)
Fraud, 102.125
Organizational changes, financial statements, claim payments, DWD 80.60(4)(a)
Payments, 102.38; DWD 80.02
Performance for evaluating application or renewal of self-insurance, DWD 80.60(4)(c)6
Social security offset reduction, 102.44(5)(c)
TTD more than 13 weeks, DWD 80.42
State agency reports, 102.08; DWD 80.60(3)(a) and (b)
Wisconsin compensation rating bureau reports, 102.31(8)
Rescue squads, 102.07(7); 102.475
Response to correspondence, 102.31(3)
Restricted work/availability
Retirement fund, public employees, 40.65; DWD 80.41
Revocation
Of exemption of self-insurer, 102.28(2)(c); 102.31(5); DWD 80.02(3)
Of license of insurance, 102.31(4); DWD 80.02(3)
Of license to appear, 102.17(1)(c); DWD 80.20
Ride sharing, See Car Pooling, 102.03(1)(c)3
Rule making authority
Rules of procedure, DWD 80

S

Safe place statute, 101.11
Safety inspection or safety advisory service, 102.03(3)
Safety Violations, See Increased Compensation and Decreased Compensation
Salary, payment during disability, 102.07(3); 102.17(4); DWD 80.62(2)(e)2
Searches of department records, 102.33(2); DWD 80.025
Seasonal employment, 102.11(1)(b)
Second injuries, special indemnity for, 102.59; DWD 80.50(1)(b); DWD 80.68
Payments to Second Injury Fund, See Appendix
Self-inflicted injury, 102.03(1)(d)
Self-insurance, 102.28; DWD 80.60
Application fees for self-insurance, 102.28(2)(b); 102.75(4)
Application fees, 102.28(2)(b); 102.75(4)
Assessment for insolvent self-insurers, 102.28(7)(8); DWD 80.40
Continuing liability, bond discharge, 102.28(2)(b); 102.32; DWD 80.60(4)(d)
Execution against for noncompliance, 102.28(5)
Governmental employers, 102.28(2)(bm)
False financial information, 102.28(2)(b)
Revocation of, 102.28(2)(c); DWD 80.02(3)
Self-insured liability fund, 20.445(1)(s); 102.28(7) and (8); DWD 80.40
Self-insurers council, See Advisory Councils
Semester break, 102.43(7)(b)
Service of papers in compensation cases, DWD 80.07
Settlements, See Compromise
Sick leave/benefits, 102.30(3); 102.43(6)
Sixty-day notice of vocational testimony, 102.17(7)(b)
Social security, 102.44(5)
Offset retraining, 102.44(5)
Reduction for failure to report payments, 102.44(5)(c)
Sole proprietor, 102.07(15); 102.075
Solicitation by employer, 102.16
Standard deviation, 102.16(2)(d)
State of Wisconsin
Employees are covered, 102.07(10)
Administration for state employees, 102.08
Awards to state employee, 102.42(8)
National Guard and State Defense Force, 102.07(9); 102.475; 106.25
Legislators, when covered, 102.03(1)(g)
Employees of political subdivisions are covered, 102.04
State treasurer, payments to
Compensation payable to fraudulent minor, 102.60(5)(b)
On account of death of employee, 102.49(5)
On account of amputation, 102.59(2)
When no dependents, death benefit, 102.47
When third party action taken, 102.49(5)(d)
Statement of employee, 102.123
Statute of limitations,
Eliminated for certain injuries, 102.17(4), 102.66(1) and (2)
Extended, 102.17(6)
Extension, occupational disease, 102.17(4); 102.66
Extension, minors, 102.17(6)
For review of compromise and stipulations, 102.16(1)
Occupational disease, 102.17(4)
Third party claims, 102.29(5)
Traumatic, 102.17(4)
Two years for filing application for hearing, 102.12
Statutory employee, 102.07(8)
Stipulations, DWD 80.10
Structured Settlements, DWD 80.03(1)(f)
Students,
As employee of technical school, 102.07(12)
Work study program, 102.07(12m)
Election by school district, 102.077
Third party actions not allowed, 102.29(8)
Subcontractor, employer liable to employees of, 102.06
Subpoena, See Hearings
Substantial fault, 102.43(9)(c)
Unemployment insurance, 108.04(5g)
Successive injuries, See Apportionment
Successor liability, See Uninsured Employers Fund
Suicide, 102.03(1)(d)
Suitable employment,
Disputed healing period, use of tie-breaker, 102.13(3)
If available and does not provide, 102.35(3)
For disfigurement, 102.56(1)
Return to without retraining, 102.61(1m)(a)
Factor in loss of earning capacity, DWD

80.34(1)(h) and (i)
Available during healing period, DWD 80.47
85 percent rule for retraining, DWD 80.49(5)
90 percent rule for retraining, 102.61(1g)(a)
Summons and complaint, See Appeals
Supplemental benefits
Costs of DOJ, 102.64(2)
Fund, 102.65
Payments, 102.44(1)
Payments for barred claims, 102.17(4); 102.66
Reimbursements, 102.44(1)(c)
Uninsured employers fund, 102.82(3)(b)
Support payments, 102.27(2)
Supreme Court, see Appeals
Surcharges, 102.35
Suspension of license to appear, See Agents

T

Tape recordings, 102.15; HA 4.12
Temporary disability: TPD & TTD
Actual wage loss, 102.43(2) and (3)
Criminal conviction, incarceration, 102.43(9)(d)
Compulsory vacation in accordance with collective bargaining agreement, 102.43(8)(b)
Escalated benefit rate after 2 years, 102.43(7)(a)
Escalated benefit rate while in course of retraining, 102.43(7)(c)
Generally, 102.43
Healing period
If total or partial, 102.43(3)
Continues if suitable employment not available, DWD 80.47
Misconduct/substantial fault, 102.43(9)(e)
Not payable for occupational hearing loss, 102.555(2)
Rate of compensation, 102.03(4); 102.11(1); 102.43(1)
Renewed period, 102.43(7)
Salary continuation, DWD 80.02 (2)(e)
Sick pay, 102.30(3); 102.43(6)
3-day waiting period, 102.43
Tie-breaker exam when extent disputed, 102.13(3)
Use as basis for social security offset, 102.44(5)(e)
Temporary help agency
Defined, 102.01(2)(f)
Has liability for entire claim, 102.04(2m)
Negligence suit against worksite employer barred, 102.29(6)
Ten percent penalty for delay, 102.22(1)
Testimony, See Hearings
Third party, common carrier, 102.03(2); 102.29(4)
Third party liability, 102.29
Against co-employee allowed, 102.03(2)
Community service participant, 102.29(8m)
Distribution of proceeds, 102.29(1)
Food Stamp employment and training program participants, 102.29(8r)
Temporary help agency employee, 102.29(6) and (7)
Work experience participants, 102.29(9)
State treasury payments, 102.49(5)(d)
Students, 102.29(8)
Uninsured employers fund, 102.81(2), (4), (6)
Three day waiting period, 102.43, See Temporary disability
Tie breaker exams, 102.13(3); 102.17(1)(g)
Tinnitus, 102.555(10)
Tort, 102.29
Total impairment,
Of eye. 102.52(16)
Permanent disability, 102.44(2)
State fund payments for, 102.59(2)
Statute of limitations, 102.17(4)
Toxic and hazardous substances, 102.565
Training, See Vocational Rehabilitation
Transcripts of testimony, 102.15(2); HA 4.13,
Translator at IME, 102.13(1)(b)
Transportation, See Car Pooling
Travel expense
During course of retraining, 102.61
Employer not liable for unreasonable travel to obtain treatment, 102.42(2)(b)
For attendance with IME, 102.13(1)(b)
For treatment, 102.42(1)
Mileage rates, See Appendix
Traveling employees, 102.03(1)(f)
Tuberculosis, treatment of, 102.42(6)
Tuition, 102.61 Vocational Rehabilitation

U

Unestranged parents, 102.48(1)
Uninsured employers
Notice
Of possible closure order, 102.28(4)(b)

Of reimbursement owed to department, 102.82(1)
Before levy, 102.835(12)
Of citation, 102.87(2)
Collection of uninsured employer payments
Warrants, 102.83
Levy, 102.835
Citation procedure, 102.87
Compensation for injured employees of, 102.81
Definition, 102.01(2)(h)
Payments, 102.82
Waiver of payments, 102.82(2)(ar)
Penalties
Judgment against uninsured employer, 102.85(5)
For false information, 102.85(2)
Assessments against, 102.85(4)
Repeat violations, 102.88
Parties to a violation, 102.89
Uninsured employers fund (UEF)
Definition, 102.01(2)(j)
Effective date, 102.80(3)
Employee cooperation, DWD 80.62(5)
Employer cooperation, DWD 80.62(6)
Established, 102.80
Insolvency of fund, 102.80(3)(ag) and (c)
Insurance service organization, 102.81(2)
Reinsurance, 102.81(2)
Reporting a claim, DWD 80.62(3)
Successor liability, 102.80(4)(a)
Unscheduled disabilities
For loss of earning capacity, DWD 80.34
1,000 weeks, 102.44(3)

V

Vacations, compulsory, 102.43(8)
Van pooling, See Car Pooling
Verified reports, See Reports
Violation of employers alcohol or drug use policy 102.58
Violation of obligation to insure, 102.82; 102.85; 102.88
Violation of safety rules, See Increased Compensation and Decreased Compensation
Vision Loss
Determination of, DWD 80.26
Permanent total disability for blindness, 102.44(2)
Schedule, 102.52(15) and (16)
Vocational experts for loss of earning capacity
Employee shall submit to exam by, 102.13(1)(am)
Notice of testimony/reports, 102.17(7)(b)
60 days for applicant
45 days for respondent
No prejudice delay exception, 102.17(7)(c)
Vocational rehabilitation
80 week limitation for retraining, 102.43(5)
Department rehabilitation specialist, 102.42(9)
Eligibility, DWD 80.49
DVR certified eligibility for, 102.61(1)
Maintenance, 102.61
Private rehabilitation services, 102.61(1m)
Costs of services, See Appendix
Specialist certification, DWD 80.49(6)
Employee choice, DWD 80.49(7)
90 day placement effort, DWD 80.49(9)
Retraining, DWD 80.49(10)
Temporary disability while in retraining, 102.43(5)
Tuition, fees and books, 102.61
Vocational students employed by school, 102.07(12)
Volunteers
Firefighters are employees, 102.07(7); 102.475;
Average weekly earnings for firefighters, DWD 80.30
Defined by department rule, 102.07(11)
For nonprofit organization, 102.07(11m)

W

WKC-16-B, 102.17(1)(d); HA 4.15
Wages, See Earnings
Annual Wages:
Concerning death benefits, 102.46; 102.48(2); 102.49(3)
Concerning disfigurement, 102.56(1)
50 times average weekly earnings, 102.11(2)
Average annual, average daily and average weekly defined, 102.11
Computation of weekly wage, DWD 80.51
Deduction of, to pay compensation liability, 102.16(3)
Other employment, 102.43(6)
Sick leave from other employment, 102.43(6)
Under age 27 presumption of maximum for permanent disability or death, 102.11(1)(g)

Workweek
Defined, 102.01(2)(k)
Use of normal workweek, 102.11(1)(a)3
Flight attendant, 102.11(1)(a)4
Firefighter, 102.11(1)(a)4
Part-time employees, 102.11(1)(am)
Seasonal employment, 102.11(1)(b)
Waiting period, 3 day, 102.43, See Temporary Disability
Waiver
For alternative benefits, 102.28(3)
Of benefits, 102.16(5)
Of penalties, 102.82(2)
Of patient privilege, 102.13(2)
Of service by appearance, 102.30(4)
Weekly compensation schedule, limitation, 102.43; 102.44
Weekly wage, 102.11
Welfare reimbursement, 102.27(2)(b)
Wellness programs, 102.03(1)(c)3
Wisconsin Compensation Rating Bureau, See Rating Bureau
Withdrawal of election by employer, 102.05
As to farming, 102.05(3)
Joint ventures, 102.28(2)(a)
Work experience programs, 102.29(9)
Work injury supplemental benefit fund, 20.445(1)(t); 102.64; 102.65; 102.66
Work permit for minor, 102.60
Work release programs, See Inmates
Work study programs, See Students
Work training, 102.07(12m)(b); 102.077; 102.29(8)
Workweek, 102.01(2)(k)
Wrap-up insurance, See Construction Projects

APPENDICES

EFFECTIVE DATE	01/01/2017	03/02/2016	01/01/2016	01/01/2015	01/01/2014	01/01/2013	04/17/2012	01/01/2012	01/01/2011	05/01/2010
MAXIMUM WEEKLY WAGE FOR	$1,441.50	$1,404.00	$1,404.00	$1,366.50	$1,338.00	$1,318.50	$1,281.00	$1,281.00	$1,230.00	$1,222.50
TEMPORARY, PERMANENT										
TOTAL & DEATH BENEFITS										
WEEKLY RATE	$961.00	$936.00	$936.00	$911.00	$892.00	$879.00	$854.00	$854.00	$820.00	$815.00
DAILY RATE	$160.17	$156.00	$156.00	$151.83	$148.67	$146.50	$142.33	$142.33	$136.67	$135.83
MAXIMUM WAGE FOR PERMANENT	$543.00	$513.00	$483.00	$483.00	$483.00	$483.00	$468.00	$453.00	$453.00	$438.00
PARTIAL ONLY										
MONTHLY RATE	$1,568.67	$1,481.89	$1,395.33	$1,395.33	$1,395.33	$1,395.33	$1,352.00	$1,308.67	$1,308.67	$1,265.33
WEEKLY RATE	$362.00	$342.00	$322.00	$322.00	$322.00	$322.00	$312.00	$302.00	$302.00	$292.00
MAXIMUM ANNUAL WAGE	$72,075.00	$70,200.00	$70,200.00	$68,325.00	$66,900.00	$65,925.00	$64,050.00	$64,050.00	$61,500.00	$61,125.00
(WEEKLY WAGE X 50)										
MAXIMUM DEATH BENEFIT	$288,300.00	$280,800.00	$280,800.00	$273,300.00	$267,600.00	$263,700.00	$256,200.00	$256,200.00	$246,000.00	$244,500.00
(ANNUAL WAGE X 4)										
MAXIMUM PAYMENT TO SPOUSE										
MONTHLY RATE	$4,164.33	$4,056.00	$4,056.00	$3,947.66	$3,865.33	$3,808.00	$3,700.66	$3,700.66	$3,553.33	$3,531.66
WEEKLY RATE	$961.00	$936.00	$936.00	$911.00	$892.00	$879.00	$854.00	$854.00	$820.00	$815.00
MAXIMUM PAYMENT FROM										
CHILDREN'S FUND										
MONTHLY RATE	$416.43	$405.60	$405.60	$394.77	$386.53	$380.90	$370.07	$370.07	$355.33	$353.17
WEEKLY RATE	$96.10	$93.60	$93.60	$91.10	$89.20	$87.90	$85.40	$85.40	$82.00	$81.50
DEATH BENEFITS TO	$6,500.00	$6,500.00	$6,500.00	$6,500.00	$6,500.00	$6,500.00	$6,500.00	$6,500.00	$6,500.00	$6,500.00
UNESTRANGED PARENTS										
MAXIMUM BURIAL EXPENSE	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00
PAYMENT INTO STATE FUND	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00
s. 102.59										
PAYMENT INTO STATE FUND	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00	$20,000.00
TOTAL DEPENDENCY-- s. 102.49										

PAYMENT INTO STATE FUND
NO DEPENDENCY--s. 102.49

01/01/2017	$57,660 per installment if max	01/01/2014	$53,520 per installment if max
	$56,360 if parents receive $6,500		$52,220 if parents receive $6,500
01/01/2016	$56,160 per installment if max	01/01/2013	$52,740 per installment if max
	$54,860 if parents receive $6,500		$51,440 if parents receive $6,500
01/01/2015	$54,660 per installment if max	01/01/2012	$51,240 per installment if max
	$53,360 if parents receive $6,500		$49,940 if parents receive $6,500

Effective For Injuries On Or After 1/1/2006
$20,000 plus 100% of Death Benefit in 5 installments

DWD is an equal opportunity employer and service provider. If you have a disability and need information in an alternate format, or need it translated to another language, please contact (608) 266-1340 voice or (866) 265-3142, TTY.

WKC-9572-P (R. 12/2016)

Mileage Rates

AFTER:	RATE PER MILE:
11/15/69	$.10
7/1/73	$.11
7/1/75	$.14
7/1/77	$.15½
7/1/78	$.17
7/1/79	$.18
7/1/80	$.19
7/1/81	$.20½
7/1/82	$.21 ½
1/1/91	$.24
1/1/94	$.26
1/1/98	$.29
1/1/02	$.32 ½
1/1/06	$.38 ½
5/1806	$.42 ½
12/1/07	$.46 ½
7/1/08	$.48 ½
7/1/12	$.51

Private Rehabilitation Counselor Fee for Services

1994	$1,000.00
1995	$1,000.00
1996	$1,028.00
1997	$1,058.00
1998	$1,083.00
1999	$1,109.00
2000	$1,133.00
2001	$1,169.00
2002	$1,193.20
2003	$1,211.00
2004	$1,239.00
2005	$1,270.00
2006	$1,312.00
2007	$1,361.00
2008	$1,392.00
2009	$1,453.00
2010	$1,449.00
2011	$1,474.00
2012	$1,509.00
2013	$1,548.00
2014	$1,585.00
2016	$1,616.00
2017	$1,631.00

Payments due Work Injury Supplemental Benefit Fund §102.49 and §102.59

	Amount due Childrens Fund §102.49					Amount due Second Injury Fund §102.59		
	Total Dependency	Partial Dependency	Annual Payment					
Effective Date						*Effective Date*		*Amount Payable*
7/1/1923		$1,000.00				8/1/1919		$150.00
8/11/1927		$1,600.00				4/23/1927		$75.00
9/17/1935		$2,000.00				7/1/1951		$150.00
8/6/1947		$2,500.00				7/1/1953		$400.00
7/1/1951		$3,000.00				7/1/1955		$850.00
7/1/1953		$4,000.00				7/1/1957		$1,500.00
7/1/1955		$5,500.00				12/30/75		$2,500.00
4/1/1959	$2,500.00	$11,000.00				1/1/1978		$4,000.00
10/1/1962	$2,000.00	$11,000.00				1/1/1986		$7,000.00
10/1/1963	$1,000.00	$11,000.00				3/30/2004		$10,000.00
10/1/1965	$500.00	$11,000.00				4/1/2006		$20,000.00
10/1/1967	0	$11,000.00						
10/1/1968	$500.00	$11,000.00						
10/1/1969	$500.00	$11,000.00						
10/1/1970	$1,000.00	$11,000.00						
*12/30/1975	$2,500.00	$25,920.00						
*1/1/1976	$2,500.00	$42,240.00	@	$8,448.00				
*1/1/1977	$2,500.00	$45,364.80	@	$9,072.96				
*1/1/1978	$2,500.00	$48,480.00	@	$9,696.00				
*1/1/1979	$2,500.00	$52,320.00	@	$10,464.00				
*5/13/1980	$2,500.00	$55,920.00	@	$11,184.00				
*1/1/1981	$2,500.00	$59,760.00	@	$11,952.00				
*1/1/1982	$2,500.00	$64,560.00	@	$12.912.00				
*1/1/1983	$2,500.00	$70,560.00	@	$14,112.00				
**1/1/1984	$2,500.00	$73,200.00	@	$14,640.00				
**1/1/1985	$2,500.00	$77,040.00	@	$15,408.00				
***1/1/1986	$5,000.00	$98,700.00	@	$19,740.00				
1/1/1987	$5,000.00	$101,400.00	@	$20,280.00				
1/1/1988	$5,000.00	$104,400.00	@	$20,880.00				
1/1/1989	$5,000.00	$108,900.00	@	$21,780.00				
1/1/1990	$5,000.00	$113,400.00	@	$22,680.00				
!		$106,900.00	@	$22,380.00				
1/1/1991	$5,000.00	$116,400.00	@	$23,280.00				
!		$109,900.00	@	$21,980.00				

	Total Dependency	Partial Dependency		Annual Payment				
1/1/1992	$5,000.00	$135,000.00	@	$27,000.00				
!		$128,500.00	@	$25,700.00				
1/1/1993	$5,000.00	$135,000.00	@	$27,000.00				
!		$128,500.00	@	$25,700.00				
#1/1/1994	0	0						
#1/1/1995	0	0						
#1/1/1996	0	0						
#1/1/1997	0	0						
#1/1/1998	0	0						
1/1/1999	$5,000.00	$161,400.00	@	$32,280.00				
!		$154,900.00	@	$30,980.00				
1/1/2000	$5,000.00	$164,700.00	@	$32,940.00				
!		$158,200.00	@	$31,640.00				
1/1/2001	$5,000.00	$174,600.00	@	$34,920.00				
!		$168,100.00	@	$33,620.00				
1/1/2002	$5,000.00	$194,100.00	@	$38,820.00				
!		$187,600.00	@	$37,520.00				
1/1/2003	$5,000.00	$200,700.00	@	$40,140.00				
!		$194,200.00	@	$38,840.00				
3/30/2004	$10,000.00	$206,100.00	@	$41,220.00				
!		$199,600.00	@	$39,920.00				
1/01/2005	$10,000.00	$213,300.00	@	$42,660.00				
!		$206,800.00	@	$41,360.00				
1/01/2006	$10,000.00	$202,800.00	@	$40,560.00				
!		$196,300.00	@	$39,260.00				
4/01/2006	$20,000.00	$223,200.00	@	$44,640.00				
!		$216,700.00	@	$43,340.00				
1/1/2007	$20,000.00	$233,100.00	@	$46,620.00				
!		$226,600.00	@	$45,320.00				
1/1/2008	$20,000.00	$241,500.00	@	$48,300.00				
!		$235,500.00	@	$47,000.00				
1/1/2009	$20,000.00	$242,400.00	@	$48,480.00				
!		$235,900.00	@	$47,180.00				

	Total Dependency	Partial Dependency		Annual Payment				
1/1/2010	$20,000.00	$244,500.00	@	$48,900.00				
!		$238,000.00	@	$47,600.00				
1/1/2011	$20,000.00	$246,000.00	@	$49,200.00				
!		$239,500.00	@	$47,900.00				
1/1/2012	$20,000.00	$256,200.00	@	$51,240.00				
!		$249,700.00	@	$49,940.00				
1/1/2013	$20,000.00	$263,700.00	@	$52,740.00				
!		$257,200.00	@	$51,440.00				
1/1/2014	$20,000.00	$267,600.00	@	$53,520.00				
!		$261,100.00	@	$52,220.00				
1/1/2015	$20,000.00	$273,300.00	@	$54,660.00				
!		$266,800.00	@	$53,360.00				
1/1/2016	$20,000.00	$280,800.00	@	$56,160.00				
!		$274,300.00	@	$54,860.00				
1/1/2017	$20,000.00	$288,300.00	@	$57,660.00				
!		$281,800.00	@	$56,360.00				

*80% of death benefit if no dependents
12/30/1975 through 12/31/1983 (if injury causes death)
payable in 5 annual installments

**80% of death benefit payable if no dependents also under §102.47(1), §102.49(5)(b)

***100% of death benefit payable + payment due under §102.47(1), §102.49(5)(a)

no payment due to WISBF for injuries occurring from 1/1/1994 through 12/31/1998

! If parents receive $6,500.00

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Suggested Forms for Procedure

HEARING APPLICATION

Please Read Instructions On Top Sheet.

Provision of your Social Security Number (SSN) is mandatory under Section 111 of Medicare, Medicaid and SCHIP Extension Act 2007 (42 U.S.C. s. 1395y (b) (7) & (8)) and will be used to identify the claimant. Failure to provide it may result in penalties and delayed payment of benefits.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

1. Employee Name, Address, City, State, Zip	2. Employer Name, Address, City, State, Zip (At Time Of Injury)	3. WC Insurance Carrier, Address, City, State, Zip 3a. Insurance Carrier Telephone No. (Area Code) ( ) 3b. Date of Injury (Mo/Day/Yr)
1a. Employee Social Security No.	2a. Federal Employer Identification Number [If Known]	3c. Last Date Employee Worked Before Disability
1b. Employee Telephone No. (Include Area Code) ( )	2b. Employer Telephone No. (Include Area Code) ( )	3d. Date Notice of Injury Given to Employer (Mo/Day/Yr):
1c. Date of Birth (Mo/Day/Yr) Sex ☐ M ☐ F	2c. Nature of Employer Business	4. Have You Applied for or are You Receiving Social Security Benefits? ☐ Yes ☐ No
1d. Employee Attorney (if any) Name & Full Address	2d. Employee Occupation When Injured 2e. Employee Gross Weekly Wage When Injured	4a. Have You Applied for or are You Covered Under Medicare? ☐ Yes ☐ No If Yes, Medicare Claim Number: _____
	Answer Questions 5 To 5c If Claim Is Made For Death Benefit	
1e. Is the Certification of Readiness included with this Application? ☐ Yes ☐ No	5. Name of Deceased and Date of Death	5a. Are You a Dependent of the Deceased? ☐ Yes ☐ No
1f. Attorney's Telephone No. (Include Area Code) ( )	5b. Applicant's Relation to Deceased ☐ Husband ☐ Wife ☐ Child ☐ Other	5c. Did You Live with the Deceased? ☐ Yes ☐ No

6. How did the Injury or Death Occur? If Possible Specify if Single Event or Long-Term Exposure.	6a. Describe Parts of the Body Affected.

7. Check the Boxes Below for which Compensation is being Sought and Specify Detail, if known:

7a. ☐ Temporary Total Disability (Day, Month and Year) From To	From To	
7b. ☐ Temporary Partial Disability From To	7c. ☐ Transportation Costs (Mileage)	
7d. ☐ Permanent Partial Disability _____ % of Body Part	7e. ☐ Permanent Total Disability Starting Date ___/____/____	
7f. ☐ Medical Expense Denied $ _____ Has Treatment Ended? ☐ Yes ☐ No	7g. ☐ Penalty	7h. ☐ Other

8. Names of Medical Practitioners who Treated Applicant:

9. Is the Employee Working Now? ☐ Yes ☐ No

10. Were Medical Expenses Paid? ☐ Yes ☐ No If Yes, By Whom?	11. Are You Currently Receiving Worker's Compensation Disability Benefits? ☐ Yes ☐ No
12. Have Sickness and Accident Benefits/Income Continuation been Paid for Lost Wages? ☐ Yes ☐ No	12a. If Yes, Indicate by whom and the Amounts.
13. I will be Ready for a Formal Hearing in: ☐ Due Course. ☐ Due Course but not before this Date _____	14. I Request the Hearing be Scheduled at the Wisconsin City shown here:
15. _____ Employee Signature Date Signed If Represented, do you agree that an Attorney's Fee, fixed by the Department at no more than 20% of your Recovery, may be paid directly from the Compensation you Recover? ☐ Yes ☐ No	16. **FOR OFFICE USE ONLY:** HR PT NR Issues_____ ☐ GL35 ☐ GL35A ☐ GL48 Length_____ ☐ GL33 ☐ GL70 ☐ GL34 Date _____ ☐ GL33A ☐ GL39 ☐ GL31

WKC-7 (R. 10/2016)

Ply's 1, 2 & 3: DWD-WORKER'S COMPENSATION; Ply 4: FOR YOUR RECORDS

WORKER'S COMPENSATION HEARING INSTRUCTIONS
PLEASE READ CAREFULLY AND KEEP FOR YOUR RECORDS

HEARING AND PREHEARING CONFERENCES:
You may file an application for hearing (WKC-7) if you believe you did not receive all the benefits to which you were entitled.

In some cases, a prehearing conference is scheduled before a formal hearing is held. The purpose of the conference is to clarify issues and, if possible, reach some agreement on the case. Bring to the prehearing conference any documents, bills or other records which may help clarify the issues in dispute. Pre-hearing conferences and formal hearings are conducted by a department attorney, called an administrative law judge. If you do not have your own attorney, the judge may ask questions to bring out the facts.

After a formal hearing, the judge issues a written decision. Any party may appeal the decision within 21 days to the Labor and Industry Review Commission (LIRC). A decision by LIRC may be appealed to circuit court within 30 days. There can be a delay of several months before your case is scheduled since there are always many cases waiting for a hearing. You will be notified by mail when a hearing date is set and given advanced notice of at least 10 days.

PREPARATION:
You can help your case by collecting any notes you have as to dates of disability, visits for treatment, mileage and unpaid bills. Bring them with you to the hearing. At the hearing, be ready to explain and prove your claim for benefits. You or your attorney should arrange to have any witnesses at the hearing who you believe will help to prove your claim. If a witness refuses to attend the hearing, you may request a subpoena to order the witness to appear.

MEDICAL TESTIMONY:
If there is a dispute over how much disability you claim or whether the disability was caused by the injury, you must have medical proof. You cannot be successful at the hearing unless you have the opinion of a physician, psychologist, podiatrist or chiropractor. You may provide this medical proof by having a doctor present at the hearing. However, you may avoid the expense of having a doctor at the hearing by having the doctor complete and sign a medical report, called WKC-16-B. Generally, your case will not be set for hearing until your doctor sends us the WKC-16-B. Medical bills should be listed separately for each health care provider and attached to a medical treatment statement form (WKC-3). We will send you the forms if you ask for them, or you may download copies of the forms from our website, http://dwd.wisconsin.gov/wc (under Resources, select WC Forms). Medical evidence and medical bills should be filed with the department at least 15 days before the hearing date.

LOSS OF EARNING CAPACITY:
You may make a claim for loss of earning capacity but only for certain types of injuries. Generally, you cannot claim loss of earning capacity for injuries to arms, legs, or hearing or vision loss. If you claim loss of earning capacity, you may have an expert testify or file a certified report that we will send you upon request.

ATTORNEY:
You may be represented by an attorney or you may present your own case. The administrative law judge is not your attorney and cannot make investigations or arrange for the appearance of witnesses. However, the judge may ask questions to bring out the facts. If you hire an attorney, the attorney should be seen as soon as possible in order to properly prepare your case. An attorney can help with investigation, producing witnesses and legal advice. The attorney may not charge more than 20% of the amount recovered for you. If the attorney gets nothing for you, you do not owe a fee for the attorney's time. However, your attorney may charge you for his or her actual costs such as charges for medical reports. Regardless of the outcome of the case, you are not required to pay attorney's fees for the employer or insurance company. Attorney's fees must be approved by the department

CERTIFICATION OF READINESS
If you are represented by an attorney, your attorney must file a Certification of Readiness before your hearing will be scheduled. The Certification will tell us that the parties to the case have shared the necessary information including medical reports and that the dispute is not likely to be resolved without a formal hearing or settlement conference.

POSTPONEMENTS OR CONTINUATIONS:
Requests for postponements or continuances of scheduled hearings will be granted only because of extraordinary circumstances. Neither the scheduling problems nor the convenience of the parties will be considered extraordinary circumstances. A postponement, continuance, or extension of time may not be granted upon the mutual agreement of the parties without the consent of the department. If you find it impossible to appear or if you decide to drop your claim, notify the Worker's Compensation Division immediately.

For More Information, See Our Website At: dwd.wisconsin.gov/wc

State of Wisconsin
Department of Workforce Development, Worker's Compensation Division
P. O. Box 7901, Madison, WI 53707-7901; (608)266-1340

INSTRUCTIONS FOR COMPLETING ATTACHED HEARING APPLICATION (FORM WKC-7)

The top three (3) copies of this application must be mailed to the Worker's Compensation Division, P.0. Box 7901, Madison, WI 53707 or filed in person at the State Office Building, General Executive Facility-I, 201 East Washington Avenue, Room C100. The last copy is to be retained for your records. If you need assistance with the application, please telephone (608)266-1340.

To ensure timely scheduling of a hearing on this claim, you should provide as much of the information requested on this application as you can. You must submit medical documentation to support each injury date claimed. Be certain to submit all medical documentation since the department will not schedule a hearing until the medical documentation in support of the claim is received.

If, at any time, you need more space than is provided on the form, use a separate sheet of paper, containing the employee's Social Security number, to provide the required information. Specific instructions for parts of the application are listed below.

BOX 1:
Regarding claims for death benefits, "EMPLOYEE" in Box 1 refers to the individual(s) requesting the hearing. All other information (including Employee's Social Security Number) pertains to the deceased worker.

BOX 7a Temporary Total Disability:
Temporary total disability is available if, while healing from the injury, the employee did not receive any wages because of the injury. Insert the begin date and the end date for each period of total wage loss that occurred while healing from the injury.

BOX 7b Temporary Partial Disability:
Temporary partial disability is available if, while healing from the injury, the employee received less than the employee's normal wage for a period because of the injury: for example, partial wage loss because of reduced work hours or normal work hours at a reduced pay rate. Insert the begin date and the end date for each period of partial wage loss that occurred while healing from the injury.

BOX 7d Permanent Partial Disability:
Permanent partial disability is available if the injury leaves the employee with a disability (decreased ability to mentally and/or or physically function), after the employee has finished healing. The "end of healing," or the "healing plateau," is the point where further improvement is unlikely. Disability in the "upper extremities" (shoulders to the fingertips) or in the "lower extremities" (hip to the toes) is rated as a percentage of total disability at the joint(s) where the disability exists. Ratings of 100% apply to amputations and disability that renders the body part useless for practical purposes. Disability in the head, neck, or torso is rated as a percentage of disability to the body as a whole.

BOX 7e: PERMANENT TOTAL DISABILITY
Permanent total disability is available if the injury leaves the employee with disability that prohibits the performance of all services except those that are so limited in quantity, quality, and/or dependability that no reasonably stable market for them exists.

BOX 13 -- FORMAL HEARING:
Applications are scheduled in first-in-first-out order based upon the date that the claim is deemed ready for hearing. This is called "due course." The "ready date" is the date on which the department receives the hearing application and a report containing a medical opinion that supports the benefits claimed in the application. Applications filed without medical support will not be scheduled for hearing until the department receives a medical report supporting the claim.

BOX 15 – EMPLOYEE'S SIGNATURE AND ATTORNEY'S FEE:
Sign and date the hearing application. If represented by an attorney, be sure to read the statement regarding attorney's fee and check either the "Yes" or "No" box.

BOX 16 – DO NOT WRITE IN THIS AREA – FOR DEPARTMENT USE ONLY.

-SEE REVERSE SIDE FOR HEARING INSTRUCTIONS-

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number - -	Sex ☐ M ☐ F	Employee Home Telephone No. ( ) -

Employee Street Address	City	State	Zip Code -	Occupation

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured? ☐ Yes ☐ No	Nature of Business (Specific Product)

Employer Mailing Address	City	State	Zip Code -	Employer FEIN -

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN -
Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN -

WAGE INFORMATION

Wage at Time of Injury $	Specify per hr., wk., mo., yr., etc. Per:	In Addition to Wages, Check Box(es) if Employee Received: ☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. No. of Days/wk Avg. Weekly Amt. $

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury : AM : PM	Last Day Worked	Date Employer Notified	☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death? ☐ Yes ☐ No	Date of Death	Was This a Lost Time or Other Compensable Injury? ☐ Yes ☐ No	Did Injury Occur Because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No
Name and Address of Treating Practitioner and Hospital:
Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number ( ) -	Position	Date Signed

WKC-12 (R. 10/2016) **SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT**

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

SUPPLEMENTARY REPORT ON ACCIDENTS AND INDUSTRIAL DISEASES

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin/wc
e-mail: DWDDWC@dwd.wisconsin.gov

SUBMIT THE WKC-12 WITH THIS REPORT IF IT WAS NOT PREVIOUSLY SUBMITTED.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

1. Name of Injured Employee		2. Social Security Number	
3. Address	City	State	Zip Code
4. Injury Date	5. Last Day Employee Worked	6. Nature of Injury or Illness	
7. Employer Name	8. Address (City, State and Zip)		
9. Insurance Carrier (Not TPA or Adjuster) ☐ Check if employer is self-insured		10. Insurer Claim Number	11. N.A.I.C. Number
12. Insurer's Claim Handling Address	City	State	Zip Code

13. Date & Type of First Compensation Payment Date:	Type: ☐ TTD ☐ TPD ☐ Salary Cont'd ☐ Other	14. Amount of 1st payment $	15. Weekly Wage Used to Set TTD Rate: $ ☐ Rate below max. - WKC-13-A attached ☐ WKC-13-A not attached - Estimated date it will be sent is:
16. TTD Rate: $			

17. If 1st Payment Was Late, (more than 14 days after injury date) State Reason:

18. Remarks: ☐ Denied ☐ Being Investigated (Attach Copy of Denial Letter) ☐ Suspended -- Lack of Medical Information ☐ Suspended -- Other Reason (Attach Copy of Suspension Letter)

Date Final Medical Report required under DWD 80.02(2)(e) 4 is anticipated:

☐ Other Remarks (Specify):

	Payment Period						
19. Type of Payment	20. Last Day of Work	21. Date of Return to Work or End of Healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer Paid Holidays	23. No. of Weeks and/or Days Paid	24. Rate	25. Amount of Comp. Paid	26. Accumulated Total Amount Paid
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							

27. Amount of Permanent Partial Disability due:
(Attach supporting medical report if not previously submitted.)
Wks. @ $ = $

Indicate amount of PPD paid to date:
$

28. Final Indemnity Payment Date Type of Payment: Date of Payment:		29. Has the worker returned to work with wages at 90% or more of wages at the time of injury? ☐ Yes ☐ No	
30. Report Prepared By	31. Work Phone No. ( ) -	32. Position	33. Date Signed

WKC-13 (R. 03/2009)

Under DWD 80.02(2), for injuries which require the first report of injury, self-insured employers and insurance companies shall submit:

- A supplementary report on a form WKC-13 on or before 30 days following that on which the injury occurred.
- Make a report within 7 days from the date that payments are stopped for any reason. If any payments are stopped for a reason other than the employee's return to work, provide an explanation to the department and the employee. The insurer shall advise the employee as to the reason for stopping payments, what the employee must do to reinstate payments, and the worker's rights to a hearing.
- Make a report on form WKC-13 with a copy to the employee when payment of compensation is changed from temporary total disability or temporary partial disability to a permanent disability.
- Include a copy of the WKC-13-A with the WKC-13 for claims where the wage is less than maximum, or provide an estimated date if the wage information is not available at the time the WKC-13 is submitted.
- Make a final report on a form WKC-13 within 30 days of when final payment of any type of compensation has been made. A practitioner's report is due if temporary disability exceeds 3 weeks or if permanent disability has resulted. The final medical report showing the extent of permanent disability and the end of healing is due within 30 days after the date that payment of final compensation is made. If you are unable to obtain one, you must submit a notice explaining why you are unable to obtain one or the date you anticipate submitting one. If the original medical report was not that of the treating practitioner, a treating practitioner's report is necessary if temporary disability exceeds 3 weeks or if permanent disability has resulted. A copy of information contained in the final WKC-13 report and the final practitioner's report must be sent to the employee.

INSTRUCTIONS ON HOW TO COMPLETE THIS FORM:

Items 1 thru 11. Fill in all blanks completely.

Item 12. Fill in the mailing address of the office or adjusting company that makes the payments.
All correspondence regarding this injury will be mailed to the insurer's designated claims handling address.

Items 13 thru 16. Fill in all blanks completely. If salary/wage is continued, check the box and include the weekly amount of salary in Item 15. If first payment covered temporary partial disability, check the box in Item 13. Include a WKC-13A for TPD if TTD rate is less than minimum.

Item 17. If the first payment was made more than 14 days after the date of injury or the day the employee left work prior to the first day for which WC is paid, give reason for the delay in payment.

Item 18. If payments are suspended for any reason other than return to work, state the reason. Explain unusual circumstances under "other remarks." If benefits are denied, be sure to include a copy of the denial letter to the worker. Enter the date the final medical report is anticipated if one is required under DWD 80.02(2)(e)4 and is not attached or previously sent. A final treating practitioner's report is due if there is any permanent disability or more than 3 weeks of temporary disability paid, including TPD or salary/wage continued.

Item 19. Check the appropriate box for the type of temporary total disability paid using sections 1-4 or attach another form if there are more payment periods of temporary total (TTD) or temporary partial disability (TPD) paid. If permanent partial disability (PPD), salary continued, vocational rehabilitation or any other types of payments were made, indicate the payment type under "other".

Items 20 and 21. Enter the last day of work and the return to work or end of healing dates. Do not enter the return to work or end of healing date unless the type of compensation paid for that period has been suspended.

Item 22. Enter the number of holidays paid by the employer and not paid WC for each period of disability.

Item 23. Enter the number of whole weeks and days paid TTD or, if TPD, the number of days for which TPD was paid. Any part of one day paid is considered a whole day for TPD purposes.

Items 24 and 25. Enter the rates and compensation paid that applies to the weeks or days in items 20-23.

Item 26. Enter the cumulative total of compensation paid for that line, items 19-25.

Item 27. Enter the number of weeks due, the permanent partial disability rate, and total compensation due for the disability. (Follow Sec.102.52, 102.53, and 102.55 where applicable.) Attach supporting medical information if it was not previously submitted.

Item 28. Enter the date of the final payment of temporary compensation if the claimant has returned to work or has been released for work and all temporary compensation due has been paid. Enter the date of final payment of PPD or other type of payment.

Item 29. Check the appropriate box if all temporary compensation has been paid and a date in item 28 has been entered.

Sample of Items 19 – 26

	Payment Period						
19. Type of Payment	22. Last Day of Work	23. Date of Return to Work or End of Healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer Paid Holidays	23. No. of Weeks and/or Days Paid	24. Rate	26. Amount of Comp. Paid	26. Accumulated Total Amount Paid
☒ TTD ☐ TPD ☐ Other:	2/1/99	6/6//99	3	17+2 days	$ 538.00	$ 9,325.32	$ 9,325.32
☐ TTD ☒ TPD ☐ Other:	6/6/99	8/8/99	0	9	$ 220.00	$ 1,980.00	$ 11,305.32
☐ TTD ☐ TPD ☒ Other: Salary Cont'd	8/8/99	9/6/99	0	4	$ 538.00	$ 2,152.00	$ 13,457.32
☐ TTD ☐ TPD ☒Other: Vocational Rehab	9/6/99	12/21/99	0	15	$ 538.00	$ 8,070.00	$ 21,527.32

WAGE INFORMATION SUPPLEMENT

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

Read instructions on reverse carefully before completing.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

Employee Name	Employee Social Security Number	Date of Injury
Employer Name		
Name of Insurance Company or Self-Insured Employer (do not list adjusting company)		
Claims Handling Address (number, city, state, zip code)		

Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)

1. Hourly Wage Multiply — Equals — Add — Equals

a. Hourly rate at time of injury:		b. Hours per week: (fill in "usual scheduled hours," check the box you use to set the wages)		c. Base weekly rate: (See reverse for computing rates for time and a half employees)		d. Additional weekly compensation from Section 3 below: (exclude tips)		e. Average weekly earnings: (hourly)
☐ Standard Base $_____ ☐ Piece Rate (if higher than the standard rate) ☐ Standard base rate plus tips Tip Rate only: $_____ Base + Tip $_____	x	☐ **Normal scheduled hours:** _____ Includes those hours paid at time-and-a-half: **(See Instructions)** _____ ☐ Actually Worked: (use with piece rate, or tips in Section 1a.) _____ ☐ Expand to: (See Section 4) 24 ☐ Expand to Normal Full-time: _____ ☐ Seasonal: (See instructions) 44	=	$_____	+	$_____	=	$_____

2. Gross Wage Divide — Equals — Add — Equals

a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips)		b. Number of weeks worked in 52-week period prior to injury:		c. Base Gross Wage:		d. Additional weekly compensation from Section 3 below:		e. Actual average weekly earnings:
$_____	÷	_____	=	$_____		$_____	=	$_____

3. Additions to Cash Wage Received by Employee Per Week (Mark any that apply)

☐ Free meals (Number/week) _____	Weekly Amount $_____	☐ Fuel Weekly Amount	$_____
☐ Room (Number of days/wk _____	Weekly Amount $_____	☐ Lights Weekly Amount	$_____
☐ Tips Amount/Week $_____ (Add only to Section 2d., not 1d.)		☐ Other Weekly Amount	$_____
☐ House or Apartment Weekly Amt $_____ ☐ Check if this is continued during disability		**Total Weekly Value:**	**$_____**

4. Part-Time Employment (Worked less than 35 hrs/wk) — Divide — Equals

Part of Class Determination	1. Normal number of hours scheduled per week:	2. Number of other part-time employees doing same work on same schedule:	÷	3. Number of full-time employees doing the same type of work:	=	4. _____% ☐ Yes, part of class (2 divided by 3 is greater than 10%) ☐ No, not part of class (2 divided by 3 is less than 10%)
	_____	_____		_____		

(Choose a, b or c that applies)

a ☐ Employee worked **less** than 24 hrs/wk, **is part of a class and does not restrict** availability for work. Check the box listed as "expand to" in Section 1b above with number of scheduled hours shown as 24.

b ☐ Employee worked less than 35 hours/wk, but **is not part of a class and does not restrict** availability for work. Check the box in Section 1b listed as "Expand to Normal full-time" and enter the number of hours which full-time employees normally work for the employer in this occupation.

c ☐ Employee works less than 27 hrs/wk., and **restricts availability** for work. Check the box in Section 1b listed as "Normal Scheduled Hours" and enter the number of normal scheduled hours. If the employee does not have "normal scheduled hours", leave Section 1b blank and complete all parts of Sections 2 and 5 using the 100% option of the result in Section 2e in Section 5b. **Attach the self-restriction statement**. See instructions on reverse for an **exception to using 100% in Section 5b.**

Important: These options are the only circumstances for which you will use a number other than the "normal hours scheduled" to compute weekly hourly wages. Use normal hours scheduled or actual hours worked (piece rate, time and 1/2 or tip rate) in Section 1b unless 4a, 4b or 4c applies.

5. Weekly Wage and TTD Rate Computation — Multiply — Equals

a. Weekly Wage (Greater of #1 or #2 above) $_____	X	**b.** ☐ 66.67% **OR** ☐ 100%(see 4.c)	=	c. Weekly TTD Rate: $_____

Insurance Claim Representative	Telephone Number ( )

Instructions for Completing the Wage Information Supplement, Form WKC-13-A

These instructions will help you complete the WKC-13-A and compute the TTD rate correctly. If more help is needed, please contact a wage specialist at (608) 266-3264 or 261-6532, or send an e-mail to **wcwage@dwd.state.wi.us.** Section DWD 80.02(2)(c) of the Wis. Admin. Code requires insurers, including self-insured employers, to submit this form within 30 days after the injury. It must be submitted for every claim where the TTD rate is less than the maximum rate for the year the injury occurred. For a reference to the maximum rates, see our website at: **http://www.dwd.state.wi.us/wc_train**

Section 1a- Hourly Rate at Time of Injury: Enter the standard base rate at the time of injury. Include in the hourly rate any additional hourly amounts which the employee received at the time of injury, e.g., shift differentials. For employees receiving time-and-a-half, enter the standard base rate, not time and a half rate. If this employee did not have an hourly rate but had a weekly, bi-weekly or monthly salary and has scheduled hours of work, divide the salary by the number of hours worked in the pay period to arrive at the hourly rate. If an employee is paid solely by commission or by mileage or some other method where scheduled hours are not used, the TTD rate will be based only on gross earnings. In such a case, enter "NA" in Section 1 and go on to Section 2. For employees paid on a piece work basis, compute the hourly piece work rate by dividing the earnings from piece work by the number of hours actually worked while on piece rate. Exclude time and a half earnings and hours in this computation. Use the piece rate amount only if the resulting rate is higher than the standard hourly rate. If the employee received tips, compute the additional hourly amount of tips. Enter that amount next to **"tip rate"** and add the hourly tip rate to the standard hourly rate to get the "standard base rate plus tips". Compute the tip rate by dividing total tip earnings (only the earnings received in tips) by total hours actually worked on a tip basis. The total hourly rate must be at least the legal minimum hourly wage.

Section 1b- Hours Per Week: Enter the normal number of hours scheduled (regular fixed schedule) at the time of injury). Include the number of hours the employee is paid at the time and a half rate. If the employee does not have regular scheduled hours, enter the number of hours which full-time employees normally work for the employer in this occupation. Include scheduled hours paid at a time-and-a-half rate in the number of "normally scheduled hours". If scheduled hours vary by more than 5 hours from week to week during the 90-day period immediately preceding the injury, use the number of hours that is normal for full time employees for this occupation. Check the box "Actually Worked" in Section 1b and enter the hours actually worked if the hourly rate in Section 1a is piece rate or includes tips. Check the "seasonal" box with **44** hours entered for employees who meet the definition of **"seasonal"** employees in s.102.11(1)(b) Wis. Stats. Seasonal employment cannot exceed 14 weeks. For part time employees, follow the instructions in Section 4.

Section 1c- Base Weekly Rate: Multiply the hourly rate in Section 1a times the hours used in Section 1b. For employees who worked a time and a half schedule at the time of injury and at least 13 consecutive weeks immediately prior to the injury, use the following formula: multiply the standard rate times the normal scheduled hours excluding those hours paid at the time-and-a-half rate; then multiply the time and a half rate times the time and a half hours, and add the two results to get the Base Weekly Rate.

Sections 1d & 1e- Hourly Wages/Additions to Base Average Weekly Wages and Average Weekly Earnings: Enter here and in Section 2d (except for tips) the weekly value of any other type of compensation the employee received, as shown in Section 3.

Section 2a-e Gross Wages and Average Weekly Earnings Enter the gross wages and the number of weeks the employee worked on that job (same type of work) in the 52-week period prior to the date of injury. When counting weeks for Section 2b, do not Include the week of injury in the 52-week period. Count partial weeks as whole weeks. Include tips and additions to wages from Section 3 in section 2e. For employees who worked less than 6 weeks, TTD will be determined solely by the hourly rate in Section 1 or, if the employee does not have an hourly rate, by wages paid in a "same or similar" occupation. Enter "same or similar" wages in Section 2e and skip 2a, 2c and 2d. Complete the computations in Sections 2c, d and e for all others.

Section 3- Additions to Cash Wages: Enter the weekly value of any additional compensation paid to the employee. This value is added to the computations in Sections 1 and 2. The standard value of **"meals"** and **"room"** is set in Wis. Admin. Code DWD 80.29 and DWD 272. The value of all other items is set by common marketplace value to the employee.

Section 4- Part-Time Employment: Complete this Section for all workers at less than the maximum TTD rate if they were scheduled to work less than 35 hours per week at the time of injury.

Part of Class Determination: Complete this part before choosing and checking the applicable Section 4a, 4b or 4c. If the employee's regular work schedule varies by more than 5 hours per week during the 90-day period immediately preceding the injury, always consider the employee as "not part of class". Choose Section 4a, 4b or 4c that applies to the employee before doing the computations in Sections 1 or 2 to set the wage for the employee. If you check Section 4b, you will need to check the box in Section 1b "expand to normal full-time" and enter the number of normal full-time hours there for this occupation. Use the number of hours that are normally considered as full-time for that employer for that occupation to compute the wage.
Self Restriction: An employee "self restricts" employment if he/she limits his/her availability on the labor market to part-time work only and was not employed elsewhere. If you indicate that the worker self-restricts in Section 4c and wages are set at 100%, you must attach a copy of a self-restriction statement signed by the employee, stating the limitation to part-time and that he/she was not working elsewhere at the time of injury. A sample statement can be found in the training website at **http://www.dwd.state.wi.us/wc_train**.

Section 5-- Wage and Rate Computation: Enter the wage used to compute the TTD rate (the higher amount from Section 1e or 2e). The rate in Section 5c is computed by multiplying the wage by either 66.67% or by 100% (see Section 4c).
Exception to using 100% in Sections 4c and 5b: If using 100% in Section 4c exceeds 66.67% of the wages of a full-time employee doing this job, use 66.67% of wages (higher of 1e or 2e) after expanding the hours in Section 1b to full-time.
Exception Note: If this employee's employment situation is unique and you cannot use the computation formulas in Sections 1 and 2, indicate the wage and TTD rate in Section 5, and attach an explanation of how you computed the wage and TTD rate to this request.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

MEDICAL REPORT ON INDUSTRIAL INJURY

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

PATIENT	WC Claim Number	Employee Name	
	Employee Social Security Number	Employee Address	
Injury	Date	Employer Name	Insurance Company
HISTORY	History as described by patient		
DIAGNOSIS (Please be as detailed as possible)			
PERMANENT DISABILITY (Describe permanent elements of disability, such as limitation of motion, pain, weakness, etc., and describe effect on working ability.)	What amputation present?	Comparative x-rays taken? ☐ Yes ☐ No	Stump: ☐ hardy or ☐ tender
	Has permanent disability resulted? ☐ Yes ☐ No	Date of Last Exam	Has healing period ended? ☐ Yes ☐ No	Patient discharged? ☐ Yes ☐ No
	Description of permanent disability (Record finger motion losses on reverse.)		
	Was surgery performed as a result of accident? ☐ Yes ☐ No If Yes, state type of surgery:		
	If healing has not ended, what is minimum permanent disability expected?		
PRIOR DISABILITY	What previous disability?		
PROGNOSIS	Prognosis:		
	Date injured was or will be able to return to a limited type of work: State any limitations:		
	Date injured was or will be able to return to full-time work subject only to permanent limitations:		
	What further treatment should be given?		
Additional comments, if any:			
Date	City	Physician or Chiropractor Signature (in own writing)	
	Phone Number ( ) -	Typed or Printed Name	

WKC-16 (R. 04/2010)

Employee Name	Employee Social Security Number

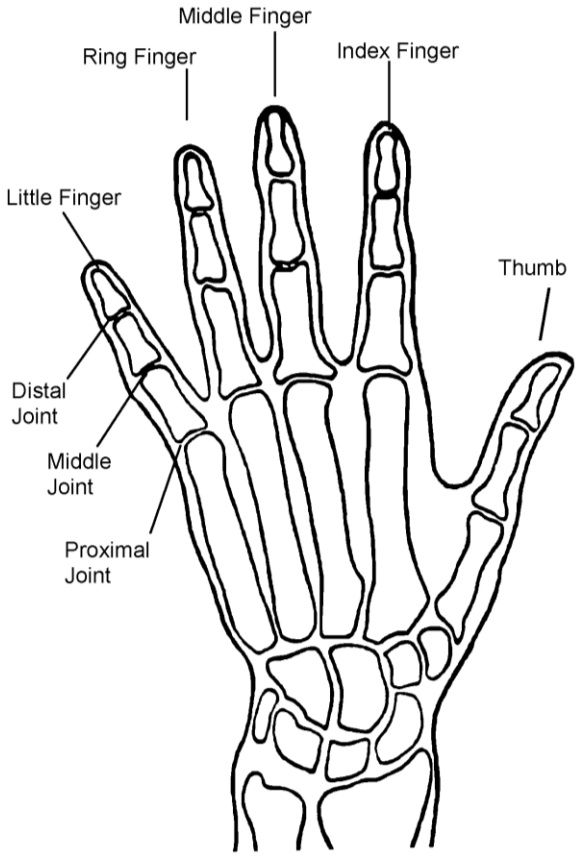
Instructions for finger injuries
Please use statutory terms in referring to fingers, such as thumbs, index, middle, ring, and little fingers, and distal, middle, and proximal joints. Where there is limitation of motion, list separately the normal range of motion in degrees, the "degrees" loss of flexion, and the "degrees" loss of extension for each joint of each finger. The Worker's Compensation Division will evaluate the loss of use due to loss of motion of the fingers.

Where there are other elements of disability of the fingers, such as deformity, weakness, pain, or lack of endurance, give your opinion on the percentage loss of use as compared to amputation for such elements of disability and specify the joint at which such loss is estimated.

Digit	Joint	Angle Ext./Flex	Normal Range of Motion	Degrees Loss Extension	Degrees Loss Flexion	**Estimate** % loss of use for additional factors at joint involved and reason for additional allowance
Thumb	Dist					
	Prox					
Index	Dist					
	Mid					
	Prox					
Mid	Dist					
	Mid					
	Prox					
Ring	Dist					
	Mid					
	Prox					
Little	Dist					
	Mid					
	Prox					

CIRCLE HAND INVOLVED: Right Left

DOMINANT HAND: Right Left



See DWD 80.32 & 80.33 for guides to evaluation for amputations, restrictions of motion, ankylosis, sensory loss, and surgical results for disability to the hip, knee, ankle, toes, shoulder, elbow, wrist, fingers and back.

If fingertip amputation is present, submit comparative x-rays or a statement indicating whether the bone loss was less than one-third, between one-third and two-thirds, or more than two-thirds of the distal phalanx.

If amputation is below the distal joint, submit comparative x-rays.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
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http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

PRACTITIONER'S REPORT ON ACCIDENT OR INDUSTRIAL DISEASE IN LIEU OF TESTIMONY

FILED ON BEHALF OF: ☐ **EMPLOYEE** ☐ **EMPLOYER OR INSURANCE CARRIER**

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

1. WC Claim Number	Employee Name
Employee Social Security Number	Employee Address

2. Employer Name	3. Date of Traumatic Event
Employer Address	Worker's Compensation Insurance Carrier

4. Describe the accidental event or work exposure to which the patient attributes his/her condition. (A copy of medical history or notes containing this information will suffice if complete.)

5. Give a complete description of physical or mental disability and diagnosis. (A copy of the medical history or notes containing this information will suffice if complete and limited to the work injury.)

6. Did you treat the patient? If so, between what dates? ☐ Yes ☐ No and	7. Date of last examination or evaluation	8. Date disability from work began

9. Date injured was or will be able to return to a limited type of work:
State any temporary limitations.

10. Date injured was or will be able to return to full time work subject only to permanent limitations:
State any permanent limitations.

11. In your opinion, is it probable that the event in Item 4 directly caused the disability? ☐ Yes ☐ No	12. If not directly, is it probable that the event described in Item 4 caused the disability by precipitation, aggravation and acceleration of a pre-existing progressively deteriorating or degenerative condition beyond normal progression? ☐ Yes ☐ No
13. If the patient suffers from a condition caused by an appreciable period of work place exposure (from Item 4), was that exposure either the sole cause of the condition, or at least a material contributory causative factor in the condition's onset or progression? ☐ Yes ☐ No	If yes, give date disability from work began:

WKC-16-B (R. 02/2014)

14. Has accident or industrial disease resulted in any permanent disability? ☐ Yes ☐ No

15. Estimate percentage of permanent disability to the member, eye or ear involved, or compare to permanent total disability if injury is to torso or head, caused by the accident or work exposure described in Item 4.

16. What elements constitute permanent disability (such as limitation of motion, deformity, weakness, pain, lack of endurance or components of illness, e.g., isoiconias, photo toxicity, liver disease)? If limitation of motion, describe nature and percentage of limitation of each part of each member affected. (Make estimates on voluntary, not passive motions.) If amputation, state exact point bone was amputated and whether stump is tender or hardy.

17. What is the prognosis of this disability? If guarded, please explain:

18. Do you expect that any further treatment will be necessary for this condition?

☐ Yes ☐ No If YES, explain:

19. Prior to this accident or illness, did employee have any permanent disability?

☐ Yes ☐ No If YES, explain:

20. I am a practitioner licensed in and practicing in Wisconsin.

Practitioner Typed or Printed Name:

Practitioner Address (Street or P.O. Box):

Practitioner Address (City, State and Zip Code):

Practitioner Phone Number:
( ) -

College:

If not licensed and practicing in Wisconsin, state where practitioner is licensed and practicing:

CERTIFICATION

I certify, subject to the penalty of fine and/or imprisonment, as provided in Sec. 943.39 of the Wisconsin Statutes, that the above report truly and correctly sets forth the history, my findings, diagnosis and opinion.

Signature of Practitioner Date Signed

IMPORTANT: Section 102.17(1)(d) of the Wisconsin Statutes provides that the contents of certified medical and surgical reports presented by parties shall constitute prima facie evidence as to the matter contained therein. Reports must be filed with the department and the other parties fifteen days prior to the date of hearing to be acceptable as evidence. If not so filed, it will be necessary to produce the doctor to give oral testimony at the time of hearing.

STATE OF WISCONSIN
LABOR AND INDUSTRY REVIEW COMMISSION

PETITION FOR REVIEW OF FINDINGS AND ORDER OF ADMINISTRATIVE LAW JUDGE

_____, Applicant

vs.

_____, Respondent

_____, Insurance Carrier

TO THE DEPARTMENT OF WORKFORCE DEVELOPMENT, MADISON, WISCONSIN

The undersigned petitions for a review of the law judge's findings issued on (mo/day/year)

_____

The specific finding(s) which the petitioner claims are in error are as follows for the reasons stated:

_____

_____

_____

_____

_____

_____

_____

_____

Petitioner Signature	Date Signed
Petitioner Street Address	City, State, Zip Code

NOTE CAREFULLY: Petition must be received by the Department of Workforce Development within twenty-one (21) days from the date a copy of the findings or order of the law judge was mailed to the last known address of the parties in interest. The petition may be filed at the Worker's Compensation Division, 201 E. Washington Ave., P.O. Box 7901, Madison, WI 53707; or the Worker's Compensation Division, Associated Bank Building, 1500 North Casaloma Drive, Suite 310, Appleton, WI 54915; or the Worker's Compensation Division, 819 N. 6th St., Milwaukee, WI 53203; or the office of the Labor and Industry Review Commission, 3319 West Beltline Highway, P.O. Box 8126, Madison, WI 53708

WKC-28 (R. 02/2009)

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

THIRD PARTY PROCEEDS DISTRIBUTION AGREEMENT

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name
Social Security Number	Employee Mailing Address (number, street, city, state, zip code)
Injury Date	Employer Name
Insurance Claim Number	Employer Mailing Address (number, street, city, state, zip code)
Worker's Compensation Insurance Carrier	
Submitted By	Mailing Address (number, street, city, state, zip code)

_____, insurer of

_____ third party, and the above parties have

agreed to settle the liability of the tort-feasor for injury sustained on _____

The proceeds will be distributed according to the provisions of 102.29, Wisconsin Statutes, as follows:

1. $_____ total amount of third party settlement
2. $_____ to employee's attorney as cost of collection (fee & costs)
3. $_____ one-third of balance to employee
4. $_____ to worker's compensation insurance carrier or self-insured employer as reimbursement for payment of

   $_____ in compensation, and

   $_____ in medical expense
5. $_____ balance to employee which shall constitute a cushion or credit against any additional claim under worker's compensation

PLEASE NOTE: APPROVAL VOID IF PROCEEDS RESULT FROM UNINSURED MOTORIST PROVISION	Employee Signature
	Attorney Signature
Agreement Date	Worker's Compensation Insurance Carrier or Self-Insured Employer Signature

SETTLEMENT AND DISTRIBUTION OF PROCEEDS AS STATED ABOVE ARE APPROVED.

_____ Date Signed

_____ Administrative Law Judge, Worker's Compensation Division

WKC-170 (R. 10/2015)

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
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Madison, WI 53707-7901
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Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

COMPROMISE AGREEMENT

Notice: To expedite processing of compromises, provide current addresses of all parties involved.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name	Employee Birth Date
Employee Social Security Number	Employee Mailing Address (number, street, city, state, zip code)	
Date of Alleged Injury	Employer Name	Employer Address (number, street, city, state, zip code)
Insurance Company Name	Insurance Company Address (number, street, city, state, zip code)	

It is ☐ disputed ☐ undisputed that the employee was employed by the respondent employer

Employee Earned Weekly Wage of **$**	Compensation Previously Paid Is **$**
The conceded disability is:	
There is a bona fide dispute between the parties as to whether the employee:	
Therefore the parties, subject to the approval of the Department of Workforce Development, agree to a Compromise Settlement as follows:	
NOTICE TO EMPLOYEE: **The employee has the right to petition the Department of Workforce Development to set aside or modify this compromise agreement within one year of its approval by the department. The department may set aside or modify the compromise agreement. The right to request the department to set aside or modify the compromise agreement does not guarantee that the compromise will in fact be reopened.**	
Employee Signature and Date Signed:	Witness Signature and Date Signed
Employee Attorney Signature and Date Signed:	Self-Insured Employer or Insurance Carrier Signature and Date Signed:
Date of Agreement:	**Attorney Fee:** _____ **Percent** **List:** **Protect:** _____ ☐ **Yes** ☐ **No** **Costs:** ☐ **Yes** ☐ **No**

WKC-176 (R. 10/2009)

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Vocational Expert Report

s. 102.17(1)(d)

Note: This report is for use with permanent disability caused by non-scheduled injuries only. It is not to be used for scheduled injuries as described in sections 102.52 to 102.55 of the statutes which include injuries to eyes, ears, and limbs.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name		Employee Birth Date
Employee Social Security Number	Employer Name		
Date of Accident or First Illness	Highest Level of Formal Education Completed	Vocational Education or Training Completed	

Previous Employment

Employer Name	Mailing Address (number, street, city, state, zip code)		
Job Duties		Date Hired	Date Job Terminated

Employer Name	Mailing Address (number, street, city, state, zip code		
Job Duties		Date Hired	Date Job Terminated

List special skills affecting employee's employability:

List employee's **preexisting** physical or mental limitations:

Nature of Injury	If surgery, give type

Resulting physical or mental limitations based on medical or chiropractic opinion:

Weekly wage at time of injury	Present wage for comparable work with same employer
$	$

Types of employment now available given age, education, work history, and physical *and* mental limitations of employee:

Continue on reverse side

Pay rates for types of employment listed in previous question for the general locality

If presently employed, identify the following:

Employer:

Pay Rate: $

Nature of Work Performed:

Date Started:

Percent of loss of earning capacity to a reasonable probability due to the injury described under ***Nature of Injury***. Give a single number percentage or a percentage range, and use the following guidelines to assist with the calculation:

_____%

A person may be classified as permanently partially disabled when by reason of his or her physical or mental condition he or she has limitations in the performance of his or her work activities. The percentage of such partial disability shall be to the degree that such disability relates to permanent total disability. The expert's opinion should include evaluation of how the disability affects this individual, having in mind his or her education, work history, training, and whether he or she can be retrained or vocationally rehabilitated.

A person may be classified as permanently totally disabled when by reason of his or her physical or mental condition he or she can perform no services other than those which are so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist.

Factors other than those identified above that were considered in analysis (if applicable):

Qualification of Expert (may attach curriculum vitae):

Education: list degree(s), field of study(ies), and date(s)

Work History:

Expert Signature	Expert Name (print or type)

WORKSHEET FOR TEMPORARY PARTIAL DISABILITY

The provision of the claimant's social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name
Employee Social Security Number	Employer Name
Injury Date	Insurance Company Name (not adjusting company)

Each period of Temporary Partial Disability (TPD) is to be entered as a line of compensation on the WKC-13-E. Use this form only to verify the TPD rate.

Figure TPD on a weekly basis, Sunday to Saturday.

This worksheet is provided for informational use only by Insurance Companies, Self-Insurers and Third Party Administrators.
Data must be submitted through the Worker's Compensation Pending Reports Internet Application

Are the wages reported in column 4 below from the job the employee had at the time of injury? ☐ Yes ☐ No
If Yes, compute and pay TPD using the "actual" wages in column 5 below that were used to set the TTD rate.
If No, are the earnings from a second job that was held at the time of injury? ☐ Yes ☐ No
*(Use "expanded wages in column 5 below if earnings were from a 2nd job held at the time of injury and expanded wages were used to set the TTD rate)
Note: If earnings were not from the same job held at the time of injury or were from another full-time or part-time job held at the time of injury and "expanded" wages were not used to set the TTD rate, pay TTD, not TPD.

1	2	3	4	5	6	7	8	9
Week Ending	Hours Emp. Worked	At Hourly Rate	Wages Earned	Weekly Wage at Time of Injury	Wage Loss	% of Wage Loss	TTD Rate	TPD Rate
TOTAL								

WKC-7359 (R. 02/2009)

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

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e-mail: DWDDWC@dwd.wisconsin.gov

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P. O. Box	City	State	Zip Code
Patient (Employee) Name	Employer Name		
Patient Social Security Number - -	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☐ A. **Physical Only**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ B. **Physical and Other**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date

WKC-9488 (R. 03/2009)

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient)	Date
If not signed by patient, authority/designation to sign is based on the fact that the patient is ☐ A minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other:	

SUGGESTED FORM OF COMPLAINT FOR A REVIEW OF AN ORDER
OR AWARD OF THE LABOR AND INDUSTRY REVIEW-COMMISSION

STATE OF WISCONSIN: IN CIRCUIT COURT: FOR: _____ COUNTY

A_____
Plaintiff,
vs. COMPLAINT

Labor and Industry Review Commission, and
B_____Company, A Wisconsin Corporation,
C_____ Insurance Company, A Wisconsin Corporation.
Defendants.

The above named plaintiff, by _____, his/her attorney for his/her cause of action against the above named defendants respectfully shows to the court that:

1. The plaintiff is a (state vocation) residing at_____ Street, in the city of_____, Wisconsin.

2 The B_____ Company is a corporation organized and existing under and by virtue of
the laws of the state of Wisconsin with its principal office in the city of_____ _____, Wisconsin.

3. The C_____ Insurance Company is a corporation organized, and existing under and by virtue of the laws of the state of Wisconsin with its principal office in the city of _____ _____, Wisconsin.

4. The _____day of _____, 20 __, in a proceeding under ch. 102. Stats., known as Wisconsin Worker's
Compensation Act, the above named defendant, Labor and Industry Review Commission, made certain findings and based upon such findings made and entered its order or award dismissing the plaintiff's application for compensation (or, that the defendants, B_____ _____ Company and C _____; Insurance company, pay to the plaintiff certain sums as compensation).

5. This plaintiff is aggrieved by reason of said findings and order or award, and brings this action for a review of said findings, order or award upon the following grounds:

(a) That said defendant, Labor and Industry Review Commission, acted without or in excess of its powers in making the following findings (here quote those findings of which you desire to complain, and only those) in that such findings are not supported by the evidence.

(b) That the findings of fact by the commission do not support its order or award in that (state with particularity the respect or respects in which the findings are claimed to be deficient as a support for the order or award).

(c) That the order or award was procured by a fraud in that (state the specific facts relied on as fraud, but bear in mind that the fraud alluded to in the statutes does not include false testimony).

Wherefore, this plaintiff demands judgment that the findings and order or award complained of be set aside, and for such other or further judgment, order or relief as the circumstances may warrant.

_____
Plaintiff's Attorney

Note: Insurance company, if any, must be joined as a defendant when claim is against an insured employer. The Labor and Industry Review Commission must always be named as a defendant. See sec. 102.23, Stats. The State of Wisconsin must be named as a party defendant when payment into or but of state funds is involved. Sufficient copies of summons and complaint must also be left with the Labor and Industry Review Commission for service upon each defendant.