

# **WEST VIRGINIA LEGISLATURE**

**2026 REGULAR SESSION**

**ENROLLED**

**Committee Substitute**

**for**

**House Bill 5515**

BY DELEGATES HALL, JEFFRIES, HOTT, AND ROHRBACH

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



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

*Be it enacted by the Legislature of West Virginia:*

#### **ARTICLE 4. DISABILITY AND DEATH BENEFITS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (3) Any party may object to the order of the Insurance Commissioner, private carrier, or  
34 self-insured employer, whichever is applicable, and obtain an evidentiary hearing as provided in  
35 §23-5-1a of this code: *Provided*, That if a private carrier or self-insured employer fails to timely  
36 issue a ruling upon any application or motion as provided by law, or if the claimant files a timely  
37 protest to the ruling of a private carrier or self-insured employer denying the compensability of the  
38 claim, denying temporary total disability benefits, or denying medical authorization, the Board of  
39 Review shall provide a hearing on the protest on an expedited basis as determined by rule of the  
40 Board of Review.

41 (b) Where it appears from the employer's report, or from proper medical evidence, that a  
42 compensable injury will result in a disability which will last longer than three days as provided in  
43 §23-4-5 of this code, the Insurance Commissioner, private carrier, or self-insured employer,  
44 whichever is applicable, may immediately enter an order commencing the payment of temporary  
45 total disability benefits to the claimant in the amounts provided for in §23-4-6 and §23-4-14 of this  
46 code, and the payment of the expenses provided for in §23-4-3(a) of this code, relating to the  
47 injury, without waiting for the expiration of the 30-day period during which objections may be filed  
48 to the findings as provided in §23-5-1a of this code. The Insurance Commissioner, private carrier,  
49 or self-insured employer, whichever is applicable, shall enter an order commencing the payment  
50 of temporary total disability or medical benefits within 15 working days of receipt of either the  
51 employee's or employer's report of injury, whichever is received sooner, and also upon receipt of  
52 either a proper physician's report or any information necessary for a determination. The Insurance  
53 Commissioner, private carrier, or self-insured employer, whichever is applicable, shall give the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**§23-4-1e. Temporary total disability benefits not to be paid for periods of correctional center or jail confinement; denial of workers' compensation benefits for injuries or disease incurred while confined.**

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

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

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

**§23-4-3. Schedule of maximum disbursements for medical, surgical, dental, and hospital treatment; legislative approval; guidelines; preferred provider agreements; charges in excess of scheduled amounts not to be made; required disclosure of financial interest in sale or rental of medically related mechanical appliances or devices; promulgation of rules to enforce requirement; consequences of failure to disclose; contract by employer with hospital, physician, etc., prohibited; criminal penalties for violation; payments to certain providers prohibited; medical cost and care program; payments; interlocutory orders.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

107

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

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

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

1 [Repealed.]

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

1 [Repealed.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (d) For all awards of permanent total disability benefits that are made on or after February  
35 2, 1995, including those claims in which a request for an award was pending before the former  
36 workers' compensation division of the Bureau of Employment Programs or which were in litigation  
37 but not yet submitted for a decision, then benefits shall be payable until the claimant attains the  
38 age necessary to receive federal old age retirement benefits under the provisions of the Social  
39 Security Act, 42 U.S.C. §§ 401 and 402, in effect on the effective date of this section. The claimant  
40 shall be paid benefits so as not to exceed a maximum benefit of 66 and two-thirds percent of the  
41 claimant's average weekly wage earnings, wherever earned, at the time of the date of injury not  
42 to exceed 100 percent of the average weekly wage in West Virginia. The minimum weekly benefits  
43 paid under this section shall be as is provided for in subdivision (b) of this section. In all claims in  
44 which an award for permanent total disability benefits was made prior to February 2, 1995, the  
45 awards shall continue to be paid at the rate in effect prior to the effective date of the amendment  
46 and reenactment of this section in the year 2003. A single or aggregate permanent disability of  
47 85 percent or more entitles the employee to a rebuttable presumption of a permanent total  
48 disability for the purpose of paragraph (2), subdivision (n) of this section: *Provided*, That the  
49 claimant must also be at least 50 percent medically impaired upon a whole body basis or has  
50 sustained a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this  
51 section. The presumption may be rebutted if the evidence establishes that the claimant is not  
52 permanently and totally disabled pursuant to subdivision (n) of this section. Under no  
53 circumstances may the Insurance Commissioner, private carrier, or self-insured employer,  
54 whichever is applicable, grant an additional permanent disability award to a claimant receiving a  
55 permanent total disability award: *Provided, however*, That if any claimant thereafter sustains  
56 another compensable injury and has permanent partial disability resulting from the injury, the total

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

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

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

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

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

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

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

- 83 The loss of other toes shall be considered a four percent disability.
- 84 The loss of other toes (one phalanx) shall be considered a two percent disability.
- 85 The loss of all toes shall be considered a 25 percent disability.
- 86 The loss of forepart of foot shall be considered a 30 percent disability.
- 87 The loss of a foot shall be considered a 35 percent disability.
- 88 The loss of a leg shall be considered a 45 percent disability.
- 89 The loss of thigh shall be considered a 50 percent disability.
- 90 The loss of thigh at hip joint shall be considered a 60 percent disability.
- 91 The loss of a little or fourth finger (one phalanx) shall be considered a three percent
- 92 disability.
- 93 The loss of a little or fourth finger shall be considered a five percent disability.
- 94 The loss of ring or third finger (one phalanx) shall be considered a three percent disability.
- 95 The loss of ring or third finger shall be considered a five percent disability.
- 96 The loss of middle or second finger (one phalanx) shall be considered a three percent
- 97 disability.
- 98 The loss of middle or second finger shall be considered a seven percent disability.
- 99 The loss of index or first finger (one phalanx) shall be considered a six percent disability.
- 100 The loss of index or first finger shall be considered a 10 percent disability.
- 101 The loss of thumb (one phalanx) shall be considered a 12 percent disability.
- 102 The loss of thumb shall be considered a 20 percent disability.
- 103 The loss of thumb and index fingers shall be considered a 32 percent disability.
- 104 The loss of index and middle fingers shall be considered a 20 percent disability.
- 105 The loss of middle and ring fingers shall be considered a 15 percent disability.
- 106 The loss of ring and little fingers shall be considered a 10 percent disability.
- 107 The loss of thumb, index and middle fingers shall be considered a 40 percent disability.
- 108 The loss of index, middle and ring fingers shall be considered a 30 percent disability.

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

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

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

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

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

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

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

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

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

133           (g) If a claimant to whom has been made a permanent partial award dies from sickness  
134 or noncompensable injury, the unpaid balance of the award shall be paid to claimant's dependents

135 as defined in this chapter, if any; the payment to be made in the same installments that would  
136 have been paid to claimant if living: *Provided*, That no payment shall be made to any surviving  
137 spouse of the claimant after his or her remarriage, and that this liability shall not accrue to the  
138 estate of the claimant and is not subject to any debts of, or charges against, such estate.

139 (h) For the purposes of this chapter, a finding of the Occupational Pneumoconiosis Board  
140 has the force and effect of an award.

141 (i) For the purposes of this chapter, with the exception of those injuries provided for in  
142 subdivision (f) of this section and §23-4-6b of this code, the degree of permanent disability other  
143 than permanent total disability shall be determined exclusively by the degree of whole body  
144 medical impairment that a claimant has suffered. For those injuries provided for in subdivision (f)  
145 of this section and §23-4-6b of this code, the degree of disability shall be determined exclusively  
146 by the provisions of said subdivision and said section. The Occupational Pneumoconiosis Board  
147 created pursuant to §23-4-8a of this code shall premise its decisions on the degree of pulmonary  
148 function impairment that claimants suffer solely upon whole body medical impairment. The  
149 Insurance Commissioner shall adopt standards for the evaluation of claimants and the  
150 determination of a claimant's degree of whole body medical impairment. Once the degree of  
151 medical impairment has been determined, that degree of impairment shall be the degree of  
152 permanent partial disability that shall be awarded to the claimant. This subdivision is applicable  
153 to all injuries incurred and diseases with a date of last exposure on or after February 2, 1995, to  
154 all applications for an award of permanent partial disability made on and after that date and to all  
155 applications for an award of permanent partial disability that were pending before the former  
156 workers' compensation commission or pending in litigation but not yet submitted for decision on  
157 and after that date. The prior provisions of this subdivision remain in effect for all other claims.

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

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

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

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

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

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

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

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

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

222 Loss of both eyes or the sight thereof.

223 Loss of both hands or the use thereof.

224 Loss of both feet or the use thereof.

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

226 (n)(1) Other than for those injuries specified in subdivision (m) of this section, in order to  
227 be eligible to apply for an award of permanent total disability benefits for all injuries incurred and  
228 all diseases, including occupational pneumoconiosis, regardless of the date of last exposure, on  
229 and after the effective date of the amendment and reenactment of this section during the year  
230 2003, a claimant: (A) Must have been awarded the sum of 50 percent in prior permanent partial  
231 disability awards; (B) must have suffered a single occupational injury or disease which results in  
232 a finding that the claimant has suffered a medical impairment of 50 percent; or (C) has sustained  
233 a 35 percent statutory disability pursuant to the provisions of subdivision (f) of this section. Upon  
234 filing an application, the claim will be reevaluated by the reviewing body pursuant to subdivision  
235 (i) of this section to determine if the claimant has suffered a whole body medical impairment of 50  
236 percent or more resulting from either a single occupational injury or occupational disease or a  
237 combination of occupational injuries and occupational diseases or has sustained a 35 percent

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

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

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

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

274 (A) 80 percent for the first year;

275 (B) 70 percent for the second year;

276 (C) 60 percent for the third year; and

277 (D) 50 percent for the fourth year: *Provided*, That in no event shall the benefits exceed  
278 100 percent of the average weekly wage in West Virginia. In no event shall the benefits be subject  
279 to the minimum benefit amounts required by the provisions of subdivision (b) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (c) Notwithstanding any other provisions of this article to the contrary, benefits payable to  
27 a part-time injured employee for any permanent disability shall be computed and paid on the same  
28 basis as if the injured employee is not a part-time employee within the meaning of this section.

**§23-4-7. Release of medical information to employer; legislative findings; effect of application for benefits; duty of employer.**

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

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

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

**§23-4-7a. Monitoring of injury claims; legislative findings; review of medical evidence;  
recommendation of authorized treating physician; medical evaluations; temporary  
total disability benefits and the termination thereof; mandatory action; additional  
authority; suspension of benefits.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**§23-4-8c. Occupational Pneumoconiosis Board; reports and distribution thereof;  
presumption; findings required of board; objection to findings; procedure thereon;  
limitations on refilings; consolidation of claims.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52 (d) In every case in which the claimant returns to gainful employment as part of a  
53 rehabilitation plan, and the employee's average weekly wage earnings are less than the average  
54 weekly wage earnings earned by the injured employee at the time of the injury, he or she shall  
55 receive temporary partial rehabilitation benefits calculated as follows: The temporary partial  
56 rehabilitation benefit shall be 70 percent of the difference between the average weekly wage  
57 earnings earned at the time of the injury and the average weekly wage earnings earned at the  
58 new employment, both to be calculated as provided in §23-4-6, §23-4-6d, and §23-4-14 of this  
59 code as the calculation is performed for temporary total disability benefits, subject to the following  
60 limitations: In no event are the benefits subject to the minimum benefit amounts required by the  
61 provisions of §23-4-6(b) of this code, nor may the benefits exceed the temporary total disability  
62 benefits to which the injured employee would be entitled pursuant to §23-4-6, §23-4-6d, and §23-  
63 4-14 of this code during any period of temporary total disability resulting from the injury in the  
64 claim: *Provided*, That no temporary total disability benefits shall be paid for any period for which  
65 temporary partial rehabilitation benefits are paid: *Provided, however*, That the aggregate award  
66 of temporary total rehabilitation or temporary partial rehabilitation benefits for a single injury for  
67 which an award of temporary total rehabilitation or temporary partial rehabilitation benefits is made  
68 on or after the effective date of the amendment and reenactment of this section in the year 2003  
69 shall be for a period not exceeding 52 weeks unless the payment of temporary total rehabilitation  
70 disability benefits is in conjunction with an approved vocational rehabilitation plan for retraining,  
71 in which event the payment period of temporary total rehabilitation disability benefits may be  
72 extended for a period not to exceed a total of 104 weeks. The amount of temporary partial  
73 rehabilitation benefits payable under this subsection shall be reviewed every 90 days to determine  
74 whether the injured employee's average weekly wage in the new employment has changed and,  
75 if the change has occurred, the amount of benefits payable under this subsection shall be adjusted  
76 prospectively. Temporary partial rehabilitation benefits shall only be payable when the injured  
77 employee is receiving vocational rehabilitation services in accordance with a rehabilitation plan

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

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

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

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

**§23-4-12. Application of benefits.**

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

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

**§23-4-14. Computation of benefits.**

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

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

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

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

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

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

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

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

**§23-4-15. Application for benefits.**

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

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

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

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

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

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

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

**§23-4-15b. Determination of nonmedical questions; claims for occupational  
pneumoconiosis; hearing.**

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

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

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

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

**§23-4-16. Jurisdiction over case continuous; modification of finding or order; time  
limitation on awards; reimbursement of claimant for expenses; reopening cases  
involving permanent total disability; promulgation of rules.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**§23-4-16a. Interest on benefits.**

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

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

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

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

**§23-4-18. Mode of paying benefits generally; exemptions of compensation from legal process.**

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

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

**§23-4-20. Postmortem examinations.**

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

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

1 [Repealed.]

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

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

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

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

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

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

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

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

**§23-4-24. Permanent total disability awards; retirement age; limitations on eligibility and  
the introduction of evidence; effects of other types of awards; procedures; requests  
for awards; jurisdiction.**

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

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

**§23-4-25. Permanent total disability benefits; reduction of disability benefits for wages earned by claimant.**

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

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

**ARTICLE 5. REVIEW.**

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

1 [Repealed.]

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

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

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

1           [Repealed.]

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

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

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

1           [Repealed.]

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

1           [Repealed.]

**§23-5-7. Compromise and settlement.**

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

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

27 (c) The amendments to this section enacted during the regular session of the Legislature,  
28 2015, apply to all settlement agreements executed after the effective date.

**§23-5-8. Designation of Office of Administrative Law Judges; powers of chief  
administrative law judge; effective until June 30, 2022.**

1 [Repealed.]

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

1 [Repealed.]

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

1 [Repealed.]

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

1 [Repealed.]

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

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

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

8 (c) The Governor shall appoint, with the advice and consent of the Senate, attorneys  
9 qualified in accordance with subsection (f) of this section to serve as members of the Board of  
10 Review. A member of the Board of Review may be removed by the Governor for official

11 misconduct, incompetence, neglect of duty, gross immorality, or malfeasance, and then only after  
12 notice and opportunity to respond and present evidence. If the board consists of five members,  
13 no more than three of the members may be of the same political party. If the board consists of  
14 three or four members, no more than two of the members may be of the same political party. The  
15 Governor shall set the salary of the members of the board: *Provided*, That the annual salary of a  
16 member of the Board of Review shall not exceed \$125,000. Members are entitled to be  
17 reimbursed for actual and necessary travel expenses incurred in the discharge of official duties in  
18 a manner consistent with the guidelines of the Travel Management Office of the Department of  
19 Administration.

20 (d) Of the initial appointments of the two additional seats created during the 2021 Regular  
21 Session, one member shall be appointed for a term ending December 31, 2025; one member  
22 shall be appointed for a term ending December 31, 2027. Thereafter, the appointments shall be  
23 for six-year terms. Notwithstanding any other provision of this code to the contrary, the term of a  
24 member shall expire pursuant to this subsection unless the member is reappointed by the  
25 Governor as set forth in subsection (c) of this section.

26 (e) A member of the Board of Review must, at the time he or she takes office and thereafter  
27 during his or her continuance in office, be a resident of this state, be a member in good standing  
28 of the West Virginia State Bar, have a minimum of 10 years' experience as an attorney admitted  
29 to practice law in this state prior to appointment, and have a minimum of five years' experience in  
30 preparing and presenting cases or hearing actions and making decisions on the basis of the  
31 record of those hearings before administrative agencies, regulatory bodies, or courts of record at  
32 the federal, state, or local level.

33 (f) No member of the Board of Review may hold any other office, or accept any  
34 appointment or public trust, nor may he or she become a candidate for any elective public office  
35 or nomination thereto. Violation of this subsection requires the member to vacate his or her office.

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

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

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

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

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

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

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

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

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

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

1 [Repealed.]

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

1 [Repealed.]

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

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

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

1 [Repealed.]

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

1 [Repealed.]



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

.....  
*Clerk of the House of Delegates*

.....  
*Clerk of the Senate*

Originated in the House of Delegates.

In effect 90 days from passage.

.....  
*Speaker of the House of Delegates*

.....  
*President of the Senate*

\_\_\_\_\_

The within is ..... this the.....  
Day of ....., 2026.

.....  
*Governor*