Issue 1. Causation; “contributing factor” vs “a major contributing cause”; Orth case. (DOL).

That § 62-1-1 be amended to read as follows:

62-1-1. Terms used in this title, unless the context otherwise plainly requires, shall mean:

(1) "Annual earnings," the average weekly wages, computed as provided in §§ 62-4-24 to 62-4-28, inclusive, multiplied by fifty-two;

(2) "Ascertainable loss," a loss becomes ascertainable when it becomes apparent that permanent disability and the extent thereof has resulted from an injury and that the injured area will get no better or no worse because of the injury;

(3) "Average weekly wages," the earnings of the injured employee, computed as provided in §§ 62-4-24 to 62-4-28, inclusive;

(4) "Department," the Department of Labor created by chapter 1-37;

(5) "Domestic servant," an employee who performs services in or around a home, which pertain to a house, home, household, lawn, garden, or family. The term includes baby sitters but does not include an independent contractor;

(6) "Earnings," the amount of compensation for the number of hours commonly regarded as a day's work for the employment in which the employee was engaged at the time of his injury. It includes payment for all hours worked, including overtime hours at straight-time pay, and does not include any sum which the employer has been accustomed to pay the employee to cover any special expense entailed by him by the nature of his employment; wherever

allowances of any character made to an employee in lieu of wages are specified as a part of the wage contract, they shall be deemed a part of his earnings;

(7) "Injury" or "personal injury," only injury arising out of and in the course of the employment, and does not include a disease in any form except as it results from the injury. An injury is compensable only if it is established by medical evidence, subject to the following conditions:

(a) No injury is compensable unless the employment or employment related activities are a major contributing cause of the injury and condition complained of; or

(b) If the injury combines with a preexisting disease or condition to cause or prolong disability, impairment, or need for treatment, the injury and condition complained of ~~is~~ are compensable if the employment or employment related injury is and remains a major contributing cause of the disability, impairment, or need for treatment;

(c) If the injury combines with a preexisting work related compensable injury, disability, or impairment, the subsequent injury is compensable if the subsequent employment or subsequent employment related activities contributed independently to the disability, impairment, or need for treatment.

The term does not include a mental injury arising from emotional, mental, or nonphysical stress or stimuli. As to subsections (a) and (b) above, proof that employment is a contributing factor to an injury or condition is insufficient to meet the employee's burden of proof. A mental injury is compensable only if a compensable physical injury is and remains a major contributing cause of the

mental injury, as shown by clear and convincing evidence. A mental injury is any psychological, psychiatric, or emotional condition for which compensation is sought;

(8) "Temporary disability, total or partial," the time beginning on the date of injury, subject to the limitations set forth in § 62-4-2, and continuing until the employee attains complete recovery or until a specific loss becomes ascertainable, whichever comes first.

Issue 2. Payment pursuant to fee schedule; Wise case. (DOL).

That § 62-1-1.3 be amended to read as follows:

62-1-1.3. If an employer denies coverage of a claim on the basis that the injury is not compensable under this title due to the provisions of subsection 62-1-1(7)(a), (b), or (c), such injury is presumed to be nonwork related for other insurance purposes, and any other insurer covering bodily injury or disease of the injured employee shall pay according to the policy provisions. If coverage is denied by an insurer without a full explanation of the basis in the insurance policy in relation to the facts or applicable law for denial, the director of the Division of Insurance may determine such denial to be an unfair practice under chapter 58-33. If it is later determined that the injury is compensable under this title, the employer shall immediately reimburse the parties not liable for all payments made, including interest at the category B rate specified in § 54-3-16 pursuant to the fee schedule. Where medical expenses have been denied by the employer, and the expenses are later determined to be compensable, the employer may satisfy its obligation for payment of medical expenses by paying such expenses directly to the medical providers concerned under the medical fee schedule.

Issue 3. "Medical findings" vs. "Medical expert opinion." (DOL).

That § 62-1-15 be amended to read as follows:

62-1-15. In any proceeding or hearing pursuant to this title, evidence concerning any injury or condition shall be given greater weight if supported by objective medical findings.

Issue 4. Willful misconduct; Vansteenwyk case. (DOL).

That § 62-4-37 be amended to read as follows:

62-4-37. No compensation shall be allowed for any injury or death due to the employee's willful misconduct, including intentional self-inflicted injury, intoxication, illegal use of any schedule I or schedule II drug, or willful failure or refusal to use a safety appliance furnished by the employer, or to perform a duty required by statute. A positive blood alcohol level as defined by SDCL 32-23-7(3) or a finding of the presence of any schedule I or schedule II drug through urine, blood or other scientifically acceptable test, or the employee's refusal of such test, establishes a presumption that the injury was due to intoxication or the use of the drug. The employee will bear the burden of rebutting the presumption to prove that the intoxication or the use of a schedule I or schedule II drug was not a substantial factor in causing the injury. In all other cases of alleged misconduct under this section, the ~~The~~ burden of proof ~~under this section~~ shall be on the ~~defendant~~ employer to prove that the employee’s willful misconduct was a substantial factor in causing the injury.

Issue 5. Employer notice and "actual knowledge"; Orth case. (DOL).

That § 62-7-10 be amended to read as follows:

62-7-10. An employee who claims compensation for an injury shall immediately, or as soon thereafter as practical, notify the employer of the occurrence of the injury. Written notice of the injury shall be provided to the employer no later than three business days after its occurrence. The notice need not be in any particular form but must advise the employer of when, where, and how the injury occurred. Failure to give notice as required by this section prohibits a claim for compensation under this title unless the employee or the employee's representative can show:

(1) The employer or the employer's representative had actual knowledge, without the need of inquiry, of the injury, and that said injury was work-related; or

(2) The employer was given written notice after the date of the injury and the employee had good cause for failing to give written notice within the three business-day period, which determination shall be liberally construed in favor of the employee.

Issue 6. Medical release. (DOL).

That chapter 62-4 be amended by adding thereto a NEW SECTION to read as follows:

Upon the request of an employer, an employee subject to this title shall supply a signed medical release to allow investigation of any matters relevant to the employee's claims.

Issue 7. Permanent total disability; Schied case. (DOL and American Insurance Association).

That chapter 62-4 be amended by adding thereto a NEW SECTION to read as follows:

If an employee is totally disabled under § 62-4-53 and is capable of obtaining other employment at a lower wage, the employer shall take an offset equal to sixty-six and two-thirds percent of the return-to-work wage or the wage the employee is capable of earning and shall pay the employee the difference between this amount and the compensation rate established under § 62-4-3.

Issue 8. Various Issues. Fern Stanton Johnson

BILL ONE - First rough draft May 3, 2007 SD Injured Workers Coalition

That chapter 62-6 be amended by adding thereto NEW SECTIONS to read as follows:

Section 1. Application:

- This section applies to insurers, self-insurers, group self-insurers, political subdivisions of the state, and the administrator of state employees' claims. This section also applies to adjuster and third-party administrators who act on behalf of an insurer, self-insurer, group self-insurer, the assigned risk plan, the South Dakota Insurance Guaranty Association, a political subdivision, or any other entity.
  This section shall be enforceable only by each the Department of Labor and the Division of Insurance. Evidence of violations under this section shall be admissible in any civil action.

Section 2. Purpose.

- This section is not intended to replace existing requirements of this chapter which govern the same or similar conduct; these requirements and penalties are in addition any others provided by this chapter. Nothing herein precludes any other remedy available to the claimant.

Section 3. Penalty:

- If an insurer or, employer fails to file with the Department of Labor any report required by this section in the manner and within the time limitations prescribed, or otherwise fails to provide a report required by this section in the manner provided by this section, the Department of Labor shall impose a penalty of $500.00 for each failure. Notice of such penalty imposed shall be made by the Department o the party in noncompliance on a form prescribed by the Department.

Section 4. Specificity of notice or statement of denial required.

- Notices of an adverse determination shall be sufficiently specific to convey clearly, without further inquiry, the basis upon which the party issuing the notice or statement is acting; and
- Reference to the criterion or supporting basis relied upon in making the adverse determination or whether other similar criterion was relied upon in making the adverse determination.

Section 5. Required Review:

- Any employer, workers' compensation insurer, or risk management pool who through its own neglect, fails, or refuses to file any report required of him or her by Title 62 shall be guilty of a class II misdemeanor for each neglect, failure or refusal. Penalties collected by the state under this subdivision shall be payable into the state treasury into a specific assigned risk account accessible to the Attorney General particularly and solely for the enforcement of this section. It

shall be the duty of the Attorney General to investigate and act as attorney for the state. Upon proper notice given, any party assessed a penalty under this section may notify the Department of Labor and request a hearing according to rules promulgated pursuant to Chapter 1-26 by the secretary of labor. The Department shall fix a time and place for the hearing and shall notify the parties as provided in § 62-7-13.

- The insurer or, if the employer is self insured, the employer shall provide for a review or investigation that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim. The review or investigation shall, in specific terms, provide for the identification of medical or vocational experts whose advice was obtained on behalf of the insurer or employer in connection with a claimant's adverse benefit determination, specifically stating without regard to whether the advice was relied upon in making the benefit determination. The health care professional engaged in purposes of a consultation under this section shall be an individual who is neither a subordinate of any such insurer or employer.

Section 6. <u>Definition of Adverse Determination.</u>

- The term "adverse benefit determination" means any of the following: a denial, reduction, termination of, or a failure to provide or make any payment, in whole or in part for a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an injured employee's eligibility for benefits.

Section 7. <u>Commencement of Payment.</u>

- As soon as reasonably possible, and no later than 30 calendar days after receiving a medical billing charge, the employer or insurer shall pay the charge or any portion of the charge not denied, or if denying all or a part of the charge the employer or insurer shall no later than 30 calendar days provide written notification to both the employee and the provider its reason for denial pursuant to section 4 herein.. All or part of a charge may be denied if any of the following conditions exists:
  (1) The injury, disease, or condition is not compensable under SDCL 62-1-1 and employer or insurer has fully provided its basis for determination as required in section 4 herein;
  (2) The charge or service is not applicable or approved in accordance with the Medical Fee Schedule;
  (3) The charges are not submitted on the prescribed billing form; or
  (4) Additional medical records or reports are required under section 8 to substantiate the nature of the charge and its relationship to the work injury. If payment is denied under clause (3) or (4), the employer or insurer shall reconsider the charges in accordance with this subdivision within 30 calendar days after receiving additional medical data, a prescribed billing form, or

documentation of enrollment or certification as a provider; and upon receipt of the same shall pay pursuant to this section.

Section 8. Medical bills and records.

- Payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer or if insured, its insurer, within 60 days after receipt of each separate, itemized billing, together with any required reports. Health care providers shall submit to the insurer an itemized statement of charges on a billing form prescribed by the department. A paper billing form is not required if the health care provider and insurer agree to electronic submission. Health care providers shall also submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury, disease, or condition. Health care providers may charge for copies of any records or reports that directly relate to the items for which payment is sought under this chapter.
- If the billing or portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered complete, within 30 working days after receipt of the billing by the employer. A Notice that a billing is incomplete shall state with specificity all additional information required to make a decision. Any properly documented amount not paid within the 60-day period shall be increased by 10 percent, together with interest at the same rate as judgments in civil actions retroactive t the date of receipt of the bill, unless the employer does both of the following:
  (1) Pays the uncontested amount within the 60-day period; and
  (2) Advises, in the manner prescribed by the administrative director, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph.

  An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under any other provision of this Title.

- A United States government facility rendering health care services to veterans is not subject to the uniform billing form requirements of this subdivision.

Section 9. Prohibited Practices.

- This section shall be enforceable only by the Division of Insurance and Department of Revenue and Regulation, and the South Dakota Attorney General. Evidence of violations under this section shall be admissible in any civil action.

Subdivision 1. Purpose. This section is not intended to replace existing requirements and penalties of this chapter which govern the same or similar conduct. Nothing herein precludes any other remedy available to the claimant.

Subdivision 3. Prohibited conduct.

The following prohibited conduct shall be prohibited.

(1) Fail or refuse to reply, within 30 calendar days after receipt, to all written communication about a claim from a claimant that requests a response or some action taken;
(2) Fail or refuse, within 60 calendar days after receipt of a written request, submission of medical benefits coverage by the provider or the employee, to commence benefits or to advise the claimant and the medical provider of the acceptance or denial of the claim by the insurer;
(3) Refuse or fail to pay or deny medical bills within 60 days after the receipt of all information as provided within Section 8 herein;
(4) Refuse or fail to file a denial of liability for workers' compensation benefits without conducting an investigation and failing to pay or deny medical bills without evidence of proof that an investigation of the claim was conducted;
(5) Refuse or fail to regularly pay weekly benefits in a timely manner as prescribed by rules adopted by the department once weekly benefits have begun. Failure to regularly pay weekly benefits means failure to pay an employee on more than three occasions in any 12-month period within three business days of when payment is due;
(6) Refuse to fail to respond to the Department of Labor or Division of Insurance within 30 calendar days after receipt of a written inquiry from the department about a claim;
(7) Refuse or fail to pay pursuant to an order or award granted by the department, compensation judge, or any court, within 10 days of the filing of the order unless the order is under appeal and a stay is granted by the department or the district court;
(8) Advising a claimant not to obtain the services of an attorney or representing that payment will be delayed if an attorney is retained by the claimant; or
(9) Making any false entry, alteration , in any book, report, or statement with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or with like intent, willfully omitting to make a true entry of any material fact pertaining to any book, report, or statement.
(10) In addition to the penalty assessment permitted within this Title, the Department may assess a civil penalty, not to exceed one hundred thousand dollars ($100,000), upon finding, after hearing, that an employer, insurer, or third party administrator for an employer has knowingly committed and has performed with a frequency of more than one occurrence as to indicate a general business practice any of the following:
    a. Induced employees to accept less than compensation due, or making it necessary for employees to resort to proceedings against the employer to secure compensation due;
    b. Refused to comply with known and legally indisputable compensation obligations; or

c. Discharged or administered compensation obligations in a manner as to cause injury to public policy.

(11) Instituted a proceeding or interposed a defense which does not present a real controversy but which is frivolous or for the purpose of delay;
(12) Unreasonably or vexatiously delayed payment;
(13) Intentionally underpaid compensation; or
(14) Unreasonably denied a claim or vexatiously discontinued or refused to pay compensation without providing a reasonable basis.

Section 10. Penalties.

- Grounds. Upon the finding of a determination as provided in section 9 herein, after reasonable notice, and hearing be given, the department, a compensation judge, or upon appeal, the district court, or the Supreme Court shall award compensation, in addition to the total amount of compensation award, up to 30 percent of total amount of award where an employer or insurer has conducted any one of the prohibited conduct.

  I addition to, any award ordered and judgment entered either by the department, the district court, or Supreme Court, the total sum thereof shall bear interest at the rate of category C pursuant to § 54-3-16.

Issue 9. Delays -- Approval of permanent benefit filings. (Farmers Insurance).

That chapter 62-4 be amended by adding thereto a NEW SECTION to read as follows:

If a claimant receives a rating pursuant to § 62-4-6 from the claimant's treating physician, or at the treating physician's direction, and the employer files a form for approval of payment of such benefits in accordance with this rating with the department, the department shall approve such filing if it finds the rating and the proposed payment of benefits accurately reflect the benefits owed to the claimant under South Dakota law. Nothing in this statute shall prevent a claimant from petitioning the department for a hearing on the nature and extent of benefits due including the proper amount of compensation paid according to § 62-4-6.

Issue 10. Delays -- Penalty for failure to provide medical reports. (Farmers Insurance).

That § 62-4-45 be amended to read as follows:

62-4-45. All medical practitioners or surgeons attending injured employees shall comply with the rules promulgated pursuant to chapter 1-26 by the Department of Labor and shall make the reports as may be required by it. All medical and hospital information relevant to the particular injury shall, upon demand, be made available to the employer, employee, insurer and the Department of Labor within ten days following the receipt of any written request for information from the employer, employee, insurer or the department. Failure to provide such information in accordance with this statute shall result in a fine of $100 per day payable to the department. Medical practitioners, surgeons, or hospitals may charge a reasonable fee for the reproduction of the medical and hospital information. No relevant information developed in connection with treatment or examination for which compensation is sought may be considered a privileged communication for purposes of a workers' compensation claim. If a medical practitioner or surgeon willfully fails to make any report required of the practitioner or surgeon under this section, the Department of Labor may order the forfeiture of the practitioner's or surgeon's right to all or part of payment due for services rendered in connection with the particular case.

Issue 11. Delays – requiring prompt payment of medical bills. (Fern Stanton Johnson).

That chapter 62-4 be amended by adding thereto a NEW SECTION to read as follows:

Within thirty days after receiving a properly submitted bill for medical payments, the employer shall:

a. Pay the charge or any portion of the bill that is not denied;

b. Deny all or a portion of the bill on the basis that the injury is not compensable, or the service or charge is excessive or not medically necessary; or

c. Request additional information to determine whether the charge or service is excessive or not medically necessary or whether the condition is compensable.

When there is a dispute over the amount of a bill or the necessity of services rendered, the employer shall promptly pay the undisputed portion of the bill. The department may promulgate rules under chapter 1-26 to implement this section.

Issue 12. Increasing penalties for late reporting. (DOL).

Part 1. That § 62-6-2 be amended as follows:

An employer covered by the provisions of this title who has knowledge of an injury that requires medical treatment other than minor first aid or that incapacitates the employee for seven or more calendar days shall file a written report with:

(1) The Department of Labor when the employer is self-insured under § 62-5-5; or

(2) The employer's insurer when the employer has insured the liability under §§ 62-5-2 or 62-5-3.

The report shall be filed within seven calendar days, not counting Sundays and legal holidays, after the employer has knowledge of the injury, unless the employer had good cause for failing to file the written report within the seven-day period. The report shall be made on a form approved by the Department of Labor. Any employer who fails to file a report as required by this section is guilty of a Class 2 misdemeanor and is subject to an administrative fine of ~~one~~ <u>five</u> hundred dollars payable to the Department of Labor.

Part 2. That § 62-6-3 be amended as follows:

62-6-3. The insurer shall file a copy of the report required by § 62-6-2 with the Department of Labor within ten days after receipt thereof. The insurer or, if the employer is self-insured, the employer, shall make an investigation of the claim and shall notify the injured employee and the department, in writing, within twenty days from its receipt of the report, if it denies coverage in whole or in part. This

period may be extended not to exceed a total of thirty additional days by the department upon a proper showing that there is insufficient time to investigate the conditions surrounding the happening of the accident or the circumstances of coverage. If the insurer or self-insurer denies coverage in whole or in part, it shall state the reasons therefor and notify the claimant of the right to a hearing under § 62-7-12. The director of the Division of Insurance, or the secretary of labor if the employer is self-insured, may suspend, revoke, or refuse to renew the certificate of authority, or may suspend or revoke all certificates of authority granted under Title 58 to any company or employer which fails, refuses, or neglects to comply with the provisions of this section. A company or employer which fails, refuses, or neglects to comply with the provisions of this section is also subject to an administrative fine of ~~one~~ <u>five</u> hundred dollars payable to the Department of Labor for each act of noncompliance, unless the company or employer had good cause for noncompliance.

Part 3. That chapter 62-4 be amended by adding thereto a NEW SECTION to read as follows:

Within thirty days after receiving a properly submitted bill for medical payments, the employer shall:

a. Pay the charge or any portion of the bill that is not denied;

b. Deny all or a portion of the bill on the basis that the injury is not compensable, or the service or charge is excessive or not medically necessary; or

c. Request additional information to determine whether the charge or service is excessive or not medically necessary or whether the condition is compensable.

When there is a dispute over the amount of a bill or the necessity of services rendered, the employer shall promptly pay the undisputed portion of the bill. The department may promulgate rules under chapter 1-26 to implement this section.