

WORKERS' COMPENSATION INDUSTRIAL COUNCIL

SEPTEMBER 4, 2014

Minutes of the meeting of the Workers' Compensation Industrial Council held on Thursday, September 4, 2014, at 1:00 p.m., Offices of the West Virginia Insurance Commissioner, 1124 Smith Street, Room 400, Charleston, West Virginia.

Industrial Council Members Present:

Bill Dean, Chairman
Kent Hartsog, Vice-Chairman
James Dissen
Dan Marshall

1. Call to Order

Chairman Bill Dean called the meeting to order at 1:00 p.m.

2. Approval of Minutes

Chairman Bill Dean: The minutes of the previous meeting were sent out. Did everybody have a chance to look them over? Is there a motion for approval?

James Dissen made the motion to approve the minutes from the June 26, 2014 meeting. The motion was seconded by Dan Marshall and passed unanimously.

3. Office of Judges Report – Rebecca Roush, Chief Administrative Law Judge

Judge Rebecca Roush: Good afternoon everyone. It's a pleasure to be here. I hope you all enjoyed your summer. I forwarded to you earlier this morning the Office of Judges' report for the month of August. I know that you have a very busy meeting coming up. There's not a lot that's notable in here, and I'll just point out to you briefly the things I think would be of interest to you.

On page one you will see that we acknowledged 396 protests in the month of August. Even though that is a small number, it is an uptick for us. If you turn to the second page, you'll see that for the months of July and August the trend is moving upward from prior months with January being our peak for 2014. The trend – even

though the number is relatively small – the trend is that we're moving slightly upward. That really is the only notable thing in this report. Other than that, you are familiar with the ins and outs of this report in and of itself. I would be happy to take any questions that you may have about anything related to our office.

Chairman Dean: Mr. Dissen, do you have any questions?

James Dissen: No, sir.

Chairman Dean: Mr. Hartsog?

Kent Hartsog: I'd just ask that if you at some point get some visibility about the uptick or if that trend continues maybe we could talk about that at some point, but nothing today.

Judge Roush: Absolutely. Sure.

Chairman Dean: Mr. Marshall?

Dan Marshall: No, Mr. Chairman.

Judge Roush: Thank you.

Chairman Dean: We'll move onto to the Public Hearing, Title 85, Series 1, Mr. Pauley.

4. Public Hearing on Amendments to Rule 1
Title 85, Series 1, "Claims Management and Administration"

Andrew Pauley, General Counsel, OIC: Mr. Chairman, thank you. Just briefly, as I discussed in the prior meeting, today is the scheduled Public Hearing for the Commissioner's proposed changes to Rule 85, Series 1, concerning some discussions had at the Access to Justice Committee, the State Bar Workers' Compensation Committee, and other practitioners. Mr. Bill Gerwig made a presentation before the Council, and we made a presentation to you in the rule submission based upon that.

On August 1, we filed with the Secretary of State the proposed changes, and we've received comments for the last 30 days culminating them today, which is a Public Hearing to hear any other comments concerning the Rule. To date we've received

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some good comments from a cross section of those practicing and implemented or concerned stakeholders – James C. Powell from Powell & Majestro; Randy Suter commented on behalf of BrickStreet Insurance; William B. Richardson, Jr. commented; we received comments from Mary Jane Glauser, practicing attorney; Mary Jane Pickens on behalf of the Westfield Group; Deborah M. Bogan on behalf of the West Virginia Access to Justice Commission; Bill Gerwig; Jeffrey Junkas on behalf of PCI Property Casualty Insurers Association of America; and the West Virginia Insurance Federation representing Property and Casualty insurers in the State of West Virginia, among others.

The process after the public comments today is that we will look at the comments and decide if we accept some of them, reject some of them, modify some of them, and make a final proposal to you presuming, of course, that our parent organization, the Secretary of Revenue and the Governor's Office approves those changes, and they would go before this body for final approval of any changes to be adopted, and final file with the Secretary of State's Office. The changes cannot deviate from the main purpose of the original Rule, so we have to stay within the confines of the original Rule's purpose. We have approximately six months after the close of comments today to final file this Rule with the Secretary of State. I think that pretty much sums up where we're at, at this point. We obviously intend to get the comments and a transcript of today's Hearing to the Council for their review in looking at these changes and these determinations. Unless I can answer anything for you, I'll sit down and we can start the proceedings.

Chairman Dean: Mr. Dissen, do you have any questions?

James Dissen: Not at this time. Thank you.

Chairman Dean: Mr. Hartsog?

Kent Hartsog: No, sir.

Chairman Dean: Mr. Marshall?

Dan Marshall: No. I might ask Andrew, after we've heard from the folks who want to speak to us here today, to summarize the comments that you have that are not going to be directly spoken to today.

Mr. Pauley: I'll do my best. But we received a lot of them just within the last hour.

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Mr. Marshall: Oh, okay. Well, I understand.

Mr. Pauley: I don't believe the Council is meeting again until November, so we have some time to get this to you well in advance of that next meeting so that you will have plenty of time to review any and all comments.

Mr. Marshall: Fine. Thank you.

Chairman Dean: Before we open up for the public comments, if you have a comment come to the podium and speak. Give your name and who you represent [for Margaret's purposes, recording secretary] so we can all hear you. With that, Mr. Gerwig you are first to sign up to speak today.

Bill Gerwig, Attorney: My name is Bill Gerwig. I'm a sole practitioner specializing in workers' compensation. My background has been that I've represented thousands of claimants, and I've represented employers in thousands of claims over my career. So I have an exposure from all sides of these issues. My primary concerns are really twofold. The first one that I'll talk about is §85-1-19.2., dealing with checks and how checks are issued in a claim. The reality is, and I think people tend to think this is the only reason for claimant's counsel needing checks is that that's the only way of getting paid in a claim. If checks are issued directly to a claimant there are claimants who will not pay the attorney, which creates a situation where counsel either has to forego payment or sue their own client, which is discouraged and completely avoidable. In no other area of insurance law does the insurance company send checks directly to the claimant. They are always sent to counsel then distributed. In workers' compensation there is an ongoing concern that Social Security requires proof of payments – not just proof of the benefit issued in the claim. What did the claimant get? How much was it each month? And what did the attorney get in terms of fees? They also want copies of the original checks to confirm that the computer printouts generated by counsel is accurate. If checks are not sent to claimant's counsel that information cannot be provided to the Social Security Administration, and benefits are held up until that information is received because they don't want to create a situation where there are overpayments. The way the offset works is claimants are only held responsible for offset purposes for benefits actually received. So it's "post fee benefits" that Social Security uses to form the calculation. If that information is not available, they offset the entire amount of the benefit. So they are withholding benefits from claimants that they are entitled to. Sending checks to claimant's counsel also allows claimants to make sure checks are issued in a timely manner. Three days have gone by. Now it's two weeks. I haven't gotten a check. Well, if the checks are being sent to me I know where the problem is. If the check is sent to the claimant, now I'm put in a position of having to

interrogate my own client. Are you trying to steal from me? That's a very awkward position to be in when the claimant may not have received the check either. So to find out if a claims administrator is properly administering the claim, I would first have to become adversarial with my client, and that's a position that we don't have to be in. There is no additional burden in sending checks to claimants' attorneys. They still have to mail it somewhere. It's no different from a claimant saying, "I've moved. I no longer live at this address." Send it here. That's gotta be changed. There is no additional cost or additional burden put on insurance companies or claims administrators to issue checks to counsel for the claimant. To not have that provision in here or at least not stated clearly enough that I can understand it I think is a mistake.

Now what is raised is that there is a discretion among claims administrators to issue checks where they think is appropriate if there are some sort of fee disputes. Well, first of all there is already a mechanism in place for handling fee disputes. If the check is sent to the attorney, the disputed portion of the fee is put into a trust account, and those issues can be handled outside the workers' compensation arena. The claims administrator is never part of that litigation. In fact, there are far more claims disputes over fees in civil litigation than there ever is in a workers' compensation claim. And I would venture to guess that insurance companies and claims administrators don't even know if that's going on. In fact, it's not their concern at all any more than how the claimant spends his money. I don't think you even need a special circumstance to say if there is a fee dispute we send the check somewhere else. Now if there is an Order from a court with competent jurisdiction that says, "Send the check here," then obviously that's what you do. And that's already what's done. The Child Advocate Office routinely says, "Hey, they owe us money for back pay. Pay us first." And their money goes there. There is no provision within the workers' compensation system that says that's how checks are handled, but there are other laws that cover that. The same way that there be other laws that cover where checks would go if there is a fee dispute. If a court says it goes to the court, or it goes to an attorney, or it goes to the claimant, then you follow those orders. Otherwise it's much simpler for everyone just to send the checks to claimant's counsel. Let them distribute those things. If there's a problem there, that's between the attorney and the client, and there are plenty of ways to handle that that don't involve the claims administrator.

The first amendment to this section that I feel is appropriate is to specifically say, "Checks need to be sent to claimant's counsel when requested." That's the way it's been done in West Virginia for a hundred years. No one has ever complained about that. The state, when it was a self-run system, did that routinely, and it didn't pose a problem for no one. I've never heard them say, "Oh, we're getting sucked up into these

fee dispute issues," because it just didn't happen. So, that is my recommendation for §85-1-19.2.

The other thing I want to address is §85-1-19.2.b., which seems like a minor issue, but it has a much more significant effect than it may at first appear – and that is charging claimants for copies of file material. In order to. . .first I guess I need to back up. Civil cases involve an entire claim. There is money in the claim if you win or plan to have the claim settled. There is always some payment from which expenses can be recovered. Workers' compensation is different. There are many issues that have no money involvement at all. A claimant wants to change a diagnosis code. They want to change physicians. Maybe they're not getting any orders at all and they ask an attorney, "Look and see what's going on." To have an attorney pay maybe hundreds of dollars to get file material on an issue that there is no chance to recover money certainly does not enhance a claimant's access to justice. In fact, it makes it makes it virtually impossible to get representation or justice at all. Claims administrators have never complained about the cost of providing these materials. If there are multiple requests in a single claim that appear to be unreasonable, those are issues that can be raised with the Office of Judges, and I have never seen one. I've been an attorney for nearly 30 years and never once has a claims administrator said, "We feel overburdened by these requests."

Now the cost of medical records – when I said it may be a few hundred dollars – seems like that may be high. Let me tell you why it's not. A lot of claims administrators don't respond. So, when a medical facility says I want authorization for an MRI; here are my records up to date; and they don't get a response. Guess what they do? They file a second response with another set of their medical records. So when I finally get the file material from a claims administrator, 40% of that file can be thrown in the trash because there are duplicate copies. By duplicate I don't mean two. There are sometimes four and five copies of the very same material. The reason the claimant comes to get counsel in the first place is they can't get responses for medical treatment.

The other thing is, are there any orders at all? It's not just getting medical records. It's just as important to find out what the claims administrator is doing. Frequently there are no orders, or they're inadequate orders. There may be an email. No protestable language. Maybe denying some treatment. The claimant has never seen that; sent right to a medical facility. That should be a protestable order. That is a basis for Failure to Timely Act Petition because they're not properly issuing orders within the meaning of the law. So to say, well, why is it fair to allow these insurance companies or require them to turn over file material and not charge for it? My answer is why is it fair for them not to act within the meaning of the law? Now I have to file a Petition for Failure to

Timely Act to force their action, and I don't get paid for that. So both sides have issues with not getting paid for certain work that they do. And that's just the way that it is. When these issues were raised it wasn't because some claims administrator said we're not getting paid for making copies. I raised these issues initially, probably five years ago because I couldn't get any copies. Now once a claim is in litigation I can issue a subpoena. When there is no response, I can file a motion at the Office of Judges and they'll compel a response. When it is not in litigation, the initial request for a file where I need to see – are there orders that need to be protested? Are there orders at all? What have they received? Are there internal medical reviews that they've had done by doctors in-house and they've not sent to anybody? Are there independent medical exams they are required to send to people that they have not? Those are all issues that I need to address that involve no pay. It's just to assess the claim in the first place. I need access to that material. When a claim is not in litigation I had no access. There is no time standard to say they must provide. . .there used to be. Before privatization there was a regulation that required claims administrators to turn over file material within 30 days of being requested. When the system was privatized, that was removed from the regulations. So there was no mechanism to say they're not compliant with the law. What I would do is I'd file a subpoena – completely unenforceable. But luckily large insurance companies don't bother learning the law so they would comply anyway. Or I'd file a Petition for Failure to Timely Act with the Office of Judges. Again, unenforceable. But claims administrators would then see that petition and then they would provide me the file material. So I had to run a bluff just to find out what's going on in the claim. And that is not a conscionable way of running any system. Any legal system that expects some form of justice should give both parties equal access to this material. And employers' attorneys get it for free. And remember the insurance company is not just an adversary to the claimant. They are the keeper of the official record. Well, when it's in their best interest they'll turn over everything they have for nothing. And to be fair, when it's subpoenaed and there's enforcement, they've turned it over to me as well without charge, and I think that's the way that it should stay. To charge for those services impedes the claimants to get representation on many issues, and makes it impossible for them to proceed pro se if he chooses not to have counsel at all. I think it's important to continue to provide these records free of charge. Now I also think it's fair to have a provision in there that if the requests become overly burdensome that that can be raised with the Office of Judges, and there can be a request to determine whether or not those records need to be provided.

Now that brings me to why those requests are made in the first place. Frequently, depending upon the company, we get disks of records. They are not in chronological order. In fact they appear to be shuffled as best I can tell. There will be an Order dated yesterday that is in the middle of a long line of records – 60 to 70 records – and this is in

the middle. And then there are records from three years earlier, and then there is a record from one year earlier, then there's a record from three days ago. So you have to go through the entire file to find these records, and that's why we can't realistically, from appearances, say I just want this information and make a limited request for records. For one, because they're not in chronological order I have no guarantee that I'll get the records I want because very few people are going to go back through all those records to find the things that are not filed in chronological order to give me what I need. What is actually in there? Is there an internal medical review that I don't know about? Is there some other information that has not been disseminated to parties that's created by the claims administrator? And I'm not talking privileged information. I'm talking about the basis for a decision that's not stated in the Order. The only way I can find out what that information is is to get a copy of the file. So even though I may have been counsel for three years, then I request a copy of the file, it's because that information appears to be in there and has not been provided to me. Sometimes it's an independent medical exam that is required. They have an affirmative obligation to provide that material in a reasonably timely manner, and some companies don't. Some companies don't even tell me the exam has been scheduled in the first place. The only way I find out is if the claimant tells me. And then I need to get a copy of that report, and then I need to force them to enter an Order based on a copy of that report just so that I can put the claim in litigation if they aren't doing what seems to be appropriate in the claim. There is an ongoing need to request file material for those reasons. If all that information were automatically disseminated the way it's supposed to be under the law, I wouldn't need to make as many requests as I do. And I try not to make many anyway. No one has ever raised that as an issue with me as being duplicative of earlier requests. They understand what the needs are.

Quite frankly, none of these concerns were part of the original reason for raising these amendments. It's just an afterthought where someone wants to. . .well, let's throw this in there since you're looking at something. But it was never a concern. It's not why this originated. It's not part of the recommendation from the Access to Justice Committee, and it's not part of the original language that was presented years ago. So I think it would be most appropriate to, in this section, remove those portions dealing with the payment of fees for the medical records. But, again, I think leaving in at least the ability to raise the abuse issue with the Office of Judges is appropriate. And those are really the only two concerns that I have with the amendments. But those are two very significant issues that come up on a daily basis in these claims.

Chairman Dean: Mr. Dissen, do you have a comment or anything for Mr. Gerwig?

James Dissen: No, sir.

Chairman Dean: Mr. Hartsog, question?

Kent Hartsog: One quick question. You made a reference to . . . that the statute already compels insurance companies to . . . I'm paraphrasing what you said, okay.

Mr. Gerwig: I'll go back to that part again because there are two possible answers to that. At one time the regulations had a rule that just says when a claimant requests – or any party requests a copy of the file – you've got 30 days to provide that.

Mr. Hartsog: Right.

Mr. Gerwig: That was taken out of the regulations at privatization because it was believed at the time that there was no authority to say turn that file over.

Mr. Hartsog: Okay.

Mr. Gerwig: Once a claim is in litigation I have the ability to issue a subpoena. Then that is something because it's already in litigation can be raised with the Office of Judges and they can compel the production of those file materials, but only if the claim is in litigation.

Mr. Hartsog: Okay. So there's nothing in statute right now that would compel an insurance company or a self-insured or whomever to automatically provide those copies.

Mr. Gerwig: That's right. Now what I can tell you is they do it. Once they get counsel in the claim, counsel understands the problem. By counsel, I mean their own counsel. They said, "Look you need to provide this information." But frequently at the initial stages there is no counsel. I have on many occasions called attorneys and say, "Look I know you do some work for this. Can you call them, try to get assigned to this case, and intervene to get the file copy for me." And they do that. There has been a lot of cooperation within the Bar, but that doesn't give new companies coming in – and they're coming in every day it seems like – or at least I'm discovering companies every day that I've never heard of. They have no idea what's going on, and they've made no effort to learn. At least let's give them something to look at and say here's what your responsibility is.

Chairman Dean: Mr. Marshall, do you have a comment or question for Mr. Gerwig?

Dan Marshall: I appreciate the comments. Thank you.

Mr. Gerwig: Thank you.

Chairman Dean: The next person who signed up is Mr. Maroney.

Pat Maroney: Good afternoon. My name is Pat Maroney, and I work with Maroney, Williams, Weaver and Pancake, and we represent claimants mainly. We do a wide range of other work, labor work and things like that too. One of my partners is on the Access for Justice, and he has been involved with the original proposal by Mr. Gerwig. What I'm going to talk about today is starting off with 19.2., as Mr. Gerwig did, but I'm going to go into more detail about it.

Starting with the second sentence, I believe that this all should be stricken out of here, and here's the reasons why. One, it offends the West Virginia Constitution and the United States Constitution. Okay, if you look down through here. . .I'm sorry it would be the third sentence. "The private carrier, self-insured employer, the Old Fund and/or any third party administrator shall reserve the right to make any determination as to its legal responsibilities to the attorney. . ." We're talking about contracts – the attorney/client contract. And as Mr. Gerwig stated, those issues are between the attorney and a client. But what this does under the West Virginia Constitution, Article 3, Section 4, it impairs our contract. You're giving an insurance carrier the right to make a determination on our contract. It goes on to say that they can withhold our fees. If we're an active representation they can use that "reserve the right" to not acknowledge us. That to me is a big issue regarding impairments to contracts, and the Constitution specifically states you can't do that. There's still other issues with it even if it would stand, okay. If you look at it, it reserves the right but there is no time limit on it. So, say that we take a case for a claim and it goes all the way to the Supreme Court. We finally get it reversed. It takes us two years to get there to get a good decision. All of a sudden they decide – the insurance carrier decides – that they're going to reserve the right not to acknowledge us, not to pay us, not to pay the claimant. They have the authority under this 19.2. to do that. Further this should be a judicial decision and not an insurance carrier's decision. This is giving judicial power to the insurance company, okay. This should be better – and I hate to dump any more work on the Office of Judges – but I think that's where it should be if there's an issue. Third, I don't think the insurance carrier has standing to bring up some of these issues. If there's a fee problem or issue, the claimant is the one that has to bring that. The insurance carrier cannot do that, and the same thing with the active representation. I mean the claimant has to be the one that says "no." Okay. Now I've had this issue one time. That's it.

Ten years. I called the claimant up. He explained to me who he wanted to represent him, and that was the end of it. He sent a letter in. It got cleared up within a matter of weeks. Again, that is not the insurance carrier's duty. The claimant has standing to bring those issues.

As Bill Gerwig mentioned, and as we go on even with this language here, it says there's other, ". . . appropriate licensing body or a court of law. . ." where these can be remedied. That's already there. We don't need this language in here. It's not needed at all. There's other remedies, as it states, you know, and that part is true. But I think this gives the insurance carrier a lot of power they shouldn't have. It's constitutionally wrong, and it impairs our, you know. . . contract impairment.

Bill spoke about 19.2.b. There's some other issues in 19.2.b. which are similar to the delay problem. Down in here it starts with, "The private carrier, self-insured employer, or Old Fund and/or its third party administrator may choose to resist the request. . .," which Mr. Gerwig was talking about. This is a file request, okay. Unless subpoenaed by either the claimant or legal representative under lawful process in order to compel. The order to compel, which Mr. Gerwig talked about, is a long process, okay. If somebody is injured and they're trying to get their claim changed to. . . say it's denied, they're trying to get it held compensable. You're maybe delaying it by two or three months. What it takes, if there's an attorney involved, it takes a lot of scheduling between our office, the defense firm, court reporter, and the claimant. It's not easy to say that this is going to happen tomorrow. We would like for it to happen that way, but in real life doesn't. It takes time to schedule things to have these depositions or a hearing or something like that. My schedule is already booked up for the next two or three months. So if an issue like this came up, I couldn't do it right away. And the person could be destitute or pretty close to destitute. It could be the breadwinner. He's got kids at home. Bills are piling up, and now he can't provide for his family. If you add on top of it 19.2., where they reserve the right to even recognize you, you could have further delays. You're talking about compounding the problems with those two sentences.

I agree with Mr. Gerwig that if there is an issue regarding a file request, the Office of Judges should handle that. I can tell you this. I don't think we've ever really had any disputes over file requests. We have problems getting them like he does. We have the same problems. We have the same problems with orders, communication between the insurance carriers and us, and the claimant. A lot of times there's no written orders or rules. I spoke to a claimant before I came over here. He had medical treatment to his knee. Two injections were authorized. I looked in his file; didn't have any authorization request; didn't have anything from his doctor; nothing from the insurance carrier. I said,

“Do you know if they’re paying it?” He said, “I think they are.” These are continuing problems that we have. I think the proper language regarding file requests was presented by the Access for Justice. It’s plain. It’s simple. It’s clear. It’s easy to understand. It’s easy to apply. It is the best way to go. These two sections here – 19.2.a. and 19.2.b. – a layperson is not going to understand it. In fact when I got this, and I got this whole 19.2., I had a hard time understanding it. It took me two or three days of reading it before I could get my head around it.

Next I want to talk about the Waivers. This is 19.2.c. Again, this is not needed. As long as I’ve been doing this, I have never heard of anybody complaining about getting documents for the insurance carrier that were either work product, attorney/client privilege, any privacy issues or anything like that. Never had that problem at all, so I don’t even know what. . .I’ve never heard this from an insurance carrier or defense attorneys. All the Defense Bars and the Plaintiffs’ Bars, when we ask for a claim file, we know what we’re going to get. There has never been an issue. So I just don’t understand this. And, again, if it is adopted there should be some type of privilege log to where we can go back and see what they’re withholding. And here’s a good example of why. There could be some facts that are needed for the claimant. And say that there is some confidentiality or attorney/client privilege mixed in, we would not be able to get those documents if it’s mixed in and they just stamp it “confidential.” There’s no way we can get it. And if there’s a privilege logged in we could raise the issue with the Office of Judges. The Office of Judges could take a look at the documents and decide whether we could get them or not. But, again, I do not believe that it has been a problem, and I’m not sure why it came up. Any questions?

Chairman Dean: Mr. Dissen?

Mr. Dissen: Early on you mentioned you thought that it was unconstitutional. I’m assuming in your written remarks you’ll site the appropriate sections in supporting cases to support your position.

Mr. Maroney: Yes. It’s Article 3, Section 4, under the West Virginia Constitution. *“No bill of attainder, ex post facto law, or law impairing the obligation of a contract, shall be passed.”* And this is impairing our contract between the client and the attorney.

Mr. Dissen: Is there any case law to support your position?

Mr. Maroney: I don’t have it on me. No. But there is. And the U. S. Constitution is similar. It is Article 1, Section 10, and it’s very similar. Our Constitution pretty much mirrors the U. S. It varies in some places.

Mr. Dissen: Any supporting case law. . .it would be good to take a look at.

Mr. Maroney: Okay.

Chairman Dean: Mr. Hartsog, do you have any questions?

Mr. Hartsog: The Access to Justice language that you were recommending. I'm assuming that's included in your comments, and Mr. Pauley will be providing us copies of those.

Mr. Maroney: We were having computer problems when we left the office. We have not submitted our comments yet, but we're hoping to get them to you as soon as we can.

Mr. Hartsog: If you would, and make sure that mine and Mr. Dissen's questions are addressed, and get those to him so he can include those in what they're going to give to us.

Mr. Pauley: I'll probably need to clarify that because I wasn't sure either. Were you talking about Mr. Gerwig's submission or are you talking about an Access to Justice submission that maybe hasn't been submitted to the Council?

Mr. Maroney: Well, I thought they were under the. . .maybe I had this wrong.

Mr. Pauley: Maybe they were. Were those Access to Justice that you submitted?

Mr. Gerwig: Actually my submission predated the Access for Justice.

Mr. Maroney: Oh, did it?

Mr. Gerwig: And they made some modifications to it.

Mr. Pauley: Okay.

Mr. Maroney: And this is maybe. . .

Mr. Gerwig: That looks like mine.

Mr. Pauley: Right. That's what Mr. Gerwig submitted.

Mr. Maroney: So I misstated that.

Mr. Hartsog: Mr. Pauley, what I was after. . .he made a reference to some wording that he liked in the Access to Justice language. That's what I wanted to look at. So, if those could be included with your comments so that Mr. Pauley could provide that to us, I'd appreciate it.

Mr. Maroney: Okay. Not a problem.

Chairman Dean: Mr. Marshall, do you have a question, sir?

Mr. Marshall: No questions. Again, your points are very well taken.

Mr. Maroney: Thank you.

Chairman Dean: Very good. Thank you, sir.

Mr. Maroney: Thank you for your time.

Chairman Dean: Next is Mr. Kirkner.

Andrew Kirkner: Good afternoon. My name is Andrew Kirkner and I represent the West Virginia Insurance Federation. I certainly appreciate the opportunity to address you all today. The West Virginia Insurance Federation – our members write about 85%, a little over 85% of the workers' comp market here in West Virginia. I'll be brief, and I'm not going to be quite as granular as the first two speakers. Kind of speak on a 10,000 foot view.

We do have a few concerns with the proposed language that we'd like to express here today. The first part of the proposed Rule that we have some issues with is Section 19.2., which has already been spoken about. That's the Acknowledgement of Representation. Two subsections in there that we have issues with. The first one is, there is some ambiguity as to what date on that Acknowledgement of Representation needs. It could be the date of receipt of the acknowledgement or it could be the date, for example, that counsel was engaged. So, if possible, we'd like some clarification as to the date. Our suggestion would be the Notice of Representation shall be the date of receipt of the Notice of Representation. In other words, it becomes effective the date that the notice of acknowledgement is received.

The second part of that Rule that we are requesting some clarification on is exactly what needs to be included in the written acknowledgement as to the reservation of rights. You've heard some opposition to that language – the reservation of right. We don't have any opposition to the language itself, but we would like some clarification as to whether that needs to be included in the written acknowledgement. In other words, does the carrier need to include in the written acknowledgement that they reserve the rights or are they reserving the rights by nature of the written acknowledgement?

The second section that we would request some clarification or have some issues with is 19.2.a., which is the Prospective Delivery of Notifications Concerning a Claimant. Now this provision essentially requires the carrier to provide ongoing updates on a number of different issues, but in particular I'd like to drill down a little bit on the medical records provision. This provision would essentially require the carriers to update the file on an ongoing basis to the claimant and counsel, and we've got a couple of issues with that. Number one, it would impose a significant duty on the carriers. It would require the carriers to go back into the file and to update the file, and not only to update the file but to produce that file to the claimant and to counsel on an ongoing basis. So, if we take that in the context of medical records. . . number one, the claimant already has first person knowledge of any updates in the medical file. They've been given that by their provider. Number two, those are updated quite frequently, and so this would require the carriers to go back in on a frequent basis, figure out what's discoverable, and send it back to the claimant. So, that's the imposition of a significant duty that we would ask to be stricken from the proposed Rule. If that language is kept though, and if the Board determines that that language is appropriate, we would ask for the inclusion in that subsection of "harmless error" or "omission" provision that would essentially state that the carriers, if there is an error or omission in the production of these documents, that the carrier be held harmless.

The third section that we have some issues with is 19.2.b., which is the Retrospective Copies of Claim Files. I think that speaks particularly to the Office of Judges' ability to review what is produced. The language used in the Rule is our largest concern. The language is "pre-protest claim file disputes." There are a couple of issues inside of that. The first thing is that the language "resist" is used in the Rule – resist versus deny. From a claims handling perspective, "deny" is a much more appropriate term. The carrier will make a determination and then "deny the request" as opposed to "resist the request." So, we would certainly ask that that be modified if this is kept. From kind of a larger perspective, this language would appear to expand the authority to the Office of Judges. Again, it's that term of art that's not defined in the Rule. The pre-protest claim file disputes – the Legislative grant, which I think is West Virginia Code §23-5-8(f), grants the Board the authority to review disputed claims, not "pre-protest file

claim disputes," which is a little bit different. Again, we talk about the "resist" versus "deny," and how there kind of needs to be a bright line. So, on a whole this Rule kind of expands the authority of the Office of Judges. If it's kept though, which we oppose, we would certainly request that that language be cleaned up a little bit.

Additionally, if the language is kept we would request that the "pre-protest claim dispute" be defined in the language. In our view, expand the Office of Judges' authority. We would certainly request that that "pre-protest claim file dispute" be defined in the Rule, and also that that expansion not be allowed to have an effect on the tolling of any applicable statute of limitation.

Then the final section of the Rule that we've got some issues with. . .frankly, we don't oppose it so this is going to kind of be the opposite position that you just heard is the "waiver" section. My only comment, as to the earlier testimony here today, would be that just because it hasn't happened to a particular individual in terms of the "waiver" doesn't mean it hasn't happened, and doesn't mean it won't happen. So, we support the inclusion of a "waiver section" in the Rule, as to privileged and confidential information. But the word "waiver" is not used in the section so the title "waiver" may be a bit if a misnomer. That's more of a technical cleanup.

That's our views on it. Several of our members are present here today, and you're going to hear from them on some more granular issues, but that's kind of the Federation's view.

Chairman Dean: Very good. Thank you. Mr. Dissen, do you have a question, sir?

Mr. Dissen: No, sir.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog: Did you submit your comments that you just went over today in writing?

Mr. Kirkner: We did. Yes sir. We were one of the ones that submitted it pretty close to the meeting.

Mr. Hartsog: Thank you.

Chairman Dean: Mr. Marshall?

Mr. Marshall: No questions or comments, Mr. Chairman.

Chairman Dean: Thank you, Mr. Kirkner.

Mr. Kirkner: Thank you very much.

Chairman Dean: The next speaker would be Mr. New.

Stephen New: Good afternoon. My name is Stephen New, and I practice law in Beckley, West Virginia, and I have represented injured workers for about 15 years. I'm not going to speak to you about statutes. I'm not going to speak to you about the Constitution, as my friend Mr. Maroney did. I want to speak to you in a very practical matter – practically speaking – what the implementation of Rule 19 does to injured workers in the State of West Virginia. And I would urge this panel to reject the adoption of Rule 19.

I will pass along some wisdom of my grandparents from the coalfields of southern West Virginia. Quite simply, if it ain't broke, don't fix it. There has been much that has imposed burdens on injured workers since the privatization of this system, and few things have gone well for them. Many practitioners no longer see injured workers in this state. Many of my fellow practitioners stopped doing workers' compensation because it got so burdensome. There are some of us who still do. There is no need to break that which does not need fixed. This system of receiving injured workers' checks isn't broken. It almost makes you wonder why then – whoever proposes or supports this Rule – would want this to be passed. The situation – practically speaking – whereby the injured worker's lawyer receives his or her check, deducts a fee, and then passes that onto the claimant is a very simple, very effective, and peaceful, to be quite honest with you situation. As Mr. Gerwig pointed out, we have obligations to Social Security, to Medicare, to other government agencies. We are able to assist these injured workers in their reporting obligations. I fear that if injured workers' checks go directly to them that their obligations to comply with other government agencies, like Social Security for instance, where the benefits get adjusted based on workers' comp benefits which may be in effect at some point, not in effect for another, might be compromised. But practically speaking, it's not broken now. The way that the system currently works doesn't need fixed.

Secondly, with respect to the receipt of the claims file, practically speaking, here's the way that it works. Frequently, in the beginning of a workers' compensation claim things will go smoothly. The doctor is very responsive to the workers' compensation carrier. The doctor gets his reports in timely. The worker receives his benefits timely,

and quite frankly the injured worker doesn't need a lawyer at that stage. The claim goes along swimmingly six months or a year. Then denials of medical treatment start coming out, or the injured worker gets rated for a percentage and the rating doctor rates a percentage, but his treating doctor believes he has not reached maximum medical improvement. All of sudden he finds himself in need of counsel. So, representing injured workers I find myself a year into the claim – a year into the claim – and I need to get brought up to speed because this injured worker has issues – pressing issues – the suspension of temporary total disability benefits; a rating on a permanent partial disability. Perhaps they need vocational rehabilitation and they don't even know it. They need Access to Justice right then. They don't need me as their lawyer tracking down a year's worth of medical treatments all over this state with subpoenas trying to put together a medical file when an insurance carrier – this is how simple it is – an insurance carrier, a claims administrator goes “select all” and burns to a CD. Practically speaking, in my office since about 2005 or 2006 I haven't gotten a stack of medical records. I've gotten a CD or a DVD containing anywhere from hundreds to thousands of pages worth of documents. It's that simple for insurance carriers. “Select all,” burn to a CD, stick it in the mail to Steve New. So, again, I ask you, if the process is that simple – “select all,” burn to CD – why does someone want to change that? I don't burden the insurance carrier. I don't send a request for my client's copy files every month to get updated. In my office what we do, practically speaking, is about every four to six months I'll send out a new request for file copies – “select all,” burn to CD. And I get updated medical records because there may be issues going along. So, the process truly is that simple. There is no burden. And I would ask insurance carriers or anybody else who believes that the process of providing the claims file to us is burdensome. I'd ask them to prove that. Prove to you – before you change this Rule – prove to you how that's burdensome because this isn't 1984, and nobody is standing at the Konica Minolta copier making a copy of a stack of a thousand pages. Those days are long gone. It's “select all,” burn to CD. It could even be transmitted electronically if they wanted to do it by email. In practical terms, which I was raised in Gilbert. . .I'm sorry, that's the only way I know how to speak is, “if it ain't broke, don't fix it.” There is no need – either on the check disbursement or on the provision of medical record to the injured worker or his representative – to make a change to Rule 19. I'd urge the rejection of it. Thank you. Any questions?

Chairman Dean: Mr. Dissen?

Mr. Dissen: In the age of electronic medical records, which I'm going through now with the hospital, does that change the game plan? I mean, if a claimant goes in, sees a physician, and the physician has to use electronic medical records. He gives the

patient a portal to get it. I mean, it seems to me that the medical records would be available almost instantaneous when the physician completes his report to everybody.

Mr. Pauley: Sure I wouldn't disagree with that except there may be a need – and I think good points there – I'm not here to counterpoint at this point. I suppose some – and I don't know if there's anybody in the room – some would say they may still want their counsel to look at it before anything is divulged to the other side.

Mr. Dissen: The only reason that I mentioned it is when they give the patient [the claimant] their own access to go in and get a complete set of medical records, it seems to me that the claimant then could just turn that over to their attorney.

Mr. Pauley: Sure.

Mr. Gerwig: I can respond to that if you'd like. It is not always important, but medical records exist in the world. What did the claim administrator have? What do they base their decision on? Is that a reasonable decision based upon the medical records in their possession? Those are questions that need to be answered, and I can't do that by getting records from the physician.

Mr. Dissen: Historical records. I was thinking more like the updated records.

Mr. Gerwig: If I could respond to the Insurance Federation's question about their ongoing responsibility. Actually the 19.2.a. refers to medical reports not medical records, which is different from IME reports because frequently there are file review reports or other internal reports generated by a physician based on records. I don't think there is an obligation for them to continually re-mail out medical records that they've received. I think the medical reports referred to in that section are those types of reports as opposed to an office note from some physician. But if the records are available, which Steve is indicating, in the future then they don't have any obligation to send that information out. We could request it as that need comes up, and just get a copy of the file to see what they have actually received and what rulings are based on that.

Mr. New: The only thing that I would conclude with, if there are no other questions or anything, is when the injured worker files the claim that is an authorization to release medical information to the insurance carrier. The insurance carrier, whether in a contested claim or a claim that's ruled compensable, then goes about the business of gathering up the injured worker's medical records. It's just nonsense to then, perhaps

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six months or a year into a claim, ask the injured worker and his counsel to do that which the carrier has already done and can easily provide. Thank you.

Chairman Dean: Mr. Hartsog, any questions?

Mr. Hartsog: No, sir.

Chairman Dean: Mr. Marshall?

Mr. Marshall: No, Mr. Chairman.

Chairman Dean: Well, those were the four people that signed up to speak? Is there anybody else from the public that would like to speak?

Mr. Gerwig: If I could, I'd like to respond to one other thing.

Chairman Dean: Come on up ma'am.

Chairman Dean: We'll get back with you, sir.

Mr. Gerwig: Okay.

Linda Garrett: Hello. Thank you for allowing me to speak. My name is Linda Garrett, and I have been practicing primarily, and at times exclusively, in the area of workers' compensation law for 37 years now. And things have changed a lot over the years, but I agree with Mr. New and the previous speakers. On behalf of claimants, I don't understand the reason for changing these rules. The problems that I encounter on a day to day basis with insurance carriers and third party administrators in providing files are primarily the out of state carriers. They don't issue orders. They don't provide records. They don't even tell claimants why they've stopped paying their checks. And they don't provide us the records. And to try to enforce this type of Rule upon them would be near impossible dealing with Zurich out of New Mexico or Travelers out of another state, even though they are licensed to do business here. It would be a nightmare. As far as interfering with the contract that I would have, and Bucci, Bailey & Javins would have with the client – that to me is unthinkable. No employer would want their contracts interfered with. No TPA would want their contract interfered with, and the attorneys and the clients don't want their contract interfered with. I have seen. . . all be it intended to be good in the field of federal black lung to protect claimants, and that is not I believe what the purpose of this is. The purpose of this, as I understand it, is to resolve some kind of dispute concerning fees owed by the claimant to the workers'

compensation attorney. The end result will be what has happened in the federal black lung field, which is, attorneys say, "This is way too much hassle. I can't make money doing this. I have to pay my secretaries. I have to pay my electric bill, and we're just not going to do it. We can't afford to do it." And the end result will be that injured workers in West Virginia will go without counsel. I see on a daily basis claimants who come in and their claims are denied for errors committed by the TPA's in misreading the law. And by and large, as I say, a lot these are out of state new insurance companies coming into this area. And they'll say, "Well, this black lung client can't reopen his claim because he's already filed two reopening's." Well, they don't realize that he was granted an additional 10%, and so that started a new five year period to reopen, and they deny the claim. And if they don't have an attorney, they may have complicated black lung and be dying, and they can't reopen their claim to go back and get an increase percentage and thereby get medical treatment for that claim. These are real living breathing people who need surgeries; who need medical treatment; and at times oxygen. I have had three clients who have had lung transplants for black lung, and this is a real problem. And I think this would be the death nail. Passage of this would be the death nail for claimants having representation in the State of West Virginia for their injuries sustained on the job. Thank you. Are there any questions?

Chairman Dean: Mr. Dissen, questions, sir?

Mr. Dissen: No, sir.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog: Are you advocating we make no changes to Rule. . . ?

Ms. Garrett: I would advocate. . . and I received, and I don't know the source. It may be the Committee of Justice. A proposed amendment in place of the amendments proposed in the Rule that acknowledges legal representation, and it states. . . it's very simple. It changes §85-1-10.8 that states, "Notification of legal representation shall take effect immediately upon receipt and shall be acknowledged in writing by the responsible party within fifteen (15) days." That could be 30 days, but some time definite from the date of receipt, which would meet the insurance industry's concerns. "From the date of receipt of such notice acknowledgement would include an agreement to issue all checks directly to counsel for the injured worker if requested. . ." And that is signed by the claimant. It's explained up front to the claimant how that works. In my practice of all these years I've never had an issue over this. ". . . As well as an agreement to provide counsel with copies of all future orders, notices, and correspondence. If directed by the attorney-client contract, all indemnity benefits shall be made payable to the claimant. . ."

The Rule, as proposed, I think states that even medical benefits could go to the claimant, and those go to the providers.

Mr. Hartsog: So, you're advocating. . .

Ms. Garrett: I'm advocating. . .

Mr. Hartsog: Take all these changes out and inserting this paragraph in there wherever it belongs.

Ms. Garrett: Yes, I am.

Mr. Hartsog: I just wanted to be clear what you were. . .

Ms. Garrett: Yes. And the file copies. . .everybody would get a copy of the file.

Mr. Hartsog: Okay.

Chairman Dean: Mr. Marshall, do you have a question?

Mr. Marshall: No, Mr. Chairman.

Chairman Dean: Thank you, Ms. Garrett.

Ms. Garrett: Thank you all.

Chairman Dean: Mr. Gerwig, you had a comment.

Mr. Gerwig: Very briefly. Just so everybody is clear. What Linda just gave you was my original proposal, which I think you guys already have.

There was some concern about using the term "resist" rather than "deny" in 19.2.b. The reason it says "resist" is because there is no denial. When you request medical records from a lot of these facilities. . . "Hello, hello." That's what you're getting. Is anyone home? You're not getting a denial. You're not getting anything. You don't know what's happening to your request. So, that's why it says "resist." What they're trying to convey is the situation where you request file material, and you are completely ignored, which is typically what happens when there is a problem. Now there are administrators that are very good about responding. Those companies are certainly not an issue.

One more thing, which is not really any kind of criticism or request for a change, it's just a point of clarification from my personal opinion. There was some question about, "When do you acknowledge counsel? What is the effective date?" And I think that what we've done all these years is use the date of receipt. . .the claims administrator has the date of the acknowledgement of counsel because they certainly can't go back retroactively and do anything differently. It's a matter from this point forward we realize you are the attorney, and we're going to send you copies of what we are required to send you, and allow you to represent your client, and we'll respond accordingly. I think that's what is meant by both of those sections. I don't have any problem with those terms in particular. But I also want to make sure that everybody understands that when people say don't fix it because it's not broken, that's only half true. We still have problems getting checks frequently. We still have problems getting file material. Those things are maybe not broken but need to be reinforced so there is something in writing explaining the obligation to do both of those things to these third party administrators who are just now entering the market and don't have the same history that BrickStreet has and some of these other companies. They need that guidance so that we can say, "Look, here is your requirement." Frequently they just take our word for it, but some companies don't ever hear our word because they won't call us back or respond in any fashion, so we need something to point to. That's it.

Chairman Dean: Very good. Thank you. Does anybody else from the public have a comment today? Seeing none, we'll move onto the general public comments on any other matter.

5. General Public Comments

Chairman Dean: Does anybody from the general public have a comment they would like to make today on anything else? [No comments.]

6. Old Business

Chairman Dean: Does anybody from the Industrial Council have anything they would like to bring up under old business? Mr. Dissen?

Mr. Dissen: No, sir.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog: No, sir.

Chairman Dean: Mr. Marshall?

Mr. Marshall: No, sir.

Chairman Dean: Mr. Pauley?

Mr. Pauley: No, Mr. Chairman.

7. New Business

Chairman Dean: We'll move onto new business. Does anybody from the Industrial Council have anything they would like to bring up under new business? Mr. Dissen?

Mr. Dissen: No, Mr. Chairman.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog: No, sir.

Chairman Dean: Mr. Marshall?

Mr. Marshall: No, Mr. Chairman.

Chairman Dean: Mr. Pauley?

Mr. Pauley: No, sir.

8. Next Meeting

Chairman Dean: The next meeting will be Thursday, November 6, 2014, at 1:00 p.m. Does that meet everybody's schedule? We're good to go with that.

9. Executive Session

Chairman Dean: The next order of business is Executive Session. The next item on the agenda is related to self-insured employers. These matters involve discussion as specific confidential information regarding a self-insured employer that would be exempted from disclosure under the West Virginia Freedom of Information Act pursuant to West Virginia Code §23-1-4(b). Therefore it is appropriate that the discussion take place in Executive Session under the provisions of West Virginia Code §6-9A-4. If there is any action taken regarding these specific matters for an employer this will be done upon reconvening of the public session. Is there a motion to go into Executive Session?

Mr. Marshall: So made.

Mr. Dissen: Second.

Chairman Dean: A motion has been made and seconded to go into Executive Session. Any question on the motion? All in favor, "aye." All opposed, "nay." The ayes have it. We will go into Executive Session.

[The Executive Session began at 2:05 p.m. and ended at 2:26 p.m.]

Chairman Dean: We are now back in regular session. The first Resolution is for the renewal of self-insured status for 25 companies. Is there a motion for renewal?

Mr. Dissen: So moved.

Chairman Dean: A motion made. Is there a second?

Mr. Marshall: Second.

Chairman Dean: A motion has been made and seconded. Any question on the motion? All in favor, "aye." Opposed, "nay?" The ayes have it. [Motion passed for renewal of self-insured status for 25 companies.]

The second Resolution is for the renewal of self-insured status for Family Dollar Stores of West Virginia, Inc. Is there a motion?

Mr. Dissen: So moved.

Chairman Dean: A motion made. Is there a second?

Mr. Hartsog: Second.

Chairman Dean: A motion has been made and seconded. Any question on the motion? All in favor, "aye." Opposed, "nay?" The ayes have it. [Motion passed for renewal of self-insured status for Family Dollar Stores of West Virginia.]

[Dan Marshall recused himself from voting on Family Dollar Stores of West Virginia.]

10. Adjourn

Chairman Dean: Is there any other business that needs to be brought up? Seeing none, is there a motion for adjournment?

Mr. Dissen: So moved, Mr. Chairman.

Mr. Hartsog: Second.

Chairman Dean: A motion has been made and seconded to adjourn. Is there a question on the motion? All in favor, "aye." All opposed, "nay." The ayes have it. Meeting adjourned.

There being no further business the meeting adjourned at 2:30 p.m.