West Virginia Offices of the Insurance Commissioner
Permanent Total Disability Review Board Procedures

When a claim is reopened for permanent total disability consideration or a permanent total disability issue in litigation is remanded by the Office of Judges, Board of Review, or Supreme Court of Appeals of West Virginia (Supreme Court), it is the Carrier/ Self-Insured Employer (SIE)/Third Party Administrator's (TPA's) responsibility to obtain current medical information and prepare the claim for review by the Permanent Total Disability Review Board (PTDRB). W. Va. Code § 23-4-6(j)(1) and CSR §85-5-3.7

DOCUMENTATION REQUIRED FOR NEW PTD APPLICATIONS

- Carrier/SIE/TPA Request for Permanent Total Disability Review form
- Claim Contact Information sheet
- A research sheet listing all claims filed by the claimant in the state of WV
- The completed permanent total disability application/petition with any supporting evidence
- The carrier/SIE/TPA permanent total disability reopening decision
- The Permanent Total Disability Research Sheet listing all workers' compensation claims with dates of injury, body parts, independent medical examiners, and impairment percentage awarded
- All permanent partial disability independent medical examination reports (If there are no awards in some of the claims please provide the closure letter)
- Current permanent total disability independent medical examinations addressing all work-related injuries and diseases sustained by the claimant
- Adjudicated permanent partial disability decisions by the Office of Judges, Board of Review, or Supreme Court
- Adjudicated permanent total disability decisions by the Office of Judges, Board of Review, or Supreme Court
- Hearing loss and occupational pneumoconiosis awards with their diagnostic studies.
- Current functional capacity and vocational rehabilitation reports

INFORMATION REQUIRED FOR REMANDED PTD APPLICATIONS

- Carrier/SIE/TPA Request for Review form
- Claim Contact Information sheet
- The remand decision by the Office of Judges, Board of Review, or Supreme Court
- Any and all medical information submitted as evidence during the litigation and listed as records considered at the Office of Judges level

Please do not copy and submit the complete file or send hospital records, office notes, unrelated orders, or general correspondence.

CATASTROPHIC CLAIMS

In traumatic or catastrophic claims, it may not be possible or practical to obtain current medical evaluations. In such cases a medical record review by the treating physician may be submitted, along with current clinical treatment notes, medical assessment reports, and rehabilitation

assessment reports. These reports should indicate the injured worker's current treatment plan and prognosis.

FEE INSTRUCTIONS

All new requests for consideration by the PTDRB by private carriers, self-insured employers or their representative must be accompanied by payment of $1,400.00. The claim will not be scheduled for consideration without payment. Payments should be submitted to the following address:

West Virginia Offices of the Insurance Commissioner
Financial Accounting Department
PO BOX 11683
Charleston, WV 25339-1683

OIC Tax ID # 55-6000786

WHERE TO SEND PTD APPLICATION PACKETS

West Virginia Offices of the Insurance Commissioner
Claims Services
Attn: Deborah Bryant
P.O. Box 50541
Charleston WV 25305

Upon receipt of the request containing all required information and the required payment, the claim will be scheduled for the next PTDRB meeting. Meetings are held each month on the second Monday of each month. If the second Monday falls on a holiday, another date will be determined by the PTDRB.

Occasionally, additional information may be needed by the PTDRB to make its determination. When this occurs, the parties are notified, and the claim is tabled to obtain the additional information. It is the carrier/SIE/TPA's responsibility to schedule appointments and obtain any additional information.

RESPONSES TO INITIAL RECOMMENDATIONS

After reviewing the evidence, the PTDRB shall issue its Initial Recommendations with an explanation for each recommendation. The Initial Recommendations shall be sent to the various parties to the claim, and each party shall be afforded a 60-day period, from receipt of the Initial Recommendations, to respond in writing to the PTDRB. In addition to filing a response during this 60-day period, a party could request an extension for additional time in order to file a response. All written correspondence should be directed to:

West Virginia Offices of the Insurance Commissioner
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540

With a copy sent to:

West Virginia Offices of the Insurance Commissioner
Claims Services
Attn: Deborah Bryant
P.O. Box 50541
Charleston WV 25305

Any additional information received with a response to the Initial Recommendations will be submitted to the PTDRB for consideration at the next scheduled meeting.

Request for extensions may be granted by the Legal Division.

If no responses or requests for extensions are received at the expiration of the 60-day period, the claim will be scheduled for the next meeting for final consideration and recommendations.

Once the PTDRB reviews the record, including any responses to the Initial Recommendations, the PTDRB shall issue its Final Recommendations to the parties. At this point, the carrier/SIE/TPA shall issue a protestable decision based on the recommendations. Once the protestable decision has been issued, any party that disagrees may file a protest with the Office of Judges.

Rules and Regulations Pertinent to the PTD Application Process

West Virginia Code of State Regulations § 85-5-3.7

"No issue of permanent total disability may be referred to reviewing body unless a properly completed and supported application for permanent total disability benefits has been received by the Commission, self-insured employer, or private carrier. Prior to the referral of any issue to the reviewing body the commission, self-insured employer, or private carrier shall conduct examinations of a claimant that it finds necessary and obtain all pertinent records concerning a claimant's medical history and reports of examinations and forward the to the reviewing body at the time of the referral.

WV Code § 23-4-6 (J)

"… all administrative and adjudicatory functions performed by the Interdisciplinary Examining Board shall be performed by the following reviewing bodies for those claims over which they have administrative jurisdiction: (1) The insurance commissioner or his or her designated administrator of the funds set forth in this chapter; (2) private carriers; or (3) self-insured employers."

WV Code § 23-4-6(J)(1)

"Prior to the referral of any issue to the interdisciplinary examining board, or, upon its termination, prior to a reviewing body's adjudication of a permanent total disability application, the commissioner or reviewing body shall conduct examinations of the claimant that it finds necessary and obtain all pertinent records concerning the claimant's medical history and reports of examinations and forward them to the board at the time of referral."

WV Code § 23-4-6(n)(1)

“Upon a finding that the claimant has a fifty percent whole body medical impairment or has sustained a thirty-five percent statutory disability pursuant to the provisions of subdivision (f) of this section, the review of the application continues as provided in the following paragraph of this subdivision.”

WV Code § 23-4-6(n)(2)

“For all awards made on or after the effective date of the amendment and reenactment of the section during the year two thousand three, disability which renders the injured employee unable to engage in substantial gainful activity requiring skills or abilities which can be acquired or which are comparable to those of any gainful activity in which her or she was previously engaged with some regularity and over a substantial period of time shall be considered in determining the issue of total disability. “

CARRIER/SELF-INSURED/TPA REQUEST FOR PERMANENT TOTAL DISABILITY REVIEW

Claims Services Division
PO Box 50541
Charleston, WV 25305

CLAIMANT INFORMATION

1. Claimant Name: First Name | Middle Name or Initial | Last Name | Generation

2. Claimant Address: Street, City, State and Zip

3. Claimant Phone #: ( ) Area Code

4. Claimant SSN: ___-___-____

5. Carrier/self-insured/TPA's Claim ID #:

Jurisdiction Claim #:

6. Date of Injury / Last Exposure: _____

REASON FOR REQUEST FOR PERMANENT TOTAL DISABILITY REVIEW

7. Please mark application reason stated below:

☐ **New Application** **Date of Permanent Total Disability Application:** _____

The following information is **required** for this review:

1) Request for PERMANENT TOTAL DISABILITY reopening application/petition with supporting documentation.
2) The carrier/self-insured/TPA's reopening decision.
3) A comprehensive research sheet listing all claims filed by the claimant including the date of injury, claim number, body part and permanent partial disability percentage.
4) Hearing Loss and OP Awards; including adjudicated awards.
5) Current PERMANENT TOTAL DISABILITY Independent Medical Evaluations referred by the carrier/self-insured/TPA.
6) Current PERMANENT TOTAL DISABILITY Vocational Rehabilitation Evaluation and Functional Capacity Evaluation.
7) Employer's evidence if applicable.

☐ **Remanded through Litigation** **Date of Order:** _____

The following information is required for this review:

1) The Decision issued by the Office of Judges, Board of Review or Supreme Court.
2) Medical evidence submitted by the parties as a result of the litigation.

CARRIER/SELF-INSURED/TPA CONTACT INFORMATION

8. Carrier/self-insured/TPA Name: _____

9. Contact Person's Name: _____

10. Contact Person's Phone Number: _____

11. Contact Person's Email Address: _____

12. Contact Person's Mailing Address: _____

13. Contact Person's Signature: _____

PLEASE RETURN COMPLETED DOCUMENT AND ATTACHMENTS TO ADDRESS AT TOP OF FORM

Incomplete requests will be returned to the carrier or responsible administrator of the claim.

West Virginia Offices of the Insurance Commissioner
Permanent Total Disability Review Board
Claim Contact Information

Claimant

Name: _____

Address: _____

City/State/Zip: _____

JCN: _____

Attorney contact Information:

_____

_____

_____

_____

Employer Self-Insured Yes ___ No ___

Name: _____

Address: _____

City/State/Zip: _____

JCN: _____

Attorney contact Information:

_____

_____

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_____

Permanent Total Disability Research Sheet

Claimant

SSN:

Claim #	DOI	Body Part	Employer	Carrier	IME Physician	PERMANENT PARTIAL DISABILITY%