APPENDIX: WORKERS' COMPENSATION ADMINISTRATIVE RULES

Three separate Wyoming administrative units are statutorily authorized to promulgate rules relevant to operation of the Wyoming workers' compensation system—the Wyoming Workers' Compensation and Safety Division, the Wyoming Medical Commission, and the Wyoming Office of Administrative Hearings. Although all of these rules may be located through the website of the Wyoming Secretary of State, the author of this work felt inclusion of the rules as an appendix to the treatise might make for convenient reference. The reader is cautioned, however, that administrative rules change frequently and that those included herein were effective as of the date of this edition of the treatise. Prudent practitioners will check the rules frequently for modifications and updates. The treatise can do no more than to provide a snapshot of the regulatory terrain in existence as the publication is going to press.

RULES OF THE WYOMING MEDICAL COMMISSION

The Wyoming Medical Commission administratively adjudicates "medically contested" cases. The rules that follow have been promulgated by and are applicable to the Medical Commission. For a fuller discussion of the Commission see the Treatise at Chapter 6.10.

RULES AND REGULATIONS
MEDICAL COMMISSION
WORKERS' COMPENSATION DIVISION

CHAPTER 1

GENERAL PROVISIONS AND DEFINITIONS

Section 1. AUTHORITY. These rules of practice and procedure are promulgated by the Medical Commission under the authority of W. S. §27-14-616 (LexisNexis 2001) and W. S. § 16-3-102 (LexisNexis 2001). The commission was created as a separate and independent impartial hearing body funded under the workers' compensation account.

Section 2. DEFINITIONS.

(a) “Access point" means a designated site where the party must go for purposes of attending the medically contested case hearing through the videoconference format;

(b) "Commission” means the Wyoming Medical Commission as set forth in W.S. §27-1 4-616;

(c) "Division" means the Workers’ Compensation Division of the Department of Workforce Services;

(d) “Executive secretary" means the employee designated by the division to assist the commission in the conduct of its activities; including acting as Hearing Officer

for all contested cases, ruling on all discovery, pretrial and procedural motions, conducting all preliminary hearings, and other procedural matters to facilitate the expeditious resolution of all contested cases.

Section 3. PURPOSE OF RULES. These rules are intended to set forth clear and comprehensive procedures for the conduct of contested cases by the Medical Commission pursuant to the Wyoming Administrative Procedure Act W.S. §16-3-101 through §16-3-115 (1977 and Cum. Supp. 1993).

Section 4. APPLICATION OF RULES. These rules shall apply to the conduct of contested cases before the Medical Commission as authorized by W.S. §27-14-616. Cases shall be determined by the Medical Commission in accordance with the contested case procedure of the Wyoming Administrative Procedure Act and the Wyoming Rules of Civil Procedure, as applicable under these rules and regulations.

Section 5. CONSTRUCTION. These rules are to be liberally construed to assure the unbiased, fair, expeditious and impartial conduct of contested case proceedings before the Medical Commission.

(e) "Medically contested case" means a case in which the primary issue is:

(i) a worker/claimant’s percentage of physical impairment;
(ii) whether a worker/claimant is permanently totally disabled;
(iii) whether a worker/claimant who has been receiving temporary total disability benefits remains eligible for those benefits under W.S. § 27-14-404 (c).
(iv) any other issue, the resolution of which is primarily dependent upon the evaluation of conflicting evidence as to medical diagnosis, medical prognosis, the reasonableness and appropriateness of fees charged by a health care provider.

(f) “Medical hearing panel" means three members of the medical commission selected by the executive secretary, under the supervision and guidance of the chairman of the medical commission, to conduct and decide a medically contested case hearing;

(g) “Parties” means the employee, employer, health care provider or division. A party may choose to not participate in a matter by failure to make an appearance at the initial pre-hearing conference after notice.

CHAPTER 2

COMMISSION MEMBERSHIP

Section 1. MEMBERS. The commission shall consist of 22 health care providers, eleven (11) members and no more than eleven (11) associate members as appointed by the Governor and as set forth in W.S. § 27-14-616 (a).

Section 2. ASSOCIATE MEMBERS. Associate members may participate in all aspects of commission activities, including the development of rules and regulations for the operation of the commission. Associate members do not hold voting privileges, except in their capacity as members of individual hearing panels reaching final administrative decisions in medically contested cases.

Section 3. OFFICERS. Members shall annually elect a chairperson and a vice-chairperson. The chairperson shall preside over all meetings of the commission membership and the vice-chairperson shall do so in the chairperson's absence.

Section 4. VACANCIES. Commission vacancies shall be filled by the Governor. The Executive Secretary, in conjunction with the director of the Wyoming Workers' Safety and Compensation Division and the Director of the Department of Labor shall submit written recommendations for the Governor's consideration. When vacancies arise on the commission, names will be forwarded from this roster to the Governor for appointment consideration. Members who have completed a term on the commission may also be reappointed to serve additional terms.

Section 5. ANNUAL MEETING. Medical commission members and associate members shall attend an annual business meeting to discuss the concerns of the medical commission.

CHAPTER 3

REFERRAL OF MEDICALLY CONTESTED CASES

Section 1. FROM THE DIVISION.

(a) The commission shall accept for hearing those cases determined by the division to be medically contested cases, and which have been submitted in writing to the commission.

(b) Following proper referral by the division, the medical hearing panel shall have jurisdiction to hear and decide all issues related to the written determinations of the division filed pursuant to W.S. §27-14-601 (k).

Section 2. FROM THE OFFICE OF ADMINISTRATIVE HEARINGS. Pursuant to W.S. §27-14-616(e), upon agreement of all parties to a case, the hearing examiner in a contested case which has been referred to the Office of Administrative Hearings may:

(i) transfer a medically contested case to the commission for hearing and decision by a medical hearing panel; or

(ii) seek the advice of the commission on specified medical issues pursuant to written request of the administrative hearing officer. The advice will be in writing and transmitted to the hearing examiner for distribution to the parties and incorporation into the contested case record.

CHAPTER 4

COMMENCEMENT OF CONTESTED CASE PROCEEDINGS

Section 1. FILING AND SERVICE OF PAPERS.

(a) The case number of the medically contested case shall be the same number as previously assigned by the division. All documents, motions, pleadings and orders filed thereafter shall be signed and shall contain:

(i) conspicuous reference to the case number and a clear delineation that the matter is before the office of the medical commission;

(ii) a caption setting forth the title of the contested case proceeding;

(iii) a brief designation describing the document filed;

(iv) the name, address and telephone number of the person who prepared the document; and

(v) certificate of service indicating that a true and complete copy of the document has been properly served on all parties.

(b) In all medically contested cases, the parties shall file all original documents, pleadings and motions with the Wyoming Workers' Safety and Compensation Division, CBC Building, 1510 E. Pershing Blvd., 1st Floor, Cheyenne, WY 82001, with true and complete copies of the particular document, pleading or motion properly served on all other parties or their attorneys and the Office of the Medical Commission, P.O. Box 20247, Cheyenne, WY 82003. If a party is represented, service of the medically contested case documents, pleadings and motions shall be made upon that party's attorney or other representative of record.

Section 2. INITIAL SCHEDULING CONFERENCE.

(a) After referral, the executive secretary may set the matter for an initial scheduling conference, which shall be conducted by telephone initiated by the medical commission.

(i) Presence of the employee/claimant is not required if the employee/claimant is represented by counsel.

(ii) Failure of an employer to participate in an initial scheduling conference shall preclude the employer from further involvement in the proceedings, unless leave to participate is otherwise granted by the hearing officer.

(b) The medical commission and parties will continue to provide copies of all material and pleadings to any non-participating employer.

(c) The purpose of the initial scheduling conference is to provide a preliminary procedure in which to identify the primary issues, identify potential conflicts with the medical commission panel members, and to set forth a timetable in which to conduct and set the formal evidentiary hearing. The initial scheduling conference shall be conducted in an informal fashion and a taped record of the initial scheduling conference shall be maintained by the medical commission.

Section 3. PRETRIAL CONFERENCE.

(a) At a mutually convenient date there shall be a pretrial conference in all cases unless deemed unnecessary by the executive secretary. The pretrial conference shall be held prior to the date of the filing of disclosure statements. The parties shall be prepared to discuss:

(i) the names of witnesses,
(ii) exhibits to be submitted,
(iii) status of discovery,
(iv) settlement discussions,
(v) anticipated length of trial, and
(vi) any other issues relevant to these proceedings.

Section 4. DISCLOSURE STATEMENT.

(a) After completion of the initial scheduling conference, the commission shall issue an order setting the hearing and notice to the parties of the deadline to file disclosure statements. The disclosure statements shall contain:

(i) a brief statement of the contentions of the party, including identifying all final determinations in dispute and the benefits sought or denied;

(ii) significant uncontroverted facts;

(iii) contested medical issues to be determined at the hearing;

(iv) name, address and a brief description of the testimony of each witness the party intends to present at the hearing;

(v) copies of all exhibits to be introduced (this does not foreclose the introduction of other exhibits which become available or are discovered later);

(b) At the discretion of the commission, the case may be dismissed for failure to timely file a disclosure statement.

(c) The disclosure statements referred to above shall be due fifteen (15) calendar days prior to the contested case hearing. Four complete copies shall be submitted to the medical commission in order to provide each medical panel member with the disclosure statement and attachments.

(d) At the discretion of the Hearing Officer, a joint disclosure statement prepared by counsel for the Employee/Claimant and signed and approved by counsel for the division may be submitted in lieu of separate disclosure statements.

Section 5. DOCUMENTS IN THE OFFICIAL CASE FILE. The medical commission will not take administrative notice in medically contested cases of the official case file maintained by the division. Individual documents in the official case file must be marked as exhibits, included in the party's disclosure statement and offered into evidence at the contested case hearing.

Section 6. EX PARTE**.** Except to the extent authorized by law, a party or party's attorney shall not communicate, directly or indirectly, in connection with any issue of fact or law with the presiding officer concerning any pending case, except upon notice and opportunity for all parties to participate. Should ex parte communication occur, the presiding officer shall advise all parties of the communication as soon as possible thereafter, and if requested, allow any party an opportunity to respond.

CHAPTER 5

MOTIONS AND ORDERS

Section 1. MOTIONS.

(a) An application to the commission for an order shall be by written motion and shall state with particularity the grounds and relief sought.

(b) Any hearing on any subject raised by motion shall be heard at the discretion of the hearing examiner. The hearing examiner may require the filing of briefs or other authority as may be deemed necessary.

(c) The hearing examiner may require the express written approval of the Employee/Claimant to any continuance of the proceedings.

Section 2. REQUESTS FOR CONTINUANCE AND EXTENSIONS OF TIME.

(a) Generally, motions requesting continuances or extensions of time are disfavored, yet they may be granted sparingly and only upon a showing of good cause or when necessary to assure fairness and otherwise avoid manifest injustice. Continuances will not ordinarily be granted ex parte.

(b) Unless time does not permit, motions for a continuance of any scheduled hearing or conference shall be in writing, shall state the reasons therefore and shall be filed and served on all parties.

(c) Motions for an extension of time for the doing of any act required or allowed by these rules or by order of the commission shall be filed and served on all parties prior to the expiration of the applicable time period.

CHAPTER 6

SELECTION OF HEARING PANELS

Section 1. SELECTION OF HEARING PANELS.

(a) The selection of commission members to serve on specific hearing panels for medically contested cases shall be made by the executive secretary under the supervision and guidance of the commission chairperson. Three commission members shall serve as a medical hearing panel and one panel member shall be designated by the executive secretary as the chairperson of that panel. W.S. §27-14-616(b)(iv).

(b) To the extent possible, the commission members' expertise relevant to the circumstances of the contested case shall guide selection of the panel. No panel appointment will be made of a commission member:

(i) whose practice has previously received compensation for care or opinion rendered to a party specific to the issue presented in the medically contested case;

(ii) who currently or previously has had a personal or professional relationship with the treating health care provider with respect to the case or issues before the panel; or

(iii) who has any other possible conflict of interest.

(c) Any party opposing the selection of any medical panel member shall file the objection to the panel member in writing, setting forth with specificity the basis of the objection. The written motion must be filed within ten (10) days of receipt of the order setting hearing.

(d) Upon receipt of the motion challenging a panelist, the executive secretary shall immediately set the matter for hearing on the motion.

(e) At any time while a case is pending, any member of the medical hearing panel or the presiding officer may recuse himself or herself from consideration of the case and must do so once he or she is aware that a conflict exists as described in Chapter 6, Section 1 (b)(i) or (ii). A notice of recusal shall be filed with the commission for service on all parties.

Section 2. DESIGNATION AND AUTHORITY OF PRESIDING OFFICER.

(a) The presiding officer of all hearings shall be the executive secretary of the medical commission or his designee. The functions of the presiding officer shall be conducted in an impartial manner.

(b) Pursuant to Section W.S. §16-3-112(b), a presiding officer shall have all powers necessary to conduct a fair and impartial hearing, including but not limited to the following:

(i) administer oaths and affirmations;

(ii) issue subpoenas;

(iii) rule upon offers of proof and receive relevant evidence;

(iv) provide for discovery and determine its' scope;

(v) preside over and regulate the course of the hearing;

(vi) hold conferences for settlement, review, or simplification of the issues;

(vii) dispose of procedural requests or similar matters;

(viii) make a recommended decision for the hearing panel's consideration;

(ix) sign all orders on the commission's behalf, except final decisions in medically contested cases; and

(x) take any other action authorized by the commission's rules and consistent with law.

Section 3. APPOINTED ATTORNEY.

(a) Upon request, the presiding officer may appoint an attorney to represent an employee under W.S. §27-14-602(d) and allow a reasonable fee upon entry of a final order. All requests for attorney fees shall be in detail showing time spent and work performed. Pursuant to *Painter v. State ex rel., Wyoming Workers' Compensation Division*, 931 P.2d 953 (Wyo. 1997), attorneys' fees and costs are payable from the date of the Final Determination letter from the division. Fees allowed by the presiding officer shall be at an hourly rate set by the director of the Office of Administrative Hearings pursuant to 27-14-602(d). Appointed attorneys shall be reimbursed for costs necessarily and reasonably incurred as set forth by the Office of Administrative Hearings.

(b) No fee shall be awarded in any case in which the presiding officer determines the claim to be frivolous and without legal or factual justification.

(c) Applications for attorneys' fees shall be submitted within ninety (90) days of the entry of a final order.

(d) Objections to attorneys' fees by any party shall be filed as a motion for reconsideration of attorneys' fees and must be in writing and filed within ten (10) days of the executive secretary's order awarding attorney's fees.

CHAPTER 7

DISCOVERY

Section 1. GENERALLY

(a) Discovery documents or notices shall not be filed with the commission except when relief is sought pursuant to W.S. §16-3-107(c).

(b) Unless otherwise prohibited by law or limited by these rules or commission order, the taking of discovery shall be available to the parties in accordance with the provisions of §16-3107(g) and Rules 26, 28 through 37 (excepting 37(b)(1) and 37(b)(2)(D) therefrom) of the Revised Wyoming Rules of Civil Procedure.

CHAPTER 8

EVIDENCE

Section 1. EVIDENCE AND TESTIMONY.

(a) Generally, the taking of evidence at the medically contested case hearing shall be governed by W.S. §16-3-108 and case law thereunder.

(b) All testimony shall be given under oath or affirmation.

(c) Irrelevant, immaterial or unduly repetitious evidence shall be excluded, without regard to whether such evidence is in verbal or written form.

(d) The law of privileged communication between health care provider and patient shall not apply. Health care providers may be required to testify under the provisions of W.S. §27-14-610.

Section 2. SUBPOENAS.

(a) Subpoenas for appearance and to produce books, papers, documents or exhibits may be issued by the commission, upon written motion of any party, or on the commission's own motion, pursuant to W.S. §16-3-107(c).

(b) Subpoenas may be enforced pursuant to W.S. §16-3-107(c).

CHAPTER 9

EVIDENTIARY HEARING PRACTICE AND PROCEDURE

Section 1. NOTICE OF HEARING.

(a) A medically contested case evidentiary hearing shall be set by Order Setting Hearing and Requiring Disclosure which shall provide the time, place and nature of the evidentiary hearing, the division's number assigned to the case, the legal authority and jurisdiction under which the evidentiary hearing is to be held, the particular sections of the statutes and the rules involved, the panel members who will hear the case, the access points if the case is to be heard via video conferencing, and a short and plain statement of the matters asserted. The order setting hearing shall be sent by mail or personally to all parties at least thirty (30) days before the date set for the evidentiary hearing.

Section 2. ORDER OF PROCEDURE AT HEARING.

(a) The evidentiary hearing shall be presided over by the executive secretary or his designee. As nearly as possible, evidentiary hearings shall be conducted in accordance with the following order of procedure:

(b) The executive secretary shall conduct the hearing, shall announce that the hearing is convened, shall indicate the docket number and title of the case to be heard, and shall identify all parties present.

(c) The executive secretary shall then take up any motions or preliminary matters to be heard.

(d) Opening statements to briefly explain the party's position may be made or waived by the parties. Opening statements may be limited at the discretion of the executive secretary.

(e) The party with the burden of proof will be the first to present evidence, all other parties being allowed to cross-examine in an orderly fashion. When the party with the burden of proof rests, other parties will then be allowed to present their evidence, again allowing for cross-examination. The members of the medical hearing panel may ask questions of any witness for the purpose of clarifying their understanding of the case. Rebuttal and surrebuttal evidence will be allowed only at the discretion of the executive secretary.

(f) Closing statements may be made at the conclusion of the presentation of evidence by both parties. These statements may include summaries of the evidence and legal arguments. Closing statements may be limited in time at the discretion of the executive secretary. In appropriate circumstances, written closing statements may be ordered in lieu of oral arguments.

(g) The executive secretary may ask for proposed findings of fact and conclusions of law from both parties, at a date established by the executive secretary.

(h) After all proceedings have been concluded, the chairperson shall dismiss and excuse all parties and declare the hearing closed. The medical hearing panel may request parties to submit supplemental briefs or other evidentiary items after the hearing is closed and during consideration of the case. The executive secretary shall advise the parties that the final decision shall be announced within due and proper time following consideration of all matters presented at the hearing.

Section 4. TELEPHONE CONFERENCES. At the discretion of the executive secretary, telephone conference calls may be used to conduct any hearing or other proceeding. At the discretion of the executive secretary, parties or their witnesses may be allowed to participate in hearings by telephone.

Section 5. VIDEO CONFERENCES.

(a) At the discretion of the executive secretary, video conferencing may be used to conduct any hearings or other proceeding. The access points for the video conferencing shall be appropriately designated in the order setting hearing.

Section 6. RECORDING AND REPORT OF PROCEEDINGS. The presiding officer shall assure that a record of the proceedings is kept pursuant to W.S. §16-3-107(p). The proceedings, including all testimony shall be reported verbatim by any appropriate means, including audio or video or written record. A copy of such proceedings will be furnished to any party upon written request.

Section 7. SPECIAL PROCEEDINGS.

(a) Small Claims. Small claims hearings shall be conducted under the provisions of W.S. §27-14-602(b)(i). For the purpose of considering an objection of a party that a matter be conducted as a small claims hearing, the executive secretary of the medical commission shall act as 'hearing officer' or appoint a presiding officer to act as 'hearing officer.'

CHAPTER 10

CASE DISPOSITION

Section 1. INFORMAL DISPOSITION.

(a) Informal disposition may be made of any case or any issue by stipulation or settlement.

(b) If the parties reach a settlement, the settlement shall be in writing and the executive secretary shall be presented with the terms thereof. The executive secretary may disapprove a settlement only if it clearly violates provisions of law or public policy. The executive secretary shall enter a final order dismissing the case upon such approved settlement or upon notice by the petitioner or division that the disputed claim is withdrawn.

(c) The executive secretary may require the signature of the Employee/Claimant on settlement documents.

Section 2. DEFAULT ORDER.

(a) If a party fails to attend or participate in an initial scheduling conference, hearing, or other stage of a contested case proceeding, the executive secretary may serve upon all parties written notice of a proposed default order, including a statement of the grounds.

(b) Within ten (10) days after service of a proposed default order, the party against whom it was issued may file a written motion requesting the proposed order be vacated and stating the grounds therefore.

(c) The executive secretary shall issue or vacate the default order promptly after expiration of the time within which the Party may file a written motion under subsection (b).

(d) Upon issuance of a default order, the executive secretary shall conduct, without the participation of the party in default, any further proceedings necessary to complete the contested case and determine all issues in the proceeding, including those affecting the defaulted party.

Section 3. FINAL DECISION.

(a) The medical hearing panel shall make and enter a written decision and order containing findings of fact and conclusions of law, separately stated. The findings of fact shall be derived from the evidence of record in the proceeding, matters officially noticed in that proceeding, and matters within the medical hearing panel's knowledge as acquired through performing its functions and duties. Such findings shall be based on the kind of evidence on which reasonably prudent persons are accustomed to rely upon the

conduct of their serious affairs, even if such evidence would be inadmissible in a civil trial. The medical hearing panel's experience, technical competence and specialized knowledge may be utilized in evaluating the evidence.

(b) When the medical hearing panel requests that counsel draft a proposed final order, counsel shall forward the original to the division, concurrently serving copies of the proposed order on all other parties along with notice that any objections to the form of the proposed order must be made within ten (10) days.

(c) All written decisions of the medical hearing panel shall be kept on file in the office of the medical commission and the original will be provided to the division for filing, and will, without further action, become the final decision and order as a result of the hearing. Upon filing, a copy of the decision shall be sent to all parties in the contested case.

Section 4. MOTION FOR RECONSIDERATION.

(a) Within ten (10) days of the date of the decision, any party may petition the commission for reconsideration of the decision and order by filing a motion with the commission for any of the following grounds:

(i) irregularity in the proceedings;

(ii) fraud, misrepresentation, or other misconduct of the prevailing party;

(iii) error in the assessment of the amount of recovery;

(iv) newly discovered evidence regarding material or evidence which the party could not, with reasonable diligence, have discovered and produced at the hearing; or

(v) error of law contained within the decision.

(b) The executive secretary shall issue a written order in response to the motion for reconsideration. A motion for reconsideration does not affect the finality of the decision and order and is not a prerequisite for judicial review.

(c) Clerical mistakes in final decisions or other parts of the record may be corrected by the commission at any time, of its own initiative, or on the motion of any party and upon notice to all parties. During the pendency of judicial review, such mistakes may be corrected only with leave of the court having jurisdiction.

Section 5. MEDIATION. After referral to the Medical Commission, and prior to the contested case hearing, the executive secretary with consent of the parties may refer the case to the Office of Administrative Hearings for mediation. The executive secretary shall enter a written order assigning the matter for mediation and the Office of Administrative Hearings shall provide a mediator's report to the Medical Commission upon conclusion of the mediation. Thereafter, a final order shall be issued incorporating the terms and conditions of the mediation, if successful, or otherwise scheduling the matter for contested case proceedings before the Medical Commission.

Section 6. JUDICIAL REVIEW. Any party aggrieved or adversely affected by a final decision in a contested case or the Division Director as provided by W.S. §27-14-614, is entitled to judicial review in the appropriate district court pursuant to W.S. §16-3-1 14, §27-14-602, and Rule 12, Wyoming Rules of Appellate Procedure. §27-14-602(c).

CHAPTER 11

SPECIAL PROCEEDINGS

Section 1. Expedited Medically Contested Cases.

(a) Upon request of a party or on the commission's own motion, a medically contested case may be expedited if the case is:

(i) a matter in which there are no disputed issues of material fact; or

(ii) a matter in which the parties agree to an expedited proceeding.

(b) If the matter is scheduled on the commission's own motion, any party shall have ten (10) days from the date of the commission order scheduling a matter as an expedited case to request reconsideration.

(c) An expedited medically contested case shall consist of review of any written argument and evidence. Limited oral argument after submission of all written material shall be permitted upon written request of a party.

(d) The commission retains the authority to convert, at any time, an expedited proceeding to a regular medically contested case when it appears that oral testimony is essential to permit adequate presentation of evidence and disposition of the case.

Section 2. Small Claims Hearings

(a) Small claims hearings shall be conducted under the provisions of W.S. §27-14-602 (b) (i).

(b) For the purpose of considering an objection of a party that a matter be conducted as a small claims hearing, the Chairperson of the Medical Commission shall act as "hearing officer" or appoint a presiding officer to act as "hearing officer".

RULES OF THE WYOMING WORKERS' COMPENSATION DIVISION

The following rules are applicable to the Wyoming Workers' Compensation Division/Workers' Compensation and Safety Division. They generally do not apply to the Medical Commission. For a fuller discussion of the Wyoming workers' compensation administrative structure see the Treatise at Chapter 6.7 et seq.

CHAPTER 1

GENERAL PROVISIONS

Section 1. Authority. These rules, regulations and fee schedules are adopted by the Administrator pursuant to the requirements and authority of the Wyoming Workers' Compensation Act (the "Act"). Specific authority and direction is found in Wyoming Statute §§ 27-14-102(a)(i), 102(a)(xii), 201(o), 201(q), 202(e), 205(b), 306(d), 401(e), 402, 404(a), 408(e)(ii), 501(a), 502(a), 506(a) and (b), 601(e), 616(b)(i) and (ii), 616(d), 802(a) and (c) and in the requirements of the Wyoming Administrative Procedure Act, W. S. §§ 16-3-101 through 115.

Section 2. Effective Date. These rules, regulations and fee schedules become effective on the date filed with the Wyoming Secretary of State, and replace all prior rules and regulations of the Employment Tax Division and Workers' Compensation Division within the Wyoming Department of Workforce Services. However, to the extent these rules affect a worker's substantive right to benefits; the rules in effect at the time of injury apply. Pursuant to W. S. § 27-14-602, eligibility for and amount of benefits are determined pursuant to the law in effect on the date of injury.

Section 3. Definitions.

(a) 49 CFR Part 40 means Title 49, Part 40 of the Code of Federal Regulations (CFR) as revised January 1, 2018.

(b) AB Rated. Drug products made by different distributors and/or repackagers that are considered therapeutically equivalent based on demonstrated bioequivalence.

(c) Actively Seeking Work. For purposes of benefit eligibility, a claimant is actively seeking work if the claimant provides tangible evidence of the work search to the Division. Completion of the work search form will be considered tangible evidence. The work search must contain a minimum of five contacts per week over the course of a six week period. The six (6) week period must be immediately preceding the date the application is filed with the Division or immediately following the date the application is filed with the Division. The contacts listed on the work search must be made for work the claimant is reasonably qualified to perform and is willing to accept. Actions that would be considered an active search for employment include completing job applications, faxing or mailing resumes (include proof), and/or visiting the employers in person. Claimant must contact the employer he was working for at the time of injury to inquire if the employer has work available within their medically documented restrictions.

(d) Actual Monthly Earnings.

(i) Income the employee was receiving from all employment at the time of injury and which is lost due to the injury, including:

(A) Actual value of board, lodging, rent, or housing and per diem expenses to be included within the actual wage as remuneration, if such board, lodging, rent or housing and per diem is lost as a result of the injury;

(B) Commissions and bonuses;

(C) The average amount of overtime pay received in the six (6) months before the injury or guaranteed by written agreement between the employer and employee entered into before the injury;

(D) Gratuities received in the course of employment, from others than the employer, only when such gratuities are received with the knowledge of the employer and reported to the United States Internal Revenue Service by the employee or the employer;

(E) Wages earned from employment at more than one occupation or employer other than the employer at the time of injury, if those wages are lost due to a compensable injury; and

(F) Unemployment insurance benefits paid to the injured employee during the twelve (12) months preceding the month of injury will be taken into account when computing the actual monthly earnings in cases where there are special circumstances under which the actual monthly earnings cannot be determined.

(ii) The term "actual monthly earnings" does not include:

(A) Severance pay;

(B) The cash value of health, medical, life or other insurance benefits or retirement benefits;

(C) Social security benefits;

(D) Passive investment income such as income from stocks, bonds, trust accounts, or individual retirement accounts;

(E) Any adjustments to the employee's income, as defined in paragraph (i) of this subsection, made subsequent to the date of accident or incident causing the original injury; and

(F) The amount reimbursed to an employee for any special expense incurred by the employee by the nature of the employment.

(e) Alcohol. Ethyl alcohol or other low molecular weight alcohols, including methyl or isopropyl, from whatever source or by whatever process produced.

(f) Alcohol Test means an analysis of breath or saliva or any other analysis, which determines the presence and level or absence of alcohol, as authorized by the United States Department of Transportation in its rules and guidelines concerning alcohol testing and drug testing.

(g) Certified Laboratory. Any United States laboratory certified by the United States Department of Health and Human Services (HHS) under the National Laboratory Certification Program as meeting the minimum standards of Subpart C of the HHS Mandatory Guidelines for Federal Workplace Drug Testing Programs.

(h) Chain of Custody. The methodology of tracking specified materials or substances for the purpose of maintaining control and accountability from initial collection to final disposition for all such materials or substances, and providing for accountability at each stage in handling testing, storing specimens, and reporting test results.

(i) Claim. An application for benefits under the Act using the forms provided by the Division.

(j) Clerical Office Occupations. Employees whose duties are confined to keeping the books and records of the business or who are engaged wholly in office work. Employees shall have a physical separation from exposure to the hazards associated with the business' normal activities. Employees shall not have direct contact with, supervision of, or be involved in physical labor of, the employer's operation, except, if incidental. Employees who qualify may include employees who work with financial or employee records, correspondence, or telephone duties. Employees qualifying for the clerical office occupation classification who perform any duties outside of the clerical office area or who perform duties which are not directly related to the performance duties inside the clerical office, become disqualified for the clerical office occupation classification for the reporting period when the non-clerical work is performed. The limited exceptions allowed are solely for the direct travel to and from a local post office, bank, office supply store or the primary business location if travel is being compensated by the employer.

(i) Employers must request the clerical coverage classification in writing on a form prescribed by the Division showing the number of clerical positions needed and a detailed description of job duties and responsibilities for the clerical coverage being requested. An election under this subsection shall become effective the first day of the calendar quarter following the calendar quarter in which the election is made.

(ii) The Division may revoke the clerical office occupation classification when sufficient cause is found such as miscategorization of wages.

(k) Chiropractic Utilization Guidelines means the *Chiropractic Utilization Guidelines for the Care and Treatment of Injured Workers* (3/1/18), as policy for the determination of compensability of appropriate and reasonable chiropractic treatment in the provision of care for injured workers. This does not include any later amendments or editions of the incorporated matter. These guidelines are available upon request through the Division and may be obtained on-line at: http://www.wyomingworkforce.org/_docs/providers/Chiropractic-Guidelines.pdf

(l) Collective Group of County Governments or County Government Entities. County government employer means any employer operating with a primary classification of "county government". Only one county collective system may exist for workers' compensation reporting purposes under W. S. § 27-14-109.

(m) Computation of Time.

(i) In computing any period of time prescribed by the Act or these rules, except the seventy-two (72) hour period prescribed in W. S. § 27-14-502 and Wyoming Uniform Rules for Contested Case Practice and Procedure, Chapter 2, Section 12, the day of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or legal holiday, or, when the act to be done is the filing of a paper, a day on which weather or other conditions have made agency offices inaccessible, in which event the period runs until the end of the following day which is not one of the aforementioned days. When the period of time prescribed or allowed is less than eleven (11) days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation. When the period of time prescribed or allowed is eleven (11) or more days, intermediate Saturdays, Sundays, and legal holidays shall be included in the computation. As used in this rule, "legal holiday" includes any day officially recognized as a legal holiday in this state by designation of the legislature or appointment as a holiday by the governor.

(ii) Whenever a party has the right or is required to do some act within a prescribed period after service of a notice or other paper upon the party, and the notice or paper is served upon the party by mail or by delivery to the agency for service, three (3) days shall be added to the prescribed period.

(n) Concurrent Review. Concurrent review is performed while the injured worker is still an inpatient and services are being rendered. The review can occur if there is a need to extend a current hospitalization, during an emergency admission, or when a provider/facility notifies the Division of an admission for a non-emergent procedure and a preauthorization was not performed.

(o) Confirmation Test. A second analytical procedure used to identify the presence of a specific drug, alcohol or metabolite in a specimen. The confirmation test shall be different in scientific principle from that of the initial test procedure. The confirmation method shall be capable of providing requisite specificity, sensitivity, and quantitative accuracy.

(p) Corporate Officers, Members of Limited Liability Companies, Partners, and Sole Proprietors.

(i) Elective coverage for officers of a corporation, members of a limited liability company, partners or sole proprietors under W. S. § 27-14-108(k) must be requested in writing on a form provided by the Wyoming Workers' Compensation Division ("Division").

(ii) Corporations which elect to obtain coverage under the act must notify the Division within 30 days of a change in corporate officers. The election of corporate officers will transfer from the prior individual to the newly elected officer in the same position.

(iii) Corporate officers shall be clearly identified as such on all reports to the Division.

(iv) Coverage will be discontinued at the end of the month in which the position no longer exists or the position becomes vacant. The Division must be notified in writing within 30 days of such changes.

(q) County government or county government entities means any employer operating with a primary classification of county government.

(r) Drug. Marijuana, Cocaine, Amphetamine, Opiate, Phencyclidine (PCP), a metabolite of any of the substances, or any other controlled substance subject to testing pursuant to drug testing regulations adopted by the United States Department of Transportation.

(s) Drug Test means any chemical, biological, or physical instrumental analysis administered by a certified laboratory for the purpose of determining the presence, or absence of a drug or its metabolites pursuant to regulations governing drug or alcohol testing adopted by the United States Department of Transportation.

(t) Elective Surgery. Elective Surgery is surgery, which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

(u) Emergency Health Care Services. Emergency health care services means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the injured worker's health in serious jeopardy.

(v) Expert Reviewer. Expert reviewer means a physician competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician's practice.

(w) Filing. Except as otherwise provided in the Act or these rules and regulations, a document shall be deemed to have been filed with the Division on the date it is received by the Division in the manner prescribed by the Act or these rules and regulations.

(x) Fiscal Year. A 12-month period of time used for State budgetary purposes which commences on July 1 of each year and ends on June 30 in the following year.

(y) Fixed Base of Operations. See definition for "Principal Place of Business" in subsection (nn) of this section.

(z) Gainful Employment. The individual having returned to work at a wage of no less than minimum wage, for at least 20 hours per week for a period of two consecutive months. W. S. §§ 27-14-404(b) and 27-14-408(a)(ii).

(aa) Hearing Examiner or Officer. See Wyoming Uniform Rules for Contested Case Practice and Procedure, Chapter 2, Section (e) or refer to: http://psc.state.wy.us/pscdocs/dwnload/OAH/All%20Chapters%20-%20Clean%20Copy.pdf

(bb) Inside Sales. (Automotive Vehicle Sales) A position predominantly engaged in automotive vehicle sales at the premises of the business. Positions with duties involving servicing equipment do not qualify for coverage under the sales classification.

(i) Employers must request the inside sales (automotive vehicle sales) classification in writing on a form provided by the Division. An election under this subsection shall become effective the first day of the calendar quarter following the calendar quarter in which the election is made.

(ii) The Division may revoke the inside sales occupation classification when sufficient cause is found such as miscategorization of wages.

(cc) Intoxicated means pursuant to W. S. § 27-14-102(a)(xi)(B)(I) a positive alcohol test result at or above .08 alcohol concentration level.

(dd) Maximum Medical Improvement (MMI). A medical condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Over time, there may be some change; however, further recovery or deterioration is not anticipated. This term may be used interchangeably with the term "ascertainable loss", defined in W. S. § 27-14-102(a)(ii).

(ee) Medical and Hospital Care. For purposes of W. S. § 27-14-102(a)(xii), "personal items" are defined as:

(i) Clothing;

(ii) Footwear, unless such items are professionally altered to accommodate the compensable injury;

(iii) Hot tubs, spas or any other devices wherein water is heated and/or circulated;

(iv) Programs, aids, medications or dietary supplements primarily intended to help the worker stop smoking or lose weight;

(v) Exercise equipment;

(vi) Beds, mattresses or mattress toppers; and

(vii) Recliners or lift chairs.

(ff) Medical Service. Means any medical, surgical, diagnostic, chiropractic, hospital, nursing care, ambulances, prescription medicine, prosthetic appliances, and physical restorative services.

(gg) Medically Necessary. "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment parameter.

(hh) Mentally Incompetent. For purposes of W. S. § 27-14-505, an individual is mentally incompetent if, due to a medically diagnosed mental disorder, the individual lacks the ability to comprehend that an injury is compensable and lacks the ability to comprehend that certain statutory guidelines must be complied with in order to receive benefits.

(ii) Normal Activities of Day-to-Day Living (ADL). Routine activities that people tend to do every day without needing assistance. There are six (6) basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence as used in W. S. § 27-14-102(a)(xi)(G).

(jj) Other Related Expenses. As used in W.S. § 27-14-403(e)(ii), "other related expenses" means expenses related to a funeral, burial or cremation, including a wake or reception, headstone or marker, transportation, and lodging for the immediate family in those situations where a work-related injury culminated in death.

(i) The surviving family member or guardian, eligible to receive reimbursement for other related expenses must submit a request for reimbursement on a form provided by the Division and follow the procedure outlined in Chapter 7, Section 3(a)(iii) of these Rules.

(A) The term "immediate family" is defined as the spouse, child(ren), step-child(ren), grandchild(ren), parent(s), step-parent(s), parent in-laws, grandparent(s), step grandparent(s), grandparent in-law(s), sibling(s), step-sibling(s), half sibling(s), and sibling in-law(s) of the deceased.

(kk) Outside Sales. A position with duties predominantly engaged in sales or collections away from the premises of the business. The position may include duties performed at the business premises that are necessary to the position's outside sales duties. Positions with duties involving servicing equipment or delivery of the employer's product do not qualify for coverage under the outside sales classification.

(i) Employers must request the outside sales classification in writing on a form provided by the Division. Duties for each outside sales classification position must be clearly identified.

(ii) An election under this subsection shall become effective the first day of

the calendar quarter following the calendar quarter in which the election is made.

(iii) The Division may revoke the outside sales occupation classification when sufficient cause is found such as miscategorization of wages.

(ll) Prescription Medication. A drug or medication lawfully prescribed by a physician for an individual and taken in accordance with the prescription.

(mm) Primary Treating Health Care Provider. The health care provider selected by the employee to administer and direct medical treatment for his/her compensable injury W. S. § 27-14-401(f).

(nn) Principal Place of Business. For purposes of W. S. § 27-14-301(b) and W. S. § 27-14-107(j), a "principal place of business within the state established for legitimate business-related purposes" must have the following characteristics:

(i) Exclusive use of fixed premises with a recognizable physical address;

(ii) A business sharing building or trailer space must have a clearly defined location used exclusively for its business.

(iii) At least one employee who regularly performs most of his services for the business in or based out of the fixed premises;

(iv) Is accessible by mail or other recognized delivery service; and

(v) Regularly conducts its primary business or necessary ancillary services at the fixed premises.

(oo) Rating System:

(i) Base Rate. As used in these rules and regulations, the term "base rate" means that percentage of total payroll necessary to maintain an actuarially sound workers' compensation insurance program. Each major industry classification shall have a separate base rate based upon that industry's primary nature of business regardless of individual occupations within that industry.

(ii) Experience Rating. As used in these rules and regulations, the term "experience rating" means that percentage increase or decrease which is applied to the base rate of an employer account. The experience rating is based upon frequency and severity of injuries reported to the Division.

(iii) Consolidated Accounts. Employers electing a consolidated account as provided in W. S. § 27-14-202(d) shall report each worker within the classification for which the worker performs the largest percentage of services.

(iv) Presumed Pay of Specified Workers. Deemed income for those categories of workers identified in W. S. § 27-14-205(b) shall be calculated by determining the amount of premium income necessary to pay actuarially anticipated losses in each category during the rating period, and considering the anticipated number of covered workers and the appropriate premium rate for each category.

(v) Pursuant to W. S. § 27-14-102(K), a collective group of county governments is defined as all county government employers consolidating into one workers' compensation account in order to operate as defined under W. S. § 27-14-109.

(pp) Reasonable Period of Recuperation. As used in W. S. § 27-14-404(b), a "reasonable period of recuperation" includes the day of surgery and the period of recuperation for the surgery performed.

(qq) Rehabilitation Therapy Utilization Guidelines. Means the May 2015 edition of the of the *Rehabilitation Therapy Utilization Guidelines for the Care and Treatment of Injured Workers*, as policy for the determination of compensability of appropriate and reasonable physical, occupational and speech therapy treatment in the provision of care for injured workers. These guidelines are available upon request through the Division and may be obtained on-line at: http://www.wyomingworkforce.org/providers/

(rr) Remuneration. Except as provided in W. S. § 27-14-102 (a)(ix), if board, lodging or any other payment in kind, considered as payment for services performed by a worker, is in addition to or in lieu of a monetary wage, the Division shall determine or approve the cash value of such payment in kind, and the employer shall use these cash values in computing the employee's wages and contributions due under the law. Remuneration shall not include per diem payments, if the employer maintains an "Accountable Plan" as required in Chapter 2, Section 14 of these rules.

(ss) Specimen means tissue, fluid, or a product of the human body capable of revealing the presence of alcohol, drugs or their metabolites.

(tt) Suitable Employment. Employment for which the worker has the necessary physical capacities, knowledge, transferable skills and abilities. W. S. § 27-14405(h)(iii).

(uu) Under the Influence of a Controlled Substance means pursuant to W. S. § 27-14-102(a)(xi)(B)(I) a positive drug test conducted in accordance with the U.S. DOT drug and alcohol testing regulations from an HHS-certified laboratory.

(vv) United States Territories. United States territories include: American Samoa, Bajo Nuevo Bank, Baker Island, Howland Island, Guam, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Northern Mariana Islands, Puerto Rico, Serranilla Bank, U.S. Virgin Islands and Wake Island, W. S. § 27-14-301(a)(ii).

(ww) University of Wyoming:

(i) UW Professionals with Lab. Professional faculty, administrators, and support personnel of institutions of learning whose duties include performing in a scientific laboratory environment.

(ii) UW Professional without Lab. Professional faculty, administrators, and support personnel of institutions of learning whose duties do not include performance in a scientific laboratory environment.

(iii) UW Clerical. Support staff of institutions of learning who typically work in an office environment, whose duties do not include performing in a scientific laboratory environment.

(iv) UW Non-Professional. Positions not defined in (i), (ii) or (iii) of this subsection.

(xx) Usual and Customary. The provider's charge to the general public for the same or similar service.

Section 4. Rules of Procedure for Hearings before the Workers' Compensation Division.

(a) Applicability. These rules and procedures shall apply to all contested cases, as defined by the Wyoming Administrative Procedure Act (W. S. §§ 16-3-101 through 115), which are not required to be referred to the Office of Administrative Hearings (OAH) or Workers' Compensation Medical Commission. For example, this section shall govern contested cases over such matters as rate classification and the Division's annual premium rate filing.

(b) Definitions.

(i) Department. The Department of Workforce Services.

(ii) Director. The Director of the Department of Workforce Services or the Director's deputy, examiner or assistant appointed by the Director in writing.

(iii) Petitioner. The person(s) or organization(s) requesting a hearing as provided in the Wyoming Workers' Compensation Act and the Administrative Procedure Act.

(iv) Hearing. The evidentiary proceeding in any "contested case" as defined in the Wyoming Administrative Procedure Act which is not required to be referred to the Office of Administrative Hearings (OAH) or Workers' Compensation Medical Commission.

(v) Hearing Officer. The Administrator of the Division or such person or persons as the Administrator designates in writing to preside over the contested case and conduct the hearing. No person shall serve as hearing officer who directly participated in making the determination which is the subject of the contested case.

(vi) Commencement of Case. All contested case proceedings shall be commenced by filing a written petition/request for hearing with the Division. The petition shall include:

(A) The name, address and telephone number of each petitioner.

(B) A statement of the facts upon which the petition is based, including, whenever applicable, particular reference to the determination, statutes, rules, regulations and orders that the applicant believes are relevant to the case.

(C) The determination or other relief requested by the petitioner.

(c) Notice upon filing of a petition. The Division shall issue a notice as required by the Wyoming Administrative Procedure Act, stating:

(i) The time, place and nature of the hearing;

(ii) The legal authority and jurisdiction under which the hearing is to be held;

(iii) The particular sections of the statutes and rules involved; and

(iv) A short and plain statement of the matters asserted.

(d) Service of Notice. Notice may be served personally, by mail or by publication, as provided by the Wyoming Administrative Procedure Act. Service by mail shall be deemed complete at the date of mailing. The hearing officer may require additional notice to be given in such manner, as the hearing officer shall direct.

(e) Docket. When a petition/request for hearing is filed, it shall be assigned a docket number in accord with a system established by the Division. The Division shall establish a separate file for each hearing in which shall be systematically placed all related papers, pleadings, documents, transcripts, evidence and exhibits. All documents filed in the case shall note the docket number assigned and the date of filing.

(f) Subpoenas. As authorized by the Administrative Procedure Act and Workers' Compensation Act, subpoenas for appearance and to produce books, papers, documents or exhibits will be issued by the hearing officer upon written request of any party.

(g) Hearing. At the date, time and place of hearing, the hearing officer shall hear all matters presented in accord with the Wyoming Administrative Procedure Act. Parties shall appear in person or by telephone and may be represented by counsel, provided that such counsel be duly authorized to practice law in the State of Wyoming or is otherwise associated at the hearing with one or more attorneys authorized to practice law in this State.

(h) Order of Procedure at Hearing. Hearings shall generally be conducted informally, in accordance with the following procedure:

(i) The hearing officer shall announce that the hearing is convened, the title of the matter and case to be heard and shall note for the record all subpoenas issued and all appearances. The hearing officer shall state that the hearing is informal, that strict rules of evidence will not apply, and shall briefly describe the method in which the hearing will be conducted.

(ii) Short opening statements may be permitted at the discretion of the hearing officer.

(iii) Presentation of evidence by petitioner(s). Witnesses may be cross-examined by the Division or other parties. All exhibits shall be marked for identification.

(iv) Presentation of evidence by the Division. Witnesses may be cross-examined by the other parties. All exhibits shall be marked for identification.

(v) Closing statements or arguments may be made at the discretion of the hearing officer.

(vi) After all proceedings have been concluded, the hearing officer shall excuse all witnesses and declare the hearing closed. The record may be supplemented with additional evidence or written briefs at the discretion of the hearing officer and within such time as directed by the hearing officer.

(i) Witnesses to be Sworn. All persons testifying at any hearing shall stand and be administered the following by the hearing officer: "Do you swear (or affirm) to tell the truth, the whole truth and nothing but the truth in this hearing now before the hearing officer?"

(j) Applicable Rules of Civil Procedure to Apply. The Wyoming Rules of Civil Procedure shall apply and be followed in hearings before the Division to the extent not inconsistent with these rules.

(k) Presence of Attorney General. In all hearings before the Division, the Division may request the Attorney General of the State of Wyoming, or a representative of his staff, to be present to assist and advise the Division.

(l) Record of Proceedings-Reporter. Hearings shall be electronically recorded unless a party provides for a court reporter at its own expense. The hearing officer may direct the party or parties requesting a transcript to assume the cost of the transcript.

(m) Depositions. In all contested cases the taking of depositions and discovery shall be available to the parties as provided in the Wyoming Rules of Civil Procedure and the Administrative Procedure Act.

(n) Decision, Findings of Fact and Conclusions of Law, and Order. The hearing officer shall make a written decision and order containing Findings of Fact, Conclusions of Law and Recommended Decision. Such decision and order shall be filed with the Division within fifteen (15) days of the close of the hearing. The Division shall send a copy by prepaid mail to

each party or their attorneys of record. The Administrator shall act on the recommendation of the hearing officer within thirty (30) days of receiving the hearing officer's report.

(o) Appeals to District Court. Appeals to the district court from decisions of the hearing officer are governed by the Wyoming Administrative Procedure Act and Rule 12 ofthe Wyoming Rules of Appellate Procedure.

(p) Transcript in Case of Appeal. In case of an appeal to the district court, the party appealing shall secure and file a transcript of the testimony and all other evidence offered at the hearing, which transcript must be verified by the oath of the person who transcribed the testimony as a true and correct transcript of the testimony and other evidence in the case. The compensation of the person making the transcript and all other costs involved in the appeal shall be borne by the party prosecuting the appeal unless otherwise ordered by the district court at the conclusion of the appeal.

(q) Pre-Hearing Conference. At any time on or before the day of any hearing, the hearing officer may direct the parties to appear before the hearing officer for a pre-hearing conference. Such conferences shall be conducted informally. The hearing officer shall prepare an order reciting or shall read into the record the results of the conference. The pre-hearing order will control the course of the hearing unless modified by the presiding officer to prevent manifest injustice. A party who believes a pre-hearing order does not fully cover the issues presented, or is unclear, may petition for a further ruling within ten (10) days after receipt of the order. The pre- hearing conference shall be convened to consider:

(i) The simplification of the issues;

(ii) The necessity or desirability of amending the pleadings;

(iii) The possibility of obtaining admissions of fact and of documents to avoid unnecessary proof;

(iv) Formulating additional procedures to govern the hearing; and

(v) Other matters as may aid in the disposition of the case.

(r) Additional Rules for Contested Ratemaking Proceedings. The following additional rules shall apply to contested cases involving the Division's annual rate filing pursuant to W. S. § 27-14-201(c) *et seq*.

(i) Any employer wishing to contest the rate filing shall file a written request for hearing with the Division, received by the Division no later than thirty (30) days after the mailing of the proposed rates by the Division. Counsel for any employer shall enter a written appearance within the same time period.

(ii) The contested rate hearing shall be held no later than seventy-five (75) days after the mailing of the proposed rates by the Division. Only those employers who filed a

timely written request for hearing directly or through counsel will be permitted to participate in the hearing.

(iii) Written interrogatories shall be filed no later than thirty (30) days before the scheduled hearing date. Responses to interrogatories shall be served on the requesting party ten (10) days after receipt of the interrogatories. Depositions shall be completed at least ten (10) days before the hearing.

(iv) Pre-hearing conferences may be conducted informally by the hearing officer, without prior written notice if such notice is impractical, but the hearing officer shall keep a detailed log of the date, time and subject matter of all contacts by parties to the contested case. Such log shall be made a part of the formal record in the case.

(v) At the hearing, those employers wishing to make an unsworn statement may do so in writing or shall be heard before the taking of any sworn testimony or evidence. Unsworn statements shall not be subject to cross-examination. The Division shall proceed next, presenting evidence in support of the rate filing, followed by those employers desiring to present sworn testimonial and documentary evidence against the proposed rate filing.

(vi) All parties shall have an opportunity to present proposed findings of fact and conclusions of law within ten (10) days after the close of the evidence.

(vii) The hearing officer shall render findings of fact, conclusions of law and recommended orders within thirty (30) days after the close of the evidence, and shall serve such findings, conclusions and orders upon the Administrator, Director, and all employers and counsel of record. The Director shall act on the recommendations of the hearing officer by written decision within thirty (30) days of receiving the hearing officer's report.

Section 5. Hearing Requests Regarding Timeliness.

(a) Hearing. Upon timely request or appeal, the party filing or paying in an apparently untimely manner shall be given a hearing on the question of the timeliness of the filing or paying.

Section 6. Rules Governing Public Records Requests.

Repeal (2020).

CHAPTER 2

EMPLOYER COVERAGE, COMPLIANCE, AND DISCOUNT PROGRAMS

Section 1. General.

(a) Application for Determination of Coverage. No employer subject to the Wyoming Workers' Compensation Act, Wyoming Statute § 27-14-101, et seq., shall commence business or engage in any work in Wyoming without applying for coverage and receiving a statement of coverage from the Division. The application shall supply such information as the Division requests regarding the nature, location, extent and duration of the intended work. Employers determined by the Division to be non-resident employers must comply with the bond or security requirements of W.S. §§ 27-1-106 and 27-14-302; a non-resident employer is defined in W.S. § 27-14-102(a)(xiii).

(b) Proof of Coverage (POC) Certificate.

(i) For the purposes of W.S. § 27-14-306 a POC certificate shall further include all of the following:

(A) The applicable time-frame of the certificate; and

(B) A statement as to the applicability of insurance coverage for employees of the nonresident employer, to specifically address employees that are Wyoming residents; and

(C) A list of all employees who are insured under the proof of coverage certificate.

(c) Employer Number; Corporations. Every employer participating under the Act shall be assigned an employer number by the Division. Employers who are incorporated must provide a copy of the certificate of authority issued by the Secretary of State of Wyoming authorizing the employer to do business in the state of Wyoming. A copy of the corporate minutes that identifies the corporate officers of the corporation must also be filed with the Division.

(d) Reports When No Premiums Have Accrued. Every employer subject to the Act is required to send in the regular reports even though no premiums have accrued with respect to a particular reporting period. Employers shall file reports for such period and shall continue to file such reports until the Division has received and approved a notification to discontinue filing reports.

Section 2. Successor Employer.

(a) For purposes of W.S. § 27-14-207(b), "account" includes: premium rate, experience modification rating, premium credit program, safety discount program, drug and alcohol testing discount program, health and safety consultation discount program, and outstanding accounts receivable including past due or delinquent premium, interest, penalties, small employer group credit, and claims reimbursement, until recalculated for the subsequent rate year.

(b) For purposes of W.S. § 27-14-207(c), "account" includes: premium rate, experience modification rating, premium credit program, safety discount program, drug and alcohol testing discount program, health and safety consultation discount program, and small employer group credit, until recalculated for the subsequent rate year.

Section 3. Experience Rating.

(a) One (1) experience modification rating (EMR) shall be assigned to each employer number for those eligible employers under the Act. An employer who elects to establish a separate employer number for each separate legal entity of the employer's businesses shall be assigned an experience rating for each employer number.

(b) An employer's EMR is computed by using three (3) years claims experience [or maximum available portions of three (3) years] for each eligible employer.

(i) Private sector employers will receive an EMR based on three (3) years claims experience effective January 1 of their fifth (5th) calendar year.

(ii) Public sector employers will receive an EMR based on three (3) years claims experience effective July 1 of their sixth (6th) fiscal year.

(c) Pursuant to W.S. § 27-14-207(j), the non-resident employer must direct their insurance company to submit their EMR history directly to the Division.

(i) If a non-resident employer expanding or moving their operations to Wyoming has previously been self-insured, and does not have any experience history available from a third party workers' insurance company, they will be assigned an EMR of one (1) and will be charged at the industry base rate for their classification.

(ii) The Division will use the employers experience history to calculate the EMR according to the current EMR split-plan calculation.

(d) For an employer having less than one (1) full year (private employers follow a fiscal year; public employers follow a calendar year) of premium obligation during the EMR period, the employer's EMR will be equal to a modification of one (1).

(e) For an employer having greater than one (1) full year of premium obligation during the EMR period, but less than three (3) full years of premium obligation, the actual premium obligation will be based on the employer's actual experience as recorded by the Division in the quarterly or monthly reports in the premium year.

(f) The Division, through the qualified actuary, as defined by W.S. § 27-14-201(b), shall annually determine key parameters of the EMR plan to meet the requirements of W.S. § 27-14-201(d). The Division will notify each employer who qualifies for an EMR of the key parameters, (i, ii, iii) of this sub-section, on the yearly EMR notice. The key parameters will also be published on the Division website for any employer to inspect.

(i) Split Point. The claim cost amount at which an employer's EMR moves from the measure of frequency to the measure of severity.

(ii) Group Premium Rate. There will be five (5) groups for premium bands. Each Group Premium Rate will have a credit/debit maximum percent amount to affect the employer's EMR. At no time shall this exceed +/- eighty-five percent (85%). Individual employer groups are based on the amount of premium over a three (3) year period and the actuarial process.

Group 1 not to exceed +/- 20%
Group 2 not to exceed +/- 25%
Group 3 not to exceed +/- 45%
Group 4 not to exceed +/- 65%
Group 5 not to exceed +/- 85%

(iii) Chargeable Minimum and Maximum – There will be a claim cost minimum on medical only cases, which are not ratable to the employer and will not affect the EMR. There will also be a claim cost maximum at which point claim cost above the maximum single loss are not ratable and will not affect the EMR.

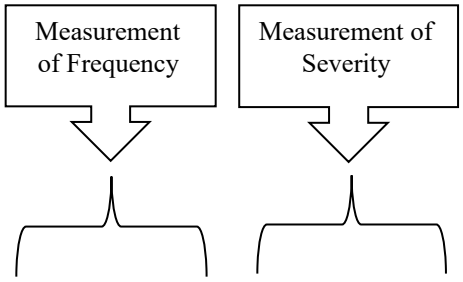
(g) For employers in Group I, the experience adjustment for claims occurring within the three (3) year EMR period shall be as follows:

(i) Zero percent (0%) if the employer's account has been charged with one (1) claim which exceeds the annual minimum claim cost amount.

(ii) Twenty percent (20%) penalty if the employer's account has been charged with two (2) or more claims which exceed the annual minimum claims cost amount.

(iii) Twenty percent (20%) credit if the employer's account has not been charged with a claim exceeding the annual minimum claims cost amount.

(h) The formula for computing the split plan EMR is defined below.



$$1 + (Z_p)\frac{A_p - E_P}{E} + (Z_e)\frac{A_e - E_e}{E} = Modification\ (EMR)$$

Where: Zp = Credibility Primary Value
Ap = Actual Primary Losses
Ep = Expected Primary Losses
Ze = Credibility Excess Value
Ae = Actual Excess Losses
Ee = Expected Excess Losses
E = Expected Losses

(See Glossary of Terminology in Section 15.)

(i) Contesting EMR. Any employer may contest the annual EMR or case reserve amounts assigned by the Division. Contest shall be made by filing a written objection with the Division within thirty (30) days after notification by the Division as provided in W.S. § 27-14-201(h). The Division shall resolve the matter administratively within forty-five (45) days after the filing of the objection. If the matter is not resolved within forty-five (45) days then the Division shall refer the objection to an independent hearing officer appointed for such purpose, pursuant to these rules and the Wyoming Administrative Procedure Act.

(j) Contesting Chargeability of Claims Costs. An employer may apply for non-chargeability of claims costs pursuant to W.S. § 27-14-201(d).

(i) An employer who is current on premium payments required by the Act may contest the chargeability of claims costs by filing a written application with the Division on a form supplied by the Division.

(ii) The application to determine chargeability must be filed no later than one (1) year after the determination of compensability for an injury occurring on or after July 1, 2015.

(iii) Upon receipt of said application, the Division shall schedule a time and date for a hearing. The employer shall be notified of the time and date of the hearing.

(iv) The hearing shall be conducted pursuant to the Division's Rules, Chapter 1, Section 4 or https://rules.wyo.gov/Search.aspx?mode=1

(v) The hearing shall be conducted by a panel from the Division, including the Administrator of the Workers' Compensation Division, the Program Manager of Employer Services, the Program Manager of Claims, the District Manager from the appropriate district, the claims analyst assigned to the underlying claim, a representative from OSHA, and a representative from the Attorney General's Office.

(vi) The employer will present its case to the panel after which the panel shall take the issue under advisement and issue a written, final determination.

(vii) If an employer fails to appear for the hearing, the initial determination on chargeability will become the final agency action.

Section 4. Classifications. The employer shall provide a true and accurate description of its business operations prior to commencing operations, which require coverage under the Act for eligible workers in the State of Wyoming. The employer is required to notify the Division in writing of any change in business operations, which affect the industrial classification of the business for purposes of workers' compensation. The employer shall grant reasonable access to the Division's representative to verify information provided by the employer with respect to the business operations.

(a) Classification Procedures. The Division will assign an industrial classification or classifications pursuant to the North American Industry Classification System (NAICS) codes provided by the Federal Bureau of Labor Statistics via the Internet or in a printed manual dated 2002 or later. The industrial classification(s) assigned will be that which best describes the primary business of the employer. Businesses conducted at one or more locations which normally prevail in the primary industrial classification will not be assigned separate classifications for supporting operations, with certain specific standard exceptions for clerical office occupations, inside sales occupations, outside sales occupations, or temporary help occupations.

(b) Classification Revisions. The Division shall correct industrial classifications which it determines to be incorrect. The Division shall give the employer written notification of any change in industrial classification and such changes shall become effective on the first day of the reporting period following the reporting period in which the Division gives written notification.

(c) Contesting Classification. Any employer may contest the industrial classification assigned by the Division. Contest shall be made by written objection to the Division within thirty (30) days of the employer's notification of the classification assigned by the Division. The

Division shall resolve the matter administratively within forty-five (45) days or refer the objection to an independent hearing officer appointed for such purpose, pursuant to the Wyoming Administrative Procedure Act.

Section 5. Audits. Investigation and examination of an employer's records may be conducted in accordance with W.S. § 27-14-803. The Division may examine books, accounts, payrolls or the business operation of any employer to determine if the employer has engaged in activity in violation of the Act, to verify information provided to the Division by the employer, and for the administration of this Act. The employer shall grant reasonable access to the Division's representative to examine information pertinent to the employers' business operations.

(a) Audit Procedures. The Division's representative will conduct an audit and review the preliminary findings with the employer. These audit findings will then undergo final review by the Division with correction of any findings, which it determines to be incorrect. The Division will then issue a Final Audit Determination Notice to the employer upon completion of the audit.

(i) Any unreported payments made to any individual, as found in an audit of an employer's records, shall be presumed to be unreported gross wages unless documentation is provided by the employer that the individual meets the statutory requirements of W.S. § 27-14-102(a)(xxiii) as an independent contractor. The burden is upon the employer to provide such documentation.

(b) Contesting Audit. Any employer may contest the audit conducted by the Division. Contest shall be made by filing a written objection with the Division within thirty (30) days after notification by the Division as provided by the Final Audit Determination Notice. The Division shall resolve the matter administratively within forty-five (45) days or refer the objection to an independent hearing officer appointed for such purpose, pursuant to the Wyoming Administrative Procedure Act.

Section 6. Non-Resident Employers' Surety Bond.

(a) Pursuant to W.S. § 27-1-106, all firms, corporations or employers of any kind who are non-resident employers as defined in W.S. § 27-14-102(a)(xiii) and expect to pay wages above the set statutory threshold in the state of Wyoming, are required to file a surety bond or other security with the Division.

(b) Non-resident employer definitions for: Individual, Sole Proprietor, Limited Liability Company (LLC), Limited Liability Partnership (LLP), Limited Partnership (LP), and/or Corporations:

(i) Employer and/or Individual or Sole Proprietor is not domiciled in Wyoming for at least twelve (12) months; or

(ii) If any partner or LLC, LLP or LP member is not domiciled in Wyoming for at least twelve (12) months; or

(iii) If more than three fourths (3/4) of the capital stock of the business is owned by individuals not domiciled in Wyoming for at least twelve (12) months (Corporations).

(c) Employers are exempt from security if:

(i) Expected wages paid to Wyoming employees are below the set threshold per W.S. § 27-1-106; or

(ii) Employer is a charitable or religious organization as defined in W.S. § 27-1-106(g).

(d) Acceptable Forms of Security. A surety bond or security can be filed with the Division in the form of:

(i) Cash bond;

(ii) Surety bond;

(iii) Letter of credit; or

(iv) Real property. Real property may be pledged in lieu of a bond if the non-resident employer delivers the following documentation on real property located in Wyoming to the Division.

(A) An appraisal on the subject property conducted by a licensed Wyoming appraiser that is ninety (90) days old or less which shows the value of the subject property is greater than the amount of the required bond;

(B) A title policy or other certification issued by a Wyoming title company showing that the subject property is owned by employer and is free from any other liens or encumbrances; and

(C) A recordable instrument signed by a duly authorized representative of the employer noting the Department's lien interest in the subject property.

(e) Duration. Surety bond or security is required for a minimum of two (2) years. This may be extended if the employer does not comply for the two (2) year period.

(f) Penalties. The penalties for willful failure of any covered non-resident employer to give bond or other security are contained in W.S. § 27-14-307.

(g) Forfeiture. Prior to proceedings for forfeiture of a bond by a non-resident employer, the Division shall notify the employer in writing of the events triggering a possible

forfeiture, the amount of the bond to be forfeited, and the employer's right to avoid forfeiture by paying an equivalent amount to the Division within thirty (30) days. The amount to be forfeited shall be the sum of the following:

(i) The remaining reserved amounts for compensable injuries to the employer's workers less the cumulative premiums paid by the employer;

(ii) All unpaid premiums, penalties and interest accruing as a result of late payment or non-payment of said premiums, and reasonable auditing expenses; and,

(iii) Any and all amounts due to the Department of Workforce Services and, any other section under W.S. Title 27 - Labor and Employment.

Section 7. Deductible Program.

(a) Pursuant to W.S. § 27-14-201(t)(i), an employer may apply to participate in a deductible program. Employers must apply for the deductible program in writing on a form prescribed by the Division. Terms of the deductible program shall be defined by contract entered into between the employer and Division.

(b) The Division may require applying employers to undergo a financial audit to ensure financial stability. The audit may include a credit check and review of company financial reports. The Division shall analyze each applicant based on risk analysis and sound business practices. The Division may refuse any applicant into the deductible program if it determines that the proposed contract does not represent a sound business practice or decision.

(c) For any employer enrolled in the deductible program, the Division will process and pay claims in accordance with the Act. The employer shall reimburse the Division for all costs paid by the Division on individual claims up to the amount of the contractually agreed deductible.

(d) The deductible levels available are: $1,000.00, $5,000.00, $10,000.00, $25,000.00, $50,000.00, $75,000.00, or $100,000.00. The maximum deductible level offered to an employer by the Division shall not be more than fifty percent (50%) of the employer's standard premium.

(e) The amount of the contractually agreed upon deductible will be applied to the employer's industry base rate before any discounts under, Sections 8-10, of this chapter are calculated and applied.

Section 8. Safety Program; Employer Discount.

(a) Pursuant to W.S. § 27-14-201(o) employers may receive a premium base rate discount, as determined through the Division's premium rate setting process for its employment classification, by participating in a safety program.

(b) Employers must have at least one (1) employee to participate in the program, establish and maintain certificates of good standing with Wyoming Workers' Compensation, Unemployment Insurance, and the Secretary of State. Certificates of good standing shall be reviewed on an annual basis to ensure compliance. If certificates of good standing cannot be established and maintained by the employer, that employer shall be disqualified from the program until such time as the employer reapplies for the program and all program requirements have been met.

(c) Pursuant to W.S. § 27-14-803 and in accordance with Section 5 of this chapter, the Division may investigate and examine the employer's documentation as pertains to compliance with its approved health and safety program(s). If the Division finds the employer to be in noncompliance after reviewing the relevant documentation, participation in the employer base rate discount program may be revoked or reduced.

(d) This program shall comply with some or all of the following provisions dependent on the level of discount participation:

(i) A formal, written declaration by the company's safety coordinator explaining the company-wide loss prevention policy;

(ii) A formal creation of a safety committee with at least one member;

(iii) Employees have undergone appropriate hazard and injury prevention training as necessary for their job;

(iv) Written policies/procedures on claims management; and

(v) A substance abuse training plan along with written policies and procedures establishing a drug-free workplace, which may include an employee assistance program to assist employees with alcohol or other drug problems. These policies shall be posted in a conspicuous place where they may be regularly viewed by employees:

(A) The policy shall:

(I) Establish that the unlawful use, possession, transfer or sale of illegal drugs or controlled substances and the misuse of alcohol by employees during work hours are prohibited;

(II) Provide an explanation of the consequences of violation of the employer's drug-free policy, which may include a referral for therapeutic help, discipline and/or discharge; and

(III) Encourage the designation of totally or partially smoke free workplace.

(B) Employers shall post a list of community resources that provide substance abuse treatment and prevention services in a conspicuous place where they may be regularly viewed by employees. The Wyoming Department of Health shall provide the list on the website of the Substance Abuse Division or in hard copy to employers requesting the list.

(C) Employers are not required to pay the costs of treatment or any other intervention to qualify for the safety discount program.

(D) Employers enrolling on or after the effective date of these rules shall comply with the drug-free workplace requirements upon enrollment.

(e) Applications to participate in this program may be submitted to the Division at any time, and upon approval, premium base rate discounts shall be implemented in the subsequent calendar quarter.

(i) To receive a three and one-third percent (3.33%) discount to its premium base rate, an employer must have a documented health and safety program;

(ii) To receive a six and two-third percent (6.66%) discount to its premium base rate, an employer must have a documented health and safety program and have an established Health and Safety committee with documented monthly safety meetings; and

(iii) To receive a ten percent (10%) discount, an employer must meet the above requirements and achieve and maintain a loss ratio of equal to or less than ten percent (10%).

(f) Premium base rate discount renewals shall be in effect each year only in the event that a renewal application has been submitted along with any updates to the employer's Health and Safety policy. If an audit is conducted and the employer is found to be out of compliance with any of the previous requirements the employer shall be removed from the program until such time as the employer reapplies for the program and all program requirements have been met.

Section 9. Drug and Alcohol Testing Program; Employer Discount

(a) Pursuant to W.S. § 27-14-201(o), employers may receive a premium base rate discount, as determined through the Division's premium rate setting process for their employment classification, by participating in a drug and alcohol testing program approved by the Division.

(b) Employers must have at least one (1) employee to participate in the program, establish and maintain certificates of good standing with Wyoming Workers' Compensation, Unemployment Insurance, and the Secretary of State. Certificates of good standing shall be reviewed on an annual basis to ensure compliance. If certificates of good standing cannot be established and maintained by the employer, that employer shall be removed from the program until such time as the employer reapplies for the program and all program requirements have been met.

(c) Applications to participate in the drug and alcohol testing program may be submitted to the Division at any time and, upon approval, premium base rate discounts shall be implemented in the subsequent calendar quarter.

(d) Upon receipt of a completed application, the Division shall review the application for compliance with these rules and either approve or deny the application. The Division shall deny an application if an applicant fails to meet all of the requirements of these rules. The Division shall also refuse to renew an application if the employer no longer meets or has violated any provision of these rules.

(e) After approval or renewal, the applicable premium base rate discount shall be applied to the following four (4) calendar quarters unless revoked pursuant to these rules.

(f) Applications shall be submitted annually.

(g) Applications shall include the employer's name, employee's printed name and title of the officer/owner, signature of the officer/owner, and date attesting the information contained in the application is a true and factual representation of the drug-free workplace program. A drug-free workplace program shall contain all of the following:

(i) The written policy, which shall include all of the following:

(A) A statement providing for inclusion of all Workers' Compensation covered employees in the substance abuse testing program.

(B) A statement of required types of substance abuse testing.

(C) A statement of actions the employer may take against an employee or job applicant on the basis of a positive confirmed test result.

(D) A statement of consequences of an employee's or job applicant's refusal to submit to a drug test.

(E) A general confidentiality statement.

(F) A statement advising employees with a positive confirmed test result that he or she may contest or explain within five (5) working days after written notification of the test result.

(G) A statement informing an employee or job applicant of the federal Drug-Free Workplace Act, if applicable.

(H) A statement affording provision of a sixty (60) day notice prior to implementation of substance abuse testing, if a new policy is implemented in order to enter into this discount program.

(I) A statement that substance abuse testing is required to be on vacancy announcements, when applicable.

(J) A statement informing employees where substance abuse testing information is posted on the employer's premises.

(K) A statement informing employees and job applicants that copies of the substance abuse policy are available in a suitable location on the employer's premises.

(ii) Substance abuse testing, to the extent permitted by federal codes, Wyoming state statutes, and local ordinances, shall include all of the following:

(A) Pre-employment, random, reasonable suspicion and post-accident testing.

(B) Drug and alcohol testing protocols as specified in Chapter 10, Section 2 shall apply to all random, reasonable suspicion and post-accident testing.

(I) Pre-employment substance abuse testing is exempt from the protocol as specified in Chapter 10, Section 2, with strong recommendation that one hundred (100%) percent of new employees be tested prior to his/her hire date. Alcohol testing is not required for job applicants.

(II) For random and reasonable suspicion testing, a commercially available urine or hair follicle test consisting of synthetic amphetamines; amphetamines; synthetic marijuana "spice"; marijuana; cocaine; opiates and PCP with specific gravity incorporating Substance Abuse and Mental Health Services Administration (SAMHSA) cutoff levels shall be utilized by a Third Party Administrator. A negative test shall require no further testing unless use of another drug not included on the on-site test is suspected, in such case the sample would be processed as if it were a positive on-site test. A positive drug or low specific gravity onsite urine test shall be immediately processed pursuant to Chapter 10, Section 2. Protocol shall require transfer of the specimen in front of the employee to a container supplied by a certified laboratory, and sealed per instruction with the employee initialing the evidence seal.

(III) Post-accident testing shall be exclusively processed per Chapter 10, Section 2 with strong recommendation that the specimen be a blood sample.

(C) To the extent permitted by federal codes, Wyoming state statutes, and local ordinances, random testing shall be conducted, at a minimum, on twenty percent (20%) of the average staff on an annual basis.

(iii) Resources must be made available for employee's needing assistance. Such assistance must include either a statement advising employee of an Employee Assistance Program (EAP) or a statement advising employee of employer's resource file of assistance programs and other persons, entities, or organizations designed to assist employees with personal or behavior problems.

(iv) Employee Education. The employer shall provide at least one (1) hour of employee substance abuse education training per year. Employers shall retain records, to include attendees' signatures, and dates and training topics, to document employee participation in education.

(v) Supervisor Training. The employer shall provide at least two (2) hours of substance abuse education training per year to all supervisors. Supervisors shall receive training to encompass at least sixty (60) minutes on alcohol misuse and at least sixty (60) minutes on drug use. Training shall incorporate physical, behavioral, speech, and performance indicators of probable alcohol misuse and use of drugs. Employers shall retain records, to include attendees' signatures, and dates and training topics, to document supervisory participation in training.

(h) Drug-free workplace program compliance and revocation.

(i) An employer shall maintain compliance with their drug-free workplace program during the time period for the discount program.

(ii) An employer shall be responsible for document retention to substantiate compliance with the substance abuse testing provisions in the employer's approved annual drug free workplace program. An employer shall preserve such records for a period of two (2) years after the calendar year in which the respective program was approved by the Division.

(iii) Pursuant to W.S. § 27-14-803 and in accordance with Section 5 of this chapter, the Division may investigate and examine the employer's documentation as pertains to compliance with their approved drug-free workplace program(s). If the Division finds the employer to be in noncompliance after reviewing the relevant documentation, participation in the employer base rate discount program for alcohol and drug testing will be revoked. Employers shall have their premium rates adjusted to the industry classification base rate as adjusted by the experience rating.

(iv) The Drug and Alcohol Testing Program; Employer Discount shall be in effect each year unless an audit is conducted and the employer is found to be out of compliance with any of the program requirements. If the preceding occurs, the employer shall be removed from the program until such time as the employer reapplies for the program and all program requirements have been met.

Section 10. Health and Safety Consultation Employer Discount Program.

(a) Pursuant to W.S. § 27-14-201(o), employers may receive a premium base rate discount, as determined through the Division's premium rate setting process for its employment classification, by participating in a health and safety consultation program.

(b) Applications to participate in this program may be submitted to the Division at any time and upon approval premium base rate discounts shall be implemented in the subsequent calendar quarter.

(c) Employers must have at least one (1) employee to participate in this program, establish and maintain certificates of good standing with Wyoming Workers' Compensation, Unemployment Insurance, and the Secretary of State. Certificates of good standing shall be reviewed on an annual basis to ensure compliance. If certificates of good standing cannot be established and maintained by the employer, that employer shall be disqualified from this program until such time as the employer reapplies for the program and all program requirements have been met.

(d) Pursuant to W. S. § 27-14-803 and in accordance with Section 5 of this chapter the Division may investigate and examine the employer's documentation as pertains to compliance with its approved health and consultation safety program(s). If the Division finds the employer to be in noncompliance after reviewing the relevant documentation, participation in the health and safety consultation employer discount program may be revoked or reduced to a lower tier.

(i) If an audit is conducted and the employer is found to be out of compliance, and/or an employer has a workplace related fatality, and/or an employer has an inspection where they are issued a repeat serious or willful citation during any time while receiving this discount they shall be immediately removed from the program until such time that they have abated all hazards and they have completed any other required obligations with state agencies. Upon completion of abatement and obligations the employer can reapply for the discount and all program requirements have been met.

(e) Health and Safety Consultation Employer Discount Program premium base rate discounts shall be applied on a quarterly basis and be in effect for up to three (3) years.

(f) Discounts shall be calculated as follows:

(i) To participate in the Tier 1 premium base rate discount of three percent (3%), an employer must complete:

(A) a full service, onsite survey; and,

(B) abates all serious hazards.

(ii) To participate in the Tier 2 premium base rate discount of five percent (5%), an employer must complete:

(A) a full service, onsite survey;

(B) abates all serious hazards; and,

(C) the Safety & Health Assessment Form. The employer must score 2's on the twenty (20) pre-selected items on the Safety & Health Program Assessment Form.

(iii) To participate in the Tier 3 premium base rate discount of seven percent (7%), an employer must complete:

(A) a full service, onsite survey;

(B) abates all serious hazards;

(C) the Safety & Health Program Assessment Form and score 2's on the twenty (20) pre-selected items on the Safety & Health Program Assessment Form; and,

(D) obtain injury and illness rates known as the Total Recordable Cases (TRC) and Days Away Restricted Time (DART) below the Bureau of Labor Statistics (BLS) current rates for their company per North American Industry Classification (NAIC's) code.

(iv) To participate in the Tier 4 premium base rate discount of ten percent (10%), an employer must complete:

(A) a full service, onsite survey;

(B) abates all serious hazards;

(C) the Safety & Health Assessment Form and score 3's on 10% and 2's on the remaining items to complete all 58 items on the Safety & Health Assessment Form; and

(D) obtain injury and illness rates known as the Total Recordable Cases (TRC) and Days Away Restricted Time (DART) below the Bureau of Labor Statistics (BLS) current rates for their company per North American Industry Classification (NAIC's) code.

(v) The Safety & Health Program Assessment Form shall be conducted by Wyoming OSHA Consultation or Compliance Assistance, a State Mine Inspector, Workers' Compensation Safety Specialist or a qualified third-party health and safety professional approved by the Department.

(g) A third-party health and safety professional shall meet the following requirements to conduct audits and recommend discounts for this program:

(i) complete and submit the Health & Safety Consultation Employer Discount application;

(ii) submit copies of any health or safety certificates/certifications,

(iii) submits copy of health or safety degree or any other health and safety paperwork for approval consideration; and,

(iv) include a copy of the letter from the State of Wyoming Office of the Attorney General, Division of Criminal Investigation's Western Identification Network or equivalent showing no criminal record.

Section 11. Specifically Enumerated Volunteers; Elected, County or Local Officials; School-to-Careers Program.

(a) A governing body's election of coverage as defined in W.S. § 27-14-108(e)(ix), shall be on forms provided by the Division containing information as requested by the Division.

(b) The school-to-careers program applies to those employers and participants who are not eligible for coverage under a qualifying employer-employee relationship. Participants under this program are not eligible for temporary total wage benefits under the Act.

(c) If the school district or community college district chooses to make the reports and payments for the employer, the wage calculation will be based on the presumed pay of the participant. The premium rate used to calculate the payment will be that of the specific school district or community college district making the report. All claims will be reported and processed against the reporting school district or community college district.

(d) If an employer-employee relationship exists, the participant will be treated as any other employee under the Act.

Section 12. Exclusions.

(a) Private Schools. Any private entity classified under NAICS 519 and 611 Education Services, is excluded from coverage under the Act, unless an election of coverage is made as provided in W.S. § 27-14-108(j).

Section 13. Concurrent Coverage.

(a) Employers covered under the Act having employees working in a state that requires workers' compensation coverage in addition to the employer's Wyoming coverage, must submit written proof of coverage from the other state. The employer may then submit its payroll report, which lists only the wages paid for hours worked in Wyoming. The proof of coverage shall be submitted on forms required by the Division. When the Division receives proof of coverage, it

will not require premium payments and coverage in Wyoming during the time the employee is working and being covered in another state.

(b) The employer and employee must notify the Division of any claim for benefits filed in another state for any injury reported in Wyoming. An employer's experience rating to be computed by using three (3) years (or maximum available portions thereof) of claims experience for each eligible employer.

(c) Three (3) years claims experience shall begin July 1 of the fifth (5th) calendar year prior to the rating year and end June 30 of the second (2nd) calendar year prior to the rating year.

Section 14. Employer Reimbursements or Allowances for Employee Business Expenses.

(a) Employer reimbursements or allowances of employee business expenses are not considered gross earnings if the employer has appropriate records to substantiate that an "accountable plan" has been established and implemented as follows:

(i) There must be a business connection for expenses incurred while performing services as an employee, officer or member of the employer.

(ii) The expense must be reasonable.

(iii) There must be actual accounting for the expense, by the employer and the employee, officer or member.

(A) For travel expenses reimbursed at established federal per diem rates, documentation of the trip will be considered actual accounting.

(B) For business entities with federally recognized expense allowances, the U. S. Treasury allowance will be considered actual accounting.

(iv) All excess reimbursement or allowance must be repaid by the employee, officer or member to the employer within one-hundred and twenty (120) days after the expense was paid or incurred.

(b) Payments that do not include all of the above or exceed federal per diem or federal allowances will be deemed to be wages gross earnings.

Section 15. Glossary of Terminology

(a) Actual (A) Losses. The incurred loss amounts for workers' compensation claims submitted by the employer, which have event dates in the three (3) year window of time used for experience rating. The losses will include the case reserves as of the evaluation date set by the

plan, and will have applicable plan minimums and caps applied for use in the experience rating formula.

(b) Actual Excess (Ae) Losses. The Actual Excess Losses for each claim represents the more random and less controllable portion of the claim. For each claim, the Actual Excess Loss is computed as the difference between the Total Actual Loss for the claim and Actual Primary Loss for the claim.

(c) Actual Primary (Ap) Losses. The experience rating plan segregates the Total Actual Loss on each claim into two components – primary and excess. The Actual Primary Loss for each claim represents the more predictive and controllable portion of the claim. The Actual Primary Loss value for each claim is obtained by the formula: Actual Primary Loss = Total Actual Loss if Total Loss is less than ten thousand dollars ($10,000.00); = ten thousand dollars ($10,000.00) if Total Loss is equal to or greater than ten thousand dollars ($10,000.00).

(d) Credibility (Z) Value. A measure of the predictive value in a given application that the actuary attaches to a particular set of data, such as the claims experience used for determining EMRs.

(e) Credibility Excess (Ze) Value. The Credibility Excess, or Ze Value, is the weight given to the risk's Actual Excess Losses relative to the average Expected Excess Losses for a similarly-sized risk in the same standard classification(s). It is intended to reflect the actuarial predictability of a risk's excess loss experience. The larger the risk is, the greater the weight is given to the excess loss experience and the greater the Ze. The excess experience of very small experience rated risks has essentially no predictive value and, as a result, the Ze for these risks may be zero (0). The complement of the Ze, (1 – Ze), is the weight given to the risk's Expected Excess Losses. The Ze Value varies with a risk's Expected Losses.

(f) Credibility Primary (Zp) Value. The Credibility Primary (Zp) Value, is the weight given to the risk's Actual Primary Losses relative to the average Expected Primary Losses for a similarly-sized risk in the same standard classification(s). It is intended to reflect the actuarial predictability of a risk's primary loss experience. The larger the risk is, the greater the weight is given to the primary loss experience and the greater the Zp. The complement of the Zp value (1 – Zp), is the weight given to the risk's Expected Primary Losses. The Zp Value varies with a risk's Expected Losses.

(g) Expected (E) Losses (also referred to as Total Expected Loss). The Expected Losses are the basis to which actual losses are compared in the experience rating formula. They are derived for each classification as the product of the payroll for the classification and the expected loss rate applicable to the classification. They are also computed as the sum of the Expected Primary Losses and the Expected Excess Losses. For other than per capita classifications, this product is then divided by one hundred (100). The Expected Loss Rate for a classification is the average rate of losses per one hundred dollars ($100.00) of payroll that is expected for the classification during an experience rating period.

(h) Expected Excess (Ee) Losses. The Expected Excess Losses are the portion of the Expected Losses that is considered excess, and are used in the experience rating formula in combination with the Actual Excess Losses. The Expected Excess Losses for a classification are determined by multiplying the Excess Expected Loss Rate for the classification per $100 of employer payroll for the classification. The total Expected Excess Losses are the sum of the Expected Excess Losses over all classifications.

(i) Expected Primary (Ep) Losses. The Expected Primary Losses are the portion of the Expected Losses that is considered primary, and are used in the experience rating formula in combination with the Actual Primary Losses. The Expected Primary Losses for a classification are determined by multiplying the Primary Expected Loss Rate for the classification by the employer payroll for the classification. The total Expected Primary Losses are the sum of the Expected Primary Losses over all classifications.

(j) Multiple Claim Occurrence (MCO). Claims with multiple claimants or catastrophe claims combines claims together which then have a $500,000.00 limit (2 X the Maximum Single Loss Amount of $250,000.00).

(k) Multiple Single Loss Amount. Maximum Single Loss is the maximum limit of incurred loss, not to exceed the state accident limit of $250,000.00.

(l) Split Plan. A method for calculating EMRs that balances the effect of more frequent losses that fall below a "split point" with more severe losses that occur above the split point.

(m) Split Point. A loss amount determined by the state based on actuarial recommendations. Losses falling below the split point are considered Primary Losses. Any remaining losses above the Primary Losses and below the Maximum Single Loss Amount are considered the Excess Losses.

(n) Maximum Loss Cap. The Maximum Loss Cap is the state's accident limit per a single claim or two (2) times the state's accident limit for multiple claimants or catastrophe.

CHAPTER 3

FAILURE OF EMPLOYER TO COMPLY

Section 1. Delinquency – Case Liability.

(a) Employers will be charged for all injury case costs if the employers' account is in non-compliance in the following circumstances:

(i) Delinquent During the Reporting Period the Injury Occurred. Employers whose accounts are in a delinquent status for the reporting period during which an injury occurred will be charged case costs for the life of any such injury.

(ii) Injured Worker not Reported. Employers who omit the name of any injured worker on the Division's report form corresponding to the month of injury and fail to pay premium on that injured worker's earnings will be charged case costs for the life of any such injury.

(iii) No Account on Date of Injury. Employers who fail to establish an account, or fail to reactivate an inactive account on any date of injury will be charged case costs for the life of any such injury.

(b) Employers shall be deemed delinquent if premiums remain unpaid more than 30 days following the due date.

Section 2. Civil Liability.

(a) When a payroll report or payment of premium is past due, pursuant to Wyoming Statutes § 27-14-202(a), the Division shall send to the employer a notice that the report and/or premium is past due and that the employer's account will become delinquent if the required report and payment are not postmarked within 30 days of the date due. When an employer's account becomes delinquent, the Division shall send to the employer a notice of delinquency.

(b) For purposes of all penalties and rights of action under the Act, an employer shall be considered delinquent if a payroll report or any payment required by the Act is not postmarked within 30 days of the due date.

(c) Applying Payments. When an employer makes a payment to the Division, the Division shall apply it to the oldest premium or interest owed by the employer unless the employer has specified in writing that the payment should be applied to a particular portion of the employer's debt. However, bankruptcy laws or reorganization plans take priority over the employer's written specification.

Section 3. Cancellation of Optional Coverage. Coverage for an employer with optional coverage will be terminated if the account remains delinquent 30 days following notification by certified mail to the employer that the employer has been delinquent in reporting of payment of premium for one calendar quarter. The employer remains liable for the unpaid

premium and case cost reimbursement, as applicable, through the date of termination. Following termination under this section, the employer shall not be eligible for reinstatement of optional coverage for a period of six months.

Section 4. Notice to Administrator. Employees of the Division who identify a possible violation by any party shall immediately notify the Administrator of the Workers' Compensation Division in writing.

Section 5. Waiver and Settlement - Tax. Upon good and sufficient cause, the Administrator of the Workers' Compensation Division may waive, compromise or otherwise settle any amount owed to the Division by an employer.

Section 6. Out of State Employers – Experience Modification Rating. If an employer who meets the criteria under Wyoming Statutes § 27-14-207(h) refuses or fails to provide the Division with the experience history from their insurance company, that employer will be assigned the maximum experience modification rating (EMR) of 1.85.

Rules, Regulations and Fee Schedules of the Wyoming Workers' Compensation Division

CHAPTER 4 - INJURY REPORT PROCEDURE

Section 1. **Worker Report of the Injury.** The report of the injury is not a claim for benefits. W.S. § 27-14-503(a). The injured worker is required by the statute to report the occurrence and general nature of the injury to the employer as soon as practical within 72 hours after the injury becomes apparent, and to file a signed injury report on the required form with the Division within ten days after the injury becomes apparent. Otherwise, there is a statutory presumption that the claim shall be denied. However, this presumption may be rebutted if the worker can establish by clear and convincing evidence that the delay does not prejudice the employer or Division in investigating the injury and in monitoring medical treatment.

Section 2. **Contents of the Worker's Report.** The report shall be on a form provided by the Division, available from the Division or employer, and shall contain the following information:

(a) The worker's full name, mailing address, telephone number and Social Security Number;

(b) The worker's birth date, sex, marital status and number of dependents;

(c) The employer's full name, address and telephone number;

(d) The worker's date of hire and job title;

(e) A statement of whether the worker is a regular worker, volunteer, inmate, a governmentally subsidized work experience program participant, or has an interest in the business as owner, partner, or corporate officer;

(f) The worker's current monthly earnings;

(g) The date, time and location of the accident or injury;

(h) A statement of how the injury occurred, including what the worker was doing at the time and what objects or substances caused the injury;

(j) A statement identifying the parts of the worker's body affected by the injury;

(k) The name(s) of any witness(es) to the events causing the injury;

(l) The names and addresses of all health care providers who have treated or provided medical services to the worker for the injury being reported;

(m) If the report is prepared by a person other than the worker, the full name, address and telephone number of the person preparing the report, and that person's relationship to the worker;

(n) Such additional information as the Division deems appropriate; and

(o) The report form shall be signed and dated by the worker, or his personal representative if the worker is incapacitated.

Section 3. **Employer Report of the Injury.** The employer must file a report of injury within ten days after the date on which the employer is notified of the injury. Failure by an employer to report may result in a fine or jail. W.S. § 27-14-506(c). The report must be filed with the Division; it shall be on the required form, dated, signed by the employer or employer's authorized representative and shall contain the following information:

(a) The worker's date of hire and job title;

(b) A statement of whether the worker is a regular employee, volunteer, inmate, governmentally subsidized work experience program participant, or has an interest in the business as owner, partner or corporate officer;

(c) The worker's current monthly earnings;

(d) The opinion of the employer as to whether the worker suffered a work-related injury that is compensable under the Act; and

(e) If the employer's opinion is that the injury is not compensable under the Act, the employer shall specify its reason for that opinion. Those matters will be addressed by the Division as part of the determination process.

Section 4. **Injury Report Forms.** Injury report forms are available, without charge, from the Division or its district offices. W.S. § 27-14-502(a) and (c). The limitation of time for filing does not apply if the worker is mentally incompetent or a minor and has no guardian. W.S. § 27-14-505. The report form shall contain a statement in boldface type that the report is not a claim for benefits.

Section 5. **Notification of Injury.** Any affected party may give notice, by electronic means to the Division, of an occurrence of injury to a worker in covered employment. Upon receipt of notice of injury, the Division will mail the appropriate forms to the injured worker and the employer for completion and signatures.

(a) If notification was electronically submitted within the deadline prescribed in W.S. § 27-14-502(a) and the Division receives the signed report within ten days of its mailing by the Division, the report shall be deemed to have been timely filed. In such a case, the Division's allotted time to respond will begin when it receives the signed report.

(b) If the Division receives the signed report more than ten days after its mailing by the Division, the report shall be deemed filed on the date the signed report is received by the Division.

(c) The Division will not approve any award nor pay any claim prior to its receipt of a signed waiver from the injured employee, on a form provided by the Division, authorizing the Division to release benefit, employment or medical information to those parties designated recipients in W.S. § 27-14-805(d).

(d) Nothing in this section shall relieve any party of the duty to submit documents bearing original signatures, when required by the Act or these Rules.

Rules, Regulations and Fee Schedules of the Wyoming Workers' Compensation Division

CHAPTER 5 - DETERMINATIONS BY THE DIVISION: COVERAGE, COMPENSABILITY AND CLAIMS

Section 1. **Coverage.**

(a) Upon receipt of the injury report, the Division will investigate and review the matter and will address questions of jurisdiction and compensability. The Division may gather additional facts prior to the determination. W.S. §§ 27-14-601(k) and 27-14-801(d). The procedures for review, determination, redetermination and request for hearing shall be as provided in Sections 2 and 3 of this chapter.

Section 2. **Determination Procedure**. The following procedures apply to all determinations by the Division, including coverage/compensability determinations, all benefits claim applications, and all medical bill reviews.

(a) The Division will review the matter within 15 days from the date any completed employer or employee injury report or claim is filed and will issue either a final determination or request for additional information.

(b) At the earliest possible date within 45 days following the request for additional information, the Division will make its final determination as to whether the injury, or death resulting from injury, is compensable and within the jurisdiction of the Act or whether and in what amount a claim or bill is allowed.

(c) Upon mutual consent of the worker, the employer, and the Division, the time limit for the determination by the Division may be extended. Otherwise, upon failure of the Division to make a decision within the time allowed by the Act, at the request of any affected party the matter shall be referred by the Division for hearing.

(d) The final determination shall be mailed to all affected parties at their last known addresses, and, when required by law, shall include a statement of reasons, and a notice of right to request a hearing and right to counsel. An affected party shall immediately notify the Division, in writing, of any change of address or physical residence.

(e) Objection. Any affected party may object to the Division's final determination by filing a written request for hearing with the Division within 15 days following the mailing of the determination. W.S. § 27-14-601. A timely written request for hearing is prerequisite to review by the appropriate hearing authority.

Section 3. **Redetermination Procedure.**

(a) The Division may issue a redetermination within one year following the issuance of a final determination if the Division receives sufficient information to establish the compensability of the case or claim. W.S. § 27-14-601(k)(vi).

(i) The Division will not issue a redetermination, or award benefits to an injured worker, if information substantiating the compensability of a case or claim is submitted more that one year after the Division issued the final determination denying the compensability of the case or claim.

(ii) The redetermination shall be formal written notification sent to the employee, employer, and known treating health care provider(s).

(A) Any affected party may object to the Division's redetermination by filing a written request for hearing within 15 days following the issuance of the redetermination.

(B) A timely request for hearing is prerequisite to review by the appropriate hearing authority.

Section 4. **Claims for Benefits** . A person seeking an award of benefits under the Act must submit a written application for benefits to the Division, on a form provided by the Division. A report of injury is not a claim for benefits. W.S. § 27-14-503(a). A claim for benefits may be filed by the injured worker, that worker's personal representative, or, in case of an injured worker who is mentally incompetent or a minor, the worker's legal guardian. In order to make an application, a claimant shall submit one of the following:

(a) Claim for Reimbursement. A claim for reimbursement of any expense(s) incurred by an injured worker because of his work-related injury must be submitted on a form provided by the Division according to the procedure outlined in Chapter 7, Section 3(a)(iii) Medical Reimbursement to Injured Worker.

(b) Claim for Temporary Total Disability (TTD) Benefits (Lost Wages).

(i) When Submitted. A claim for TTD must be filed within 60 days after the first day of certified temporary total disability. W.S. § 27-14-404(d).

(ii) Certification. An award of TTD cannot be made without certification from a treating health care provider that the worker is temporarily and totally disabled (that is, incapacitated from performing any gainful employment for which the worker is reasonably suited by experience or training). The certification shall specify the reasons for the total disability and the expected period of disability.

(iii) A physician assistant shall be deemed a health care provider for purposes of examinations and TTD certifications pursuant to W.S. §§ 27-14-404(d)(ii), 404(g) and 501(b), if the TTD certification is accompanied by or the Division has on file, a written statement, signed and dated by the supervising licensed physician, stating "I [insert name of physician] certify that the physician assistant signing this form has authority to do so and that the certification is provided under my supervision." W.S. § 33-26-502(b). Both the supervising physician and the physician assistant shall have a continuing duty to notify the Division immediately if a previously-designated physician assistant is no longer employed by the physician, is no longer

licensed as a physician assistant in Wyoming, or is no longer authorized by the physician to certify TTD.

(iv) Where Submitted. A claim for TTD benefits must be filed with the Division. W.S. § 27-14-501(3).

(c) Claim for Temporary Partial (Light Duty) Disability (TPD). An employer may make a written bona fide offer of temporary light duty work to an employee receiving temporary total disability in accordance with W.S. § 27-14-404(j).

(d) Initial Claim for Permanent Partial Impairment (PPI) Benefits.

(i) When Submitted. An application for PPI benefits may be filed when a worker has suffered an ascertainable loss as defined in W.S. § 27-14-102(a)(ii).

(ii) Applications For PPI Award. If a physician determines that the injury has resulted in a permanent impairment according to the *American Medical Association's Guide to the Evaluation of Permanent Impairment* or its successor, the physician shall notify the Division in writing. The Division shall file the written documentation of permanent impairment, copying all parties. Based upon the rating given by the physician, the worker may apply with the Division for the appropriate award, pursuant to W.S. §§ 27-14-405 or 406.

(e) Claim for Vocational Rehabilitation Benefits.

(i) At any time after the injury when medical evidence indicates that an injured worker cannot return to employment as outlined in W.S. § 27-14-408(a)(ii) the worker may submit an application to the Division on a form provided by the Division for vocational rehabilitation benefits.

(ii) The Division may extend or increase a rehabilitation program's limits defined in W.S. § 27-14-408(e)(ii) upon consideration of one of the following extenuating circumstances:

(A) The injured worker's disability is so severe as to limit his ability to complete his vocational rehabilitation plan within specified time frames;

(B) Medical services or complications prevent the injured worker from completing his vocational rehabilitation program on time;

(C) The educational institution's scheduled course offerings prevent the injured worker from completing the vocational rehabilitation program on time; or

(D) Any other circumstance mutually agreed upon by the Division, Division of Vocational Rehabilitation and the injured worker.

(iii) The application for vocational rehabilitation shall include a statement that the applicant elects to accept vocational rehabilitation instead of any PPD award under W.S. § 27-14-405(h) and (j) arising from the same physical injury.

(f) Application for Permanent Partial Disability (PPD) Benefit. An application for PPD may be filed no sooner than three months after the date of ascertainable loss or threemonths before the last scheduled PPI payment, whichever date is later. and must be filed within one year of the later date. W.S. § 27-14-405(h)(ii).

(g) Miscellaneous Benefit Application.

(i) Applications for other benefits, including death benefits, permanent total disability, benefits for dependents or survivors, and extended benefits shall be made to the Division as soon as practical after the applicant becomes aware of entitlement to such benefits and within applicable statutes of limitations.

(ii) Where death results from an injury, the claim for death benefits shall be filed by the surviving spouse, by the guardian of a surviving spouse who is incompetent, by the guardian of dependent minor children, by the worker's dependent parent(s), or by the guardian of the worker's incompetent dependent parent(s).

(iii) Application for extended children's benefits for education beyond the age of 18 and until the age of 21 may be made with the Division. Beneficiaries will receive notification and must complete and submit a Verification of Enrollment Form provided by the Division.

Section 5. **Waiver and Settlement - Benefits**. Upon good and sufficient cause the Administrator or designee(s) of the Workers' Compensation Division may waive, compromise or otherwise settle any claim for benefits.

CHAPTER 6
CONTESTED CASE PROCEEDINGS

Section 1. **Referral for Hearing.**

(a) Upon receipt of a request for hearing, the Division shall immediately transmit a copy of the request and a notice of request for hearing to the Office of Administrative Hearings (OAH) or Workers' Compensation Medical Commission as appropriate. For purposes of judicial review of agency inaction under W.S. § 16-3-114(a), the Division is deemed to have denied any timely, written request for a hearing pursuant to W.S. § 27-14-601(k)(iv) when it has failed to transmit a notice of request for hearing within 30 days after receipt of the request.

(i) For purposes of referring contested cases to the Workers' Compensation Medical Commission for hearing, W.S. § 27-14-616(b)(iv), the phrase "medically contested cases" shall include those cases in which the primary issue is:

(A) a claimant's percentage of physical impairment;

(B) whether a claimant is permanently totally disabled;

(C) whether a claimant who has been receiving TTD benefits remains eligible for those benefits under W.S. § 27-14-404(c); or,

(D) any other issue, the resolution of which is primarily dependent upon the evaluation of conflicting evidence as to medical diagnosis, medical prognosis, or the reasonableness and appropriateness of medical care.

Section 2. **Establishment of Fees for Members of Medical Commission.** Members of the medical commission established pursuant to W.S. § 27-14-616 shall be compensated at the rate of $200 per hour for their professional services on behalf of the commission, including necessary travel time. In addition, members of the commission shall be reimbursed for necessary travel expenses to the same extent and upon the same conditions as Wyoming State employees are reimbursed under the rules and regulations of the State Auditor.

Section 3. **Small Claims.** If the Division requests that the matter be resolved as a small claims hearing, the Notice of Referral shall include the following notice:

(a) The Division determines that the amount at issue is less than $2,000 and does not involve an issue of the compensability of the injury. The Division therefore requests that the matter be resolved as a small claims hearing as provided in W.S. § 27-14-602(b)(i).

(b) The purpose of a small claims hearing is to provide expedited review by a hearing examiner. In a small claims hearing, the Division will not pay a claimant’s attorney, nor will the Office of the Attorney General represent the Division.

(c) If any party objects to a small claims hearing request within 15 days of the notice, the hearing examiner will decide whether a small claims hearing or a contested case hearing is appropriate.

CHAPTER 7

BENEFITS

Section 1. Awards of Compensation.

(a) Computation of Disability Awards.

(i) Procedure for Determining Temporary Total Disability (TTD).

(A) Temporary wage rate is computed as follows:

(I) Hourly rate multiplied by the total number of hours worked within the employer's established work week = weekly rate;

(II) Weekly rate multiplied by 52 and divided by 12 = monthly rate.

(B) Overtime will be considered if verification is received from the employer as outlined in the definition of actual monthly earnings Chapter 1, Section 3(d)(i)(C).

(C) If a worker is paid other than hourly, weekly or monthly, the worker shall verify income by documenting at least three months of wage history with the worker's employer(s) at the time of the injury. If the worker cannot obtain three months of information, the Division shall obtain verification of average monthly wages from the employer(s).

(ii) Procedure for Determining Temporary Partial Disability (TPD). TPD benefits will be calculated by taking 80% of the difference between the light duty wage and the employee's actual monthly earnings at the time of injury.

(A) The claimant will receive TPD benefits plus light duty wages. The combination of earnings and benefits is intended to pay the claimant more than TTD alone, and as close to pre-injury wage as possible, but cannot exceed the statewide average monthly wage for the quarterly period in which the injury occurred.

(B) TPD will terminate when any of the following occurs:

(I) The claimant returns to work in a full duty capacity, without limitations or restrictions, with the pre-injury or new employer;

(II) The light duty wages are 95% or more of the claimant's pre-injury wage;

(III) The claimant is working more than one light duty, modified, or part-time job, and the total wages earned equal or exceed 95% of the pre-injury wage;

(IV) The claimant is unable to work at a gainful occupation for which he is reasonably suited by experience or training, and is certified temporarily totally disabled by his treating physician;

(V) The claimant incurred an ascertainable loss from the work-related injury and was given a PPI rating by his treating physician;

(VI) The claimant voluntarily terminates light duty employment due to non-injury related reasons.

(iii) Procedure for Determining Permanent Partial Disability (PPD). The award shall be calculated using the statutory formula which adds months to the award for each of five labor market factors: The worker's remaining work-life (14 months maximum), experience in other occupations (six months maximum), education (eight and one half months maximum), career plans (two months maximum) and age over 40 (three months maximum). The application for the award shall contain such information as the Division deems necessary to apply the formula. Workers older than 65 at the time of ascertainable loss will be deemed to be 65 years old for purposes of the formula.

(b) Computation of Impairment Award. The calculation of the award pursuant to W.S. § 27-14-405(g) will be based upon the percentage of whole body impairment as determined by the most recent edition of the American Medical Association Guides to the Evaluation of Physical Impairment or its successor publication.

(i) Permanent Partial Impairment Rating (PPI) Benefits Payment. After the Division receives a PPI rating from a physician, the Division shall compute the amount of benefits due, and offer a PPI award to the injured worker.

(A) If the injured worker disagrees with the PPI rating and requests a second impairment rating, the Division will schedule an appointment with an independent physician.

(I) Upon receipt of the second impairment rating the Division shall consider both ratings and issue a final determination.

Section 2. Benefit Suspension, Limitations and Discounting.

(a) Failure to Appear for Medical Appointment. TTD benefits shall be suspended if the worker fails to appear and cooperate in any examination or testing at an appointment with his health care provider(s), or one scheduled by the Division. Payment shall be suspended until such time as the worker appears at a subsequent rescheduled appointment. Payment will not be

suspended if:

(i) The worker notifies the Division prior to the appointment or within 24 hours after missing the appointment. The worker should call his claims analyst at the claims analyst's direct number and leave a message if the claims analyst is not available;

(ii) The Division determines that the worker made all reasonable efforts to appear at the appointment.

(b) Limitation on Period of Temporary Total Disability (TTD); Extraordinary Circumstance.

(i) The period for receiving a TTD award under W.S. § 27-14-404 resulting from a single incident, accident, or period of cumulative trauma or exposure shall not exceed a cumulative period of 24 months, except that the Division, in its discretion, may award additional TTD benefits if the claimant establishes by clear and convincing evidence that the claimant:

(A) Remains totally disabled, due solely to a work-related injury;

(B) Has not recovered to the extent that he or she can return to gainful employment;

(C) Reasonably expects to return to gainful employment within 12 months following the date of the first TTD claim occurring after the expiration of the 24- month period;

(D) Does not have an ascertainable loss which would qualify for benefits under W.S. §§ 27-14-405 or 406;

(E) Has taken all reasonable measures to facilitate recovery, including compliance with the recommendations of the treating physician.

(c) Discounting of Lump Sum Payments. Pursuant to W.S. § 27-14-403(f), awards to an injured worker or an injured worker's spouse for PPD, Permanent Total Disability (PTD) or death, or any part of such awards, may be discharged by the payment of a lump sum if the Administrator determines that a lump sum payment is justified by exceptional necessity. All lump sum payments shall be discounted using a discount factor determined by the State Treasurer's Office, based upon the average rate of return on the Division's investments for the prior fiscal year.

Section 3. Medical and Hospital Care.

(a) Health Care Benefits.

(i) Workers with injuries compensable under the Act shall be provided reasonable and necessary health care benefits as a result of such injuries.

(ii) Change of Health Care Provider. A worker wishing to change treating health care providers while under treatment shall file a written request with the Division, stating all reasons for the change and the name of the intended new treating health-care provider. The Division shall send notice of the change to the employer, the worker, and the current and intended new treating health care providers.

(iii) Medical Reimbursement to Injured Worker. Requests for reimbursement may be submitted to the Division by an injured worker for expense paid out-of-pocket for medical service(s) deemed reasonable, necessary and directly related to his work-related injury on a form provided by the Division.

(A) Requests for reimbursement will be considered only if the original receipt, which must be itemized, displays the transaction date, and substantiates proof of payment, is submitted with the Division's form.

(B) The Division may reimburse an injured worker 100% for the initial expense including taxes, paid out-of-pocket for prescribed medical service, prescribed drug or supply required to treat a compensable injury, when the service, drug or supply had been provided prior to the Division's notifying the injured worker of the case number assigned to his reported injury. The Division will not reimburse an injured worker for insurance co-pays or deductibles.

(C) Expenses incurred by an injured worker for over-the-counter (OTC) medication or medical supplies prescribed or recommended by the treating health care provider will be reimbursed at 100% of the purchase price, including taxes.

(iv) Travel Reimbursement. Reimbursement for travel necessary to obtain the closest available medical or hospital care needed by the employee will be payable at the rates provided for state employees in the rules and regulations of the State Auditor. W.S. § 27 14-401(d)(iii).

(A) Reimbursement for mileage will be based on map mileage from address to address and travel within the community of residence will only be paid if the distance exceeds ten miles one way.

(B) Requests for reimbursement of meal, lodging, bus, air travel, cab, train, parking, and other travel expenses must be accompanied by the original receipt. Reimbursement will not be paid for car rental expenses under any circumstances.

(C) Reimbursement for meals shall be paid as provided for state employees in the rules and regulations of the State Auditor.

(D) Unless medically necessary, there shall be no reimbursement for the travel and associated expenses incurred by other persons or for phone charges incurred

during such travel. Necessity for accompanied travel should be reflected in the documentation provided from the health care provider.

(E) Reimbursement for travel will be considered only if filed on the appropriate form provided by the Division.

(F) Claims for reimbursement shall be submitted to the Division within one (1) year from the date travel or other expenses were in

Rules, Regulations and Fee Schedules of the Wyoming Workers' Compensation Division

CHAPTER 8 - CHIROPRACTIC PANEL; REHABILITATION PANEL

Section 1. Chiropractic Panel. The Administrator shall establish a Chiropractic Panel to provide guidance to the Division in making recommendations and establishing utilization guidelines, which shall address the appropriateness and reasonableness for the care and treatment of injured workers, for use in auditing and adjudicating chiropractic claims. Membership on the panel is limited to those chiropractors that have a current license to practice in the state of Wyoming; are in good standing with the applicable state regulatory bodies; and have demonstrated special competence and interest in industrial health. The panel will provide guidance to the Division on utilization matters and standards of care, and will function as peer review for Division issues. The Administrator will solicit expressions of interest in serving on the panel from the membership of the Wyoming Chiropractic Association.

Section 2. Rehabilitation Panel. The Administrator shall establish a Rehabilitation Panel to provide guidance to the Division in making recommendations and establishing utilization guidelines, which shall address the appropriateness and reasonableness for the care and treatment of injured workers, for use in auditing and adjudicating physical, occupational and speech therapy claims. Membership on the panel is limited to those therapists that have a current license to practice in the state of Wyoming; are in good standing with the applicable state regulatory bodies, and have demonstrated special competence and interest in industrial health. Recruitment of the panel members will be by the Administrator who will solicit expressions of interest in serving on the panel from each therapy discipline's state association. This panel may include, but is not limited to members of Wyoming Physical Therapy Association, Wyoming Occupational Therapy Association, and/or Wyoming Speech-Language-Hearing Association.

CHAPTER 9
FEE SCHEDULES

Section 1. General Guidelines. Pursuant to Wyoming Statutes § 27-14-401(b), (e), and (g) medical and or hospital care shall be reviewed for appropriateness and reasonableness and shall be reimbursed according to the adopted schedule(s). The following guidelines are applicable to each section within this chapter.

(a) All claims shall be paid in accordance with the fee schedule in effect at the time of service.

(b) Certain services may be subject to preauthorization pursuant to Chapter 10 of these rules. These guidelines can be found at: http://www.wyomingworkforce.org/providers/preauth/

(c) The Division shall use accepted medical resources and publications to aid in adjudicating bills. This shall include, but not be limited to, the American Medical Association (AMA) (2020), Current Procedural Terminology codebook (CPT) (2020), the AMA Knowledge Base System (2020), and The American Academy of Orthopaedic Surgeons (2020), Complete Global Values Service Data for Orthopaedic Surgery Guidelines (2020), Centers for Medicare and Medicaid Services (CMS), and the Division's medical advisors.

(d) The Division may change billed codes to achieve compliance with the current rules and regulations. The provider payment statement shall advise of code changes and the right to appeal.

(e) Codes designated as Relativity Not Establish (RNE), or By Report (BR) shall be assigned the unit value of a comparable procedure or procedures.

(f) In no case shall any provider bill for charges greater than those charged the general public for like services.

(g) The Division shall not pay more than the total billed amount.

Section 2. Fee Schedules.

(a) The Division adopts *Relative Values for Physicians (RVP)* (2020 ed.), as published by Optum360, LLC, as authored by Relative Value Studies, Inc., insofar as it addresses medical matters under the Act unless otherwise defined in this chapter. The Division adopts *Relative Values for Dentists (RVD)* (2020 ed.), as published and authored by Relative Value Studies, Inc., Thornton, Colorado, insofar as it addresses dental matters under the Act.

(i) The Division has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (a) of this section;

(iii) The incorporated code, standard, rule or regulation is maintained at 5221 Yellowstone Road, Cheyenne, WY 82002 and is available for public inspection and copying at cost at the same location.

(b) Each code incorporated by reference in these rules is further identified as follows:

(i) *Relative Values for Physicians (RVP)* and *Relative Values for Dentists (RVD)*, (2020 ed.), as they were in effect on January 1, 2020, and adopted by the Department of Workforce Services, Wyoming Workers' Compensation Division.

(ii) National Correct Coding Initiative/Medicare Unlikely Edits, NCCI and MUE as they were in effect on January 1, 2020, and adopted by the Department of Workforce Services, Wyoming Workers' Compensation Division found at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

(c) Conversion Factors for Professional Fees. The Division adopts the following conversion factors.

SPECIALTY GROUP	CONVERSION FACTOR
Anesthesia	$ 51.06
Surgeon	$ 120.21
Radiology/Nuclear Medicine	$ 21.97
Pathology/Laboratory	$ 15.23
Medicine	$ 7.91
Physical Medicine	$ 6.39
Evaluation and Management	$ 8.34
Dental	$ 55.73

(d) Modifiers for Anesthesia and Surgical Assistants.

(i) Surgical Assistants.

(A) MD assistants shall be paid 20% of the surgical allowance.

(B) Non-MD assistants shall be paid 15% of the surgical allowance.

(ii) Anesthesia.

(A) All services are paid in accordance with the Wyoming Fee Schedules in effect at the time that services are rendered.

(B) Modifiers P1-P6 are suggested but not required.

(C) AA-anesthesia services performed by the Anesthesiologist, are paid at one hundred percent (100%) of the allowable fees.

(D) AD-medical supervision by a Physician with more than four (4) concurrent anesthesia procedures are paid at fifty percent (50%) of the allowable fees.

(E) QK-medical direction of two (2), three (3) or four (4) concurrent anesthesia procedures involving qualified individuals are paid at fifty percent (50%) of the allowable fees.

(F) QX-qualified non-physician Anesthetist with medical direction by a Physician are paid at fifty percent (50%) of the allowable fees.

(G) QY-medical direction of one qualified non-physician Anesthetist by an Anesthesiologist are paid at fifty percent (50%) of the allowable fees.

(H) QZ-CRNA (Certified Registered Nurse Anesthetist) without medical direction by a Physician are paid at one hundred percent (100%) of the allowable fees.

(e) Fees for Independent Medical Evaluations (IME), Permanent Partial Impairment Ratings (PPI), Medical Testimony and Deposition(s). See Chapter 10, and Chapter 9, Section 1 for additional guidelines. Medical bills must indicate total time spent on review of records, actual examination and writing of the report on the written report and the CMS-1500 claim form. The medical report must include a breakdown of the total time spent. Medical bills must also include time spent on travel, if applicable.

(i) Independent Medical Evaluations (IME) or Impairment Ratings. The Division shall pay according to the following fee schedule:

(A) If the IME or Impairment Rating is completed by the physician, use Code 99455. If the IME or Impairment Rating is completed by a physician, other than the treating healthcare provider, use Code 99456.

Code	**Time**	**Payment**
99455-99456	1st hour	$750.00
	Each additional 15 minutes	$93.75

(ii) Medical Testimony and Deposition Charges. The Division shall pay according to the following fee schedule:

Code	**Time**	**Payment**
99075	1st hour	$750.00
	Each additional 15 minutes	$65.00

Section 3. Fees for Home Health Nursing.

(a) The Division adopts the following fee-based schedule guidelines for home health nursing services being provided by independent Medicare/Medicaid certified agencies. This is a straight fee, no overtime, holiday rate, or shift differential shall be paid and Fair Labor Standards Act (FSLA) exempt. A visit equals a range of fifteen (15) minutes to a maximum of four (4) hours per day. See Chapter 10, Section 17 and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Per Visit Rate
RN	$146.50
LPN	$146.50
CNA	$66.34

(b) The Division adopts the following fee-based schedule guidelines for Private duty services/attendant care. This fee schedule is for long term daily care at home and is Fair Labor Standards Act (FSLA) exempt. This is a straight hourly fee, no overtime, holiday rate or shift differential shall be paid. See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Hourly Rate
RN	$35.00
LPN	$35.00
CNA	$16.00
*Attendant	*Federal minimum wage

*Attendant care includes personal care for activities of daily living. A physician prescription and time limit is required. Attendant care shall be provided by individuals approved by the primary treating health care provider.

Section 4. Fees for Supplies, Implants, Durable Medical Equipment (DME), Orthotics and Prosthetics.

(a) The Division adopts the Wyoming Medicare rate plus thirty percent (+30%) of the Healthcare Common Procedure Coding System (HCPCS) as the rates were published as of January 1, 2020 for the payment of supplies, DME, orthotics and prosthetic devices prescribed by a health care provider. See Chapter 9, Section 1 for additional guidelines. The Division shall not pay for any supplies, DME, orthotics, or prosthetics unless prescribed by the primary health care provider.

(i) The Division has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection a of this section;

(iii) The incorporated code, standard, rule or regulation is maintained at 5221

Yellowstone Road, Cheyenne, WY 82002 and is available for public inspection and copying at cost at the same location.

(b) Each code incorporated by reference in these rules is further identified as follows:

(i) Reference to Wyoming Medicare rate of the Healthcare Common Procedure Coding System (HCPCS) is adopted by the Division and effective on January 1, 2020, found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

(c) Any related charges for supplies, DME, orthotics and prosthetics not listed in the Medicare HCPCS fee schedule shall be paid at eighty percent (80%) of billed charges. Charges deemed excessive shall require additional documentation for justification.

(i) Any single supply/implant charged at $1,000.00 or more, shall require a suppliers' invoice. Reimbursement shall be at 130% of invoice cost. Shipping and handling charges shall not be reimbursed.

(ii) The Division shall not provide direct payment to suppliers or manufacturers for implantable items.

(d) The preceding fees are not intended to address newly developed items or technologies.

Section 5. **Fees for Hearing Aids/Prescription Lenses.** See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) The Division shall pay 130% of the supplier's/manufacturer's invoice price for hearing aids when the provider submits the invoice to the Division.

(b) The Division shall reimburse for frames and lenses as prescribed for compensable vision loss, or replacement due to a work-related accident, not to exceed 80% HCPCS usual and customary benchmarks as determined annually by the Division. The Division may demand additional documentation and justification for any charges deemed excessive by the Division.

(c) The Division shall reimburse an injured worker for the repair or comparable replacement of a hearing aid device or prescription lens damaged or destroyed in a work- related accident.

Section 6. Fees for Pharmacy Items. Pharmaceuticals must be billed with a National Drug Code (NDC). See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) Pharmaceuticals shall be reimbursed at the lower of:

(i) Average Wholesale Price (AWP) minus 10% plus a $5.00 dispensing fee; or

(ii) The provider's usual and customary charge. In no case shall any provider bill for charges greater than those charged to the general public for like services. The Division reserves the right to review such charges and reimburse at the usual and customary rate if a discrepancy is found.

(b) Reimbursement shall be decreased by $2.50 per prescription if a paper claim is submitted unless:

(i) The provider has received prior approval from the Division to submit a claim on paper.

(ii) Electronic billing is unavailable at the time of service making and it is unreasonable to submit the claim through the online process.

(c) Over the counter items that do not have a valid NDC number shall be considered supplies and shall not be paid with an added dispensing fee. See Chapter 9, Section 4 for additional guidelines.

(i) Please see the nutritional supplements section in Chapter 10, Section 18 for additional information.

(d) If the pharmaceutical is a repackaged drug, as determined by the NDC for the product dispensed, reimbursement shall be calculated per Section 6(a) using the AWP of the lowest cost therapeutic equivalent product.

(e) If a pharmaceutical intended for outpatient use is dispensed through the office of a medical care provider, reimbursement will be calculated per Section 6(a) – (d), equivalent to the reimbursement provided to a retail pharmacy.

Section 7. **Fees for Compounded Medications. –** See Chapter 10, Section 7, and Chapter 9, Section 1 for additional guidelines.

(a) Physicians billing for compounded drugs must provide the pharmacy invoice. The Division shall pay 130% of the supplier's/manufacturer's invoice price.

(b) Compounding pharmacies that bill directly, shall be compensated for the drugs prescribed and related materials in accordance with Chapter 9, Section 6. The Division shall allow a fee for compounding services. Compounding medications shall be reimbursed per line item if each ingredient is determined to be coverable per Chapter 10, Section 7, Compound Prescription Medications.

Section 8. **Fees for Ambulance Services.**

(a) Ambulance services shall be paid the lesser of the billed charge or the maximum allowable rate for the code appropriate for the documented service. The maximum allowable rates are all-inclusive. Mileage shall be reimbursed per documented loaded statute mile. See Chapter 9, Section 1 for additional guidelines. Contact the Division for additional information regarding Air Ambulance codes and reimbursement.

(b) The Division adopts CMS Medicare rates plus 10%, these rates can found at: https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/ambulance-fees

(c) The following codes shall be recognized by the Division:

Code	Short Descriptor	Maximum Allowable – Medicare plus 10%
A0425	Mileage, Ground	$8.45 per statute mile
A0426	Advance Life Support – 1, Non-Emergent	$387.60
A0427	Advance Life Support - 1, Emergent	$613.69
A0428	Basic Life Support, Non-Emergent	$322.99
A0429	Basic Life Support, Emergent	$516.79
A0433	Advance Life Support – 2	$888.24
A0434	Specialty Care Transport	$1,049.74

Section 9. Facility Fees.

(a) Fees for Inpatient Hospital Services.

(i) Inpatient hospital services shall be reimbursed in accordance with the CMES IPPS (Inpatient Prospective Payment System) payment methodology. With the Wyoming Base Rate ($5,801.13 + 30%): $7,541.47 and the MS-DRG (Medicare Severity-Diagnosis Related Group) weight according to the CMS Table 5 (for the corresponding year of service) found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables

(ii) Required documentation to support billed charges are as follows:

(A) Detailed itemization;

(B) Anesthesia graphic;

(C) Operative report;

(D) History and physical;

(E) Discharge summary;

(F) Implant Log/itemization; and,

(G) Supplier's invoice for any single supply/implant charged at one thousand dollars ($1,000.00) or more. Such items shall be reimbursed at one hundred thirty percent (130%) of invoice amount if the MS-DRG allows for a device special payment for device intensive procedures. Shipping and handling charges shall not be reimbursed.

(I) List of MS-DRGs that may quality for device special payment can be found at: https://www.cms.gov/medicaremedicare-fee-service-paymentacuteinpatientppsacute-inpatient-files-download/files-fy-2020-final-rule-and-correction-notice

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(v) Critical Access Hospitals (CAH) will be paid in accordance with the Tricare Cost-to-Charge Ratio's plus a twenty percent (20%) increase for the year of service submitted. More information can be found at: https://www.tricare-west.com/content/hnfs/home/tw/prov/claims/billing_tips/CAH_Reimbursement.html

(b) Fees for Skilled Nursing Services.

(i) Inpatient Skilled Nursing Services shall be reimbursed in accordance with the Annual Skilled Nursing Facility Per Diem Room Rate Survey conducted by the Division.

(ii) The per diem room rates for a semi-private bed shall be the usual and customary rates charged to the general public. Such rates shall be effective automatically on the first day of each calendar year.

(A) The per diem room rates will be all inclusive of the care for the claimant for the day. This includes but is not limited to:

(I) Administration of oxygen and related medication;

(II) Hand feedings;

(III) Incontinence Care;

(IV) Tray Service;

(V) Therapy Services, including physical therapy, occupational therapy, speech and language therapy;

(VI) Over the counter medications.

(B) Certain items are permitted to be billed outside of the per diem rate, such as:

(I) Ambulance services when medically necessary;

(II) Some durable medical equipment (DME) items;

(III) Wheelchairs;

(IV) Braces;

(V) Medical services including laboratory, radiology and surgical

procedures;

(VI) Physician and other practitioner services, excluding physical therapy, occupational therapy and speech and language therapy;

(VII) Prosthetics.

(c) Fees for Inpatient Rehabilitation Services.

(i) Inpatient Rehabilitation Services shall be reimbursed at eighty percent (80%) of billed charges.

(ii) Required documents to support billed charges are as follows:

(A) History and physical;

(B) Daily Notes including physician visits, therapy notes, nursing notes, etc.; and,

(C) Discharge summary, if applicable.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(d) Fees for Ambulatory Surgery Services.

(i) Ambulatory Surgery Services shall be reimbursed in accordance with Wyoming Medicare ASC (Ambulatory Surgery Center) rates at one hundred thirty percent (130%) of the allowed amount, found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC

(ii) Required documentation to support billed charges are as follows:

(A) Operative report.

(B) Implant Log/itemization – if applicable (device allowance will be calculated into the ASC total allowance).

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(e) Fees for Outpatient Facility Services.

(i) Outpatient Services shall be reimbursed in accordance with Wyoming Medicare

APC (Ambulatory Payment Classifications) rates at one hundred thirty percent (130%) of the allowed amount, found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC

(ii) Required documentation to support billed charges are as follows:

(A) Treatment notes to support the billed services.

(B) Physicians Order/Prescription.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

CHAPTER 10

MISCELLANEOUS MEDICAL PROTOCOLS

Section 1. Acupuncture.

(a) The Division shall pay for acupuncture procedures only if the services are performed by a health care provider as defined in W.S. § 27-14-102(a)(x), who is certified to perform acupuncture. Before the Division will issue any payment for acupuncture services, the health care provider shall submit to the Division proof of certification in acupuncture from an accredited school or a school that is a candidate foraccreditation.

(i) The Division shall pay for acupuncture procedures performed by Acupuncturists who have been issued a license to practice acupuncture by the Wyoming Board of Acupuncture. The Division will only consider payment to a fully licensed Acupuncturist upon receipt of written orders from the injured worker's treating health care provider specifying the diagnosis and number of sessions or time frame. To verify licensure go to: http://acupuncture.wyo.gov

Section 2. Alcohol and Drug Testing Protocols.

(a) Nothing in this rule is intended to authorize any employer to test any employee for alcohol or drugs in any manner inconsistent with constitutional, federal or statutory requirements.

(b) Nothing in this rule shall be construed to require an employer to test, or create a legal obligation upon the employer to request an employee to undergo drug or alcohol testing. An employer's decision to post-accident test should be consistent with their substance abuse and testing policy.

(c) All drug and alcohol testing, initial and confirmation, conducted in conjunction with the employer's drug-free workplace policy will be at the employer'sexpense.

(i) All testing for alcohol and controlled substances will be conducted in accordance with the requirements of 49 CFR Part 40, which procedures are designed toprotect the employee and the integrity of the testing process, safeguard the validity of the test results, and ensure those results are attributed to the correct employee.

(ii) Pursuant to 49 CFR Part 40, a covered employer may test for any and all metabolites: including synthetic forms of: Amphetamines; Marijuana (cannabinoids); Cocaine (benzolylecgonine); Opiates (codeine, morphine, heroin); PCP (phencyclidine); Alcohol; or any controlled substance subsequently subject to testing pursuant to drug testing regulations adopted by the United States Department of Transportation.

Section 3. Alternative Medicine. Except as provided in Section 10 of this Chapter, the Division will not authorize or pay for any alternative medicine treatments, defined as any medical practice or intervention that lacks sufficient documentation for safety or effectiveness

against specific conditions, or lacks a valid scientific base.

Section 4. Biofeedback. Biofeedback services shall be paid according to Chapter 9, Section 2 of these rules. The following conditions apply:

(a) individual meets the definition of "injury" under W.S. 27-14- 102(a)(xi); and,

(b) the services must be prescribed by the primary treating healthcare provider.

(c) Administration of biofeedback treatment is limited to those practitioners who are certified by the Biofeedback Certification Institute of America;

(d) Practitioners must submit a current copy of their biofeedback certification to the Division of Workers' Compensation;

(e) Treatment can be authorized when the following is presented to the Division:

(i) An evaluation report documenting:

(A) the basis for the injured worker's condition;

(B) the condition's relationship to the work injury;

(C) an evaluation of the injured worker's functional measurable modalities (e.g., range of motion, uptime, walking tolerance, medication intake, etc.);

(D) an outline of the proposed treatment program; and,

(E) an outline of the expected restoration goals.

(ii) The injured worker's progress must be documented in the medical records to include continued medical necessity, expected number of sessions, and ability to facilitate any further positive functional gains.

Section 5. Biological or Chemical Exposure Injury. The Division shall pay for the laboratory testing of any specimen collected from the body of an employee in order to determine his exposure to biological or chemical agents in covered employment, if such tests are ordered by the treating health care provider.

(a) If medical emergency response personnel determine that an employee should be treated in a hospital emergency room, the Division will pay for ambulance transportation from the place of exposure to the nearest hospital.

(b) The Division shall pay for hospitalization of the employee, subsequent to his receipt of treatment in an emergency room, if it is determined by the treating physician that in- patient confinement is necessary to establish the existence and extent of exposure, and to

diagnose the effects of the exposure.

(i) Except to the extent expressly provided, nothing in this section shall relieve a worker of the burden to prove the elements of an "injury" as defined by W.S. § 27-14-102(a)(xi).

Section 6. Blood-borne Pathogen Testing and Prophylactic Care.

(a) Benefits for human blood-borne pathogen testing and prophylactic care under W.S. § 27-14-501(a) shall be limited to the cost of reasonable and necessary initial and follow-up testing and reasonable and necessary prophylactic treatment. Benefits under this section shall be available only to workers reasonably believed to have incurred a potentially significant exposure.

(b) Nothing in this section shall limit benefits for testing and prophylactic care to any particular covered occupation or group of covered occupations included in the definition of "injury" under W.S. § 27-14-102(a)(xi) and prescribing reasonable prophylactic medical treatment during the disease's latency period.

(c) Except to the extent expressly provided, nothing in this section shall relieve a worker of the burden to prove the elements of an "injury" as defined by W.S. § 27-14-102(a)(xi).

(d) Nothing in this subsection shall limit benefits for an exposure to a disease that has resulted in an "injury" as defined in W.S. § 27-14-102(a)(xi).

(e) The Division will follow current recommendations of the Centers for Disease Control and Prevention for post-exposure prophylaxis.

Section 7. Compound Prescription Medications. The Division shall pay for compound prescription medications per Wyoming Workers' Compensation formulary listed at: http://www.wyomingworkforce.org/providers/bulletins/, National Drug Code (NDC) and the fee schedule listed in Chapter 9, Section 7 of these rules.

Section 8. Durable Medical Equipment (DME). The limitations in this section are in addition to any other limitations or restrictions that may apply to the Division's rental or purchase of any physical item or apparatus as a benefit under the Act.

(a) The Division will not rent or purchase or provide reimbursement for any physical item or apparatus for use by an injured employee unless there is proof that the item:

(i) is medically necessary for the documented compensable work injury;

(ii) is prescribed by a health care provider;

(iii) is the most cost effective method of meeting the medical need;

(iv) is not considered to be experimental or investigational;

(v) is designed to withstand repeated use in the home;

(vi) generally is not useful to a person in the absence of an illness or injury;

(vii) has primary purpose other than enhancing the personal comfort of the claimant or providing convenience for the claimant or caregiver;

(viii) is the type of item that is suitable and commonly provided for home use or mobility under employer provided health insurance coverage, Medicare or Medicaid; and,

(ix) generally has an expected lifetime of at least three (3) years.

(b) The Division may choose to rent or purchase any physical item or apparatus depending on its assessment as to which option is most reasonable and cost effective.

(c) DME Repair or Replacement. Requests for repair or replacement of equipment purchased by the Division shall be reviewed on an individual case-by-case basis. Approval will be dependent upon evidence the equipment was used in a safe and appropriate manner and, due to normal wear and tear, needs to be repaired or replaced. Evidence of improper use or abuse of equipment may warrant denial of the repair or replacement of the equipment.

(d) An injured worker or claimant shall be responsible for reasonable care and maintenance of any physical item or apparatus provided.

(i) The Division may cover needed repairs and maintenance when a professional is required and the services are not covered under warranty within the warranty period.

(ii) Providers shall not bill for equipment, parts, or services covered under manufacturer warranty within the warranty period.

(iii) The Division may require a copy of a warranty from the provider to be submitted upon request.

Section 9. Emergency or After Office Hours Care. Emergency or necessary after office hours care performed in a non-emergency room setting shall be coded 99058. This code shall be paid in addition to other services provided during the same visit. Emergency department services shall be billed using the appropriate CPT codes.

Section 10. Experimental Care. Experimental care is defined as any device, drug, procedure or test used in the delivery of medical, pharmaceutical, surgical or therapeutic services that are not customary and considered investigational, unusual, controversial and/or obsolete. The Division will neither authorize nor pay for these services.

Section 11. Functional Capacity Evaluation. A functional capacity evaluation

can be requested by the Division, the health care provider, or the employer to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. The functional capacity evaluation must be performed by a licensed physical therapist or occupational therapist credentialed or experienced in performing functional capacity evaluations, or a licensed medical doctor who practices rehabilitation medicine or physiatry and is credentialed or experienced in performing functional capacity evaluations. The functional capacity evaluation must have objective components which measure the validity of the test results.

Section 12. Hearing Aids. If it has been determined through medical examination and testing that an injured worker incurred a hearing impairment as a result of a compensable injury, the Division shall pay for examinations and testing of the ear(s), and the purchase of hearing aid device(s) approved by the Food and Drug Administration (FDA), and respective supplies, in order to restore the injured worker's hearing as close to pre-injury status as possible.

(a) A hearing test must be performed, and the results submitted to the Division, in order to substantiate the existence of a compensable hearing loss and to establish a base line from which to measure any potential increase in hearing impairment in the future.

(b) The Division shall pay for a replacement hearing aid only if the treating physician submits a written report to the Division, specifying that a new hearing aid is required due to an increase in hearing impairment which is directly related to the compensable injury. The report must include the results of a current hearing test, which evidences an increase in hearing impairment over the base line, or the results of the last hearing test on file with the Division.

(c) If the Division verifies that an employee's pre-existing hearing aid, not his hearing, was damaged or destroyed as a result of a work-related accident, the Division shall pay for one comparable replacement hearing aid.

(i) The Division will not pay for a cochlear implant, tympanoplasty, or other similar surgery as a replacement for a damaged or destroyed hearing aid device.

(ii) The Division will not pay for a subsequent replacement hearing aid if the first replacement hearing aid was lost, stolen, or broken.

Section 13. Home and Vehicle Modifications.

(a) Workers who have experienced a catastrophic injury may be eligible for home and vehicle modifications. Catastrophic injuries include, but are not limited to paralysis, quadriplegia, severe head trauma, amputation and multiple traumas. Requests for home or vehicle modifications will be reviewed by Division staff to determine if the home or vehicle modification meets the injured worker's needs for safety, mobility, and activities of daily living. Only one residence and one current vehicle of a catastrophically injured worker will be modified. Modifications must be reasonable and appropriate for the injured worker's actual functional disability and level of care.

(i) A home modification is defined as a physical structural change to an injured worker's permanent residence. If the injured worker does not own the property of his residence, he must obtain and submit to the Division written permission for structural modification and proof of ownership from the property owner before modifications will be considered.

(A) The Division will not pay for any structural modifications performed prior to the Division giving written consent.

(B) The Division will not pay to restore the modified structure to its original condition when the injured worker ceases to reside on the property.

(ii) Modifications can be done at the time a home is being built, but the Division shall only pay for the cost difference between a standard home structure and the modified structure. The modifications must be in compliance with accessibility standards.

(iii) The Division will not purchase any real estate or new or used motor vehicle for the injured worker.

Section 14. Impairment Ratings-Requirements.

(a) Pursuant to W.S. § 27-14-405(g) any physician determining permanent physical impairment shall:

(i) have a current, active, and unrestricted license to practice medicine, issued by a state medical board; and,

(ii) use the instructions and complete all required measurements referencing all tables contained in the *American Medical Association's Guide to the Evaluation of Permanent Impairment*. The Division requires impairment ratings to be submitted in the same format as the forms contained within that publication.

Section 15. Independent Medical Evaluation. The Division may require an employee to submit to an Independent Medical Evaluation by a non-treating health care provider for the purpose of obtaining a second opinion regarding the diagnosis, prognosis or treatment of an employee's injury complaints, or to obtain a permanent partial impairment rating of the residual affects attributed to a compensable injury per W.S. § 27-14-401(f). The evaluation may include: review of medical records, diagnostic studies, or other relevant materials; examination of the injured worker; consultations with other health care providers or Division representatives; and, any technical preparation by office staff.

(a) The Division may request a non-treating health care provider to conduct a paper review of an injured worker's medical records for the purpose of obtaining a second opinion regarding the diagnosis, prognosis, or treatment of an employee's injury complaints. When conducting a paper review, the health care provider conducting the review will be paid at the same rate as a physician who performed an Independent Medical Evaluation for the Division.

Section 16. Massage Therapy. Massage therapy treatment will be permitted when given by a massage practitioner upon written orders from the injured worker's treating health care provider. Massage therapy treatment must be under the direct supervision of a healthcare provider as defined in W.S. § 27-14-102(a)(x) and it is in conjunction with other therapy modalities.

Section 17. Nursing Services. No fee under this section shall be allowed by the Division without first reviewing the fee for appropriateness and reasonableness in accordance with its adopted fee schedules.

(a) Home Health Nursing Services.

(i) Home Health Nursing Services shall be intermittent, medically necessary, related to the work injury, documented in a plan of treatment, expected to last six (6) months or less, and ordered by a physician.

(ii) Initial prescriptions/orders for home health nursing services shall include the reason for home health skilled nursing, frequency, and duration.

(iii) Face to face visit. All new home health orders shall be accompanied by documentation of a face to face visit having occurred within ninety (90) days prior to the start of home health services.

(iv) Only independent Medicare/Medicaid certified agencies may provide home health nursing care;

(v) Only Certified Nurses Assistants, Licensed Practical Nurses, Licensed Vocational Nurses or Registered Nurses working for a Medicare/Medicaid certified agency can provide home health nursing care;

(vi) If the injured worker's residence is not within a fifty (50) mile radius of a Medicare/Medicaid certified agency, the Division may approve other alternatives such as Private Duty Nursing Services. Any such arrangement must have prior approval from the Division.

(vii) Home Health Nursing Services beyond six (6) consecutive months shall be reviewed by the Division to determine continued medical necessity.

(viii) Private Duty Services/Attendant Care. Private duty services/attendant care for long term daily care at home not being provided by a Home Health Agency, includes but not limited to; personal care for activities of daily living.

(ix) Initial prescriptions/orders for services shall include the reason for private duty services/attendant care, frequency, and duration.

(x) Private duty services/attendant care shall be provided by individuals who

are approved by the primary treating health care provider.

(xi) Private duty services/attendant care shall be paid for a maximum of twelve (12) hours per day per provider.

(xii) Private duty services/attendant care required beyond twelve (12) consecutive months shall be reviewed by the Division; every twelve (12) months thereafter to determine continued medical necessity.

(b) Disclaimer of Employment. Persons performing services in the home of an injured worker are not employees of the State of Wyoming. The provider or the provider's employer shall retain all responsibility for the payment of any and all federal income tax, state or federal unemployment insurance, state or federal social security premiums, and workers' compensation premiums that may be due.

(c) Fees. See Chapter 9, Section 3 for specific information on fees for homehealth nursing, private duty services and attendant care.

(d) Nursing Facility Care Referral Process.

(i) A referral for nursing facility placement shall be made by the treating health care provider. The referral shall be communicated to the Division by the treating health care provider and, when possible, the nursing facility, indicating the injured worker's medical needs require admission to or on the premises of a nursing facility. The request shall be reviewed by the Division for relatedness to the work injury and approved by the Director or designated representative. See Chapter 10, Section 28, Special Agreements for additional information on fee schedules and/or payment rates.

Section 18. Nutritional Supplements. The Division shall reimburse nutritional supplements, vitamins, and non-prescription drugs recommended by the treating health care provider, only if FDA approved and the supporting medical records document severe clinical dietary problems attributed to the compensable injury.

Section 19. **Off-label use of Medical Services.** Medications, treatments, procedures or other medical services used for other than the approved Food and Drug Administration (FDA) indications. These services should be medically necessary, i.e., have a reasonable expectation of cure or significant relief of a condition consistent with any applicable treatment parameter (Rules and Regulations Chapter 1, Section 3, Subsection (gg)). The Health Care Provider must document in the medical record the off-label use is medically necessary, and will submit to the Division a comprehensive review of the medical literature. This review will include at least two (2) reliable prospective, randomized, placebo-controlled, double-blind trial. The Division will consider the quality of the evidence and determine medical necessity.

Section 20. Payment for Medical Services and Professional Fees.

(a) Claims for medical services provided to an employee for a compensable injury, and any associated fees charged by professionals, will be denied if: they fail to comply with the

following standards for content of medical records:

(i) If handwritten, medical notes must be legible to anyone reading them,

(ii) If handwritten notes are illegible, medical notes must be typewritten,

(iii) Medical notes must include date of patient visit,

(iv) Medical notes must specify the reason for the encounter/visit and be described using the patient's own words,

(v) Medical notes must include a history and physical exam focused relative to patient's complaint to include a description of the findings of the examine relating to the reason for the complaint,

(vi) Medical notes must specify the diagnosis relative to the patient presenting complaint,

(vii) Medical notes must delineate a course of treatment consistent with the diagnosis,

(viii) The studies ordered of the patient must pertain to the complaint being addressed,

(ix) Medical notes must delineate the education instruction to the patient,

(x) Medical notes must contain an indication of the specifics of the follow-up care plan and include return-to-work expectations.

Section 21. Physical Medicine and Restorative Services.

(a) Chiropractors, physical therapists, physical therapist assistants, occupational therapists, and occupational therapist assistants may perform treatment modalities in the management of soft tissue injuries for the progressive development of strength and mobility, and to improve functional outcomes. An initial evaluation should document the diagnoses or clinical impression consistent with the presenting complaint(s) and the results of the examination and diagnostic procedures conducted. Subsequent visits performed require documentation of measured, objective, significant findings.

(b) The Division shall pay physical therapy and occupational therapy services only if they are provided pursuant to a prescription from the injured employee's primary treating health care provider, as defined in Chapter 1, Section 3 (mm) of these Rules.

(c) The Division shall monitor claims for services and may require provider to submit a formal written treatment plan or supplemental report detailing the medical necessity, specific goals, number of sessions and timeframes for review and authorization to continue the service. If the injured worker is not responding within the recommended duration periods, per

the assessment of the provider, other treatment interventions, further diagnostic studies or consultation may be considered.

(d) The Administrator adopts the *Rehabilitation Therapy Utilization Guidelines For The Care And Treatment of Injured Workers* and *Chiropractic Utilization Guidelines For The Care And Treatment Of Injured Workers*, which will be used by the Division in its evaluation and payment of physical therapy and chiropractic claims. These guidelines are available at: http://www.wyomingworkforce.org/providers/.

Section 22. Podiatry Treatment. Fees for services of a podiatrist will be limited to those allowed for minor surgery under the General Surgery section of the Relative Values for Physicians, as adopted in Chapter 9, Section 2 of these Rules.

Section 23. Preauthorization. The Division pursuant to its rules and regulations may issue a determination of preauthorization for an injured worker's nonemergency hospitalization, surgery or other specific medical care. W.S. § 27-14-601(o) as amended.

(a) Treatment rendered by a health care provider to a Wyoming workers' compensation claimant for injuries, will be professionally reviewed and preauthorized on issues of whether proposed treatment is reasonable, medically necessary and in compliance with the Division's rules, regulations and treatment guidelines. Such treatment guidelines shall be predicated on relevant medical literature consistent with current evidence-based medicine, or insurance industry standards or practices, or the guidance of the Medical Commission, and shall be available upon request. Policy establishing treatment guidelines shall be available in written format and also maintained on the Division's Internet web site located at: www.wyomingworkforce.org/providers/preauth/

(b) The Division will institute procedures of preauthorization and utilization review. Policy outlining the description, medical definitions, and a required list of treatments to be preauthorized shall be developed, implemented and maintained.

(c) The Division will inform Health Care Providers when treatment guidelines are expanded or modified, or there are changes in division policy or procedures.

(d) The Preauthorization Process

(i) Health Care Provider notification to the Division.

(A) The Health Care Provider must complete the request for preauthorization review form in writing, in advance of the injured worker receiving treatment for hospitalizations, surgeries or health care requiring preauthorization and submit it to the Division by fax, mail, or e-mail. The Provider Request for Preauthorization form can be obtained from the Division or through the Internet at: www.wyomingworkforce.org/providers/preauth/

(B) Concurrent with submission of the Provider Request for Preauthorization, the Health Care Provider must supply relevant clinical information. This

will include chart notes that document the injured worker's history, physical examination findings, diagnostic test results, treatment plan, and prognosis.

(ii) The Division will make a determination to authorize or deny treatment as requested per the preauthorization review form, pursuant to the procedures outlined in W.S. 27-14- 601(k).

(e) The Administrator or the Administrator's designee will make medical coverage decisions to ensure quality of care and prompt treatment of injured workers. Medical coverage policies and procedures will include, but are not limited to, decisions on health care services, hospitalizations, surgical procedures, medical care, pharmaceuticals, rehabilitative modalities, devices, diagnostic tests, ambulatory services, and supplies rendered for the purpose of diagnosis, treatment or prognosis.

Section 24. Pregnancy Tests. The Division shall pay for a pregnancy test only if it is ordered by an injured worker's treating health care provider to rule out pregnancy prior to performing a procedure or treatment considered potentially harmful to a fetus.

Section 25. Prescribed Drugs and Pharmacy Services.

(a) The Division shall pay for prescription and over-the-counter medications only if a prescription, written by the treating care provider is valid at the time of service.

(b) When medications prescribed for a compensable injury are dispensed on an out-patient basis, the Division will cover a brand name drug with an AB rated generic equivalent only if there is a documented medical necessity for utilization of the brand name. Prior authorization may be required for a brand name drug with an AB rated generic equivalent with the exception of certain drugs to be determined by the Division, to include specific anticonvulsant medications. The prescribing physician must provide the Division with medical justification for brand name medications, excluding anticonvulsants prescribed specifically for seizure control secondary to work injury.

(i) An injured worker may choose to pay the difference between the generic and the name brand product, in which case the Division shall pay only the wholesale generic price or substitute equivalent plus a dispensing fee.

(c) Healthcare providers directly dispensing prescriptions will be paid based on the original manufacturer's NDC code and the Wyoming Fee Schedule for pharmaceuticals as set forth in the *Rules Wyo. Dep't of Workforce Servs., Workers' Com. Div., Ch. 9, § 6(2019).*

Section 26. Prescription Lenses. If it has been determined through medical examination and testing that an injured worker incurred a visual impairment as a result of a compensable injury, the Division shall pay for examinations and testing of the eye(s), and the purchase of prescription lenses to restore the injured worker's vision as close to pre-injury status as possible.

(a) A vision test must be performed, and the results submitted to the Division, in order to substantiate the existence of a compensable vision loss and to establish a base-line

from which to measure any potential increase in visual impairment in the future.

(b) The Division shall pay for the replacement of prescription lenses only if the treating physician, ophthalmologist, or optometrist submits a written report to the Division which specifies that new lenses are required due to an increase in visual impairment which is directly related to the compensable injury. The report must include the results of a current eye examination, which results in an increase in visual impairment over the baseline, or the results of the last eye examination on file with the Division.

(c) If the Division verifies that an employee's prescription lenses and/or frames, not his vision, were damaged or destroyed as a result of a work-related accident, the Division shall only pay for one replacement of prescription lenses and/or frames and associated examination costs.

(i) The Division will not pay for cosmetic refractive procedures, or other laser type surgery as a replacement for damaged or destroyed prescription lenses.

Section 27. Smoking Cessation.

(a) Tobacco Cessation products, including varenicline (Chantix), nicotine patches, gum and lozenges, and bupropion (generic Zyban)**,** will be covered for appropriate clients undergoing a surgical procedure (including spinal fusion surgery), suffering from an orthopedic fracture or break, or with a wound in which healing may be negatively affected by smoking.

(b) A maximum coverage period of six (6) months will be approved for designated therapies.

Section 28. Special Agreements. The Division may enter into special agreements for services provided by, or under the direction of, licensed providers authorized to treat Wyoming claimants. Special agreements may be made for services not covered under the fee schedules adopted by the Division, and may include multi-disciplinary or interdisciplinary programs, pain management, work hardening, and physical conditioning, rehabilitation programs, and long-term nursing care. The Division shall establish payment rates for special agreements based on individual cases and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements, and other criteria to ensure injured workers receive good quality and effective services at a reasonable cost. The Division may terminate special agreements and programs upon 30 days written notice to the provider.

Section 29. Therapeutic Injections. Therapeutic injections such as trigger point injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks shall be compensable only if administered to anatomical sites where they are reasonably calculated to treat the compensable injury. Prior to the first injection, the health care provider shall document in the injured worker's medical record the medical necessity for the injections, other active modalities, and instructions for the injured worker's home exercise plan. If additional injections are indicated, the prescribing

health care provider shall provide subsequent documentation indicating the medical necessity and continued need for service in the injured worker's medical record. Payment for injections shall be based upon the appropriate CPT code. The Division will not pay for injections beyond a period of six (6) consecutive months unless the health care provider certifies the medical necessity and need for additional injections in the injured worker's medical record.

Section 30. Third Party Payments. No fee shall be paid to a third party unless the place of service or point of sale is identified on each bill.

Section 31. Vocational Evaluation. The Division may require an injured worker to participate in a vocational evaluation to determine his future employment potential, after he has applied for a permanent award, including permanent partial disability, loss of earnings for injuries occurring before July 1, 1994, and permanent total disability.

(a) A vocational evaluation must be performed by a qualified vocational evaluator.

(i) An evaluator is considered qualified if he possesses: a B.A. or B.S. degree and three years of experience in completing vocational evaluations; a Master's degree in Vocational Rehabilitation; or national certification as a vocational evaluator (CVE).

(b) The vocational evaluation report must be submitted in the format determined by the Division.

Section 32. Spinal Cord Stimulators. The Division shall not authorize payment for any neurostimulator procedures, including spinal cord dorsal stimulators and dorsal root ganglion neuroaugmentation, or any medical or surgical costs related to the placement, revision, or removal of any spinal cord stimulator.

CHAPTER 11

WORKPLACE SAFETY CONTRACTS

Section 1. Authority. The Department of Workforce Services (DWS) is authorized under the Department of Workforce Services Act W.S. 9-2-2602(b)(vi) and W.S. 9-2-2608(c), and the Wyoming Administrative Procedures Act, W.S. 16-3-101, *et seq.* to promulgate rules and regulations to be used by the Department of Workforce Services in the discharge of its functions.

Section 2. Purpose. The Workplace Safety Contracts program provides opportunities for public and private sector employers to enhance or implement workplace safety programs, including assistance in purchasing occupational health or safety equipment or for the provision of workplace safety training, which exceed OSHA and/or MSHA standards. These rules and regulations are adopted by the Department of Workforce Services pursuant to the requirements and authority granted by W.S. 9-2-2601(g)(vii) and W.S. 9-2-2608(a) through (d).

Section 3. Definitions.

(a) "Administrator" means the Administrator of the Department of Workforce Services, Standards and Compliance, or his/her designee.

(b) "Applicant" means any business, proprietor or business entity that applies for a Workplace Safety Contract.

(c) "Consultation" means technical assistance, consultation program, and safety specialists within the Department of Workforce Services.

(d) "Department" means the Department of Workforce Services (DWS), Workers' Compensation Division.

(e) "Director" means the Director of the Department of Workforce Services.

(f) "Employee" means any person as defined by W.S. 27-14-102(a)(vii)(A) through (R).

(g) "MSHA" means the Mine Safety and Health Administration or Wyoming Mine Inspector.

(h) "OSHA" means the Occupational Safety and Health Administration, a division within the Department of Workforce Services.

(i) "Panel" means the group of DWS professionals reviewing applications; comprised of at least the DWS Director or Administrator or his/her designee, a Consultation member, Safety Specialist, a Risk Manager and the State Occupational Epidemiologist.

(j) "Program" means the Workplace Safety Contracts Program.

Section 4. Application Process and Eligibility Requirements.

(a) Eligibility. Program eligibility requires the Applicant to be registered and in good standing with the Department at the time of application submission and contract payment. The program also requires the applicant be in good standing with Wyoming Unemployment Insurance and the Secretary of State.

(i) Preference will be granted to Applicants who are currently enrolled in the Safety Discount Program, Drug-Free Workplace Program, Health & Safety Consultation Discount Program or the Deductible Program.

(b) Application Process. Applications for the Program will be reviewed on a quarterly basis. Applications will be reviewed by the Panel to determine the following:

(i) The application demonstrates how the purchase of equipment or training will alleviate existing or potential hazards in the Applicant's workplace.

(ii) The equipment or training applied for goes above and beyond OSHA or MSHA minimum requirements for the Applicant's industry.

(iii) The Applicant indicates how funding from the program will reduce workplace injury frequency and severity.

(iv) The Applicant has clearly shown what equipment or training will be purchased, to include product or course information and cost information.

(v) The Applicant has applied for allowable expenses, such as:

(A) Equipment directly related to the Applicant's employee safety.

(B) Direct training costs which include tuition, registration, class fees, class materials, and trainee travel costs directly related to the training; along with instructor's fees and instructor travel fees when the instructor is brought to the Applicant's location for training when the instructor is not an employee of the Applicant.

(vi) Applications requesting non-allowable items, as listed below, may receive an automatic denial, with no review by the Panel.

(A) Capital construction of any kind;

(B) Employee wages or benefits of any kind;

(C) Assessments, testing and certification exams not included in the cost of training;

(D) Any and all equipment or training intended to meet minimum OSHA or MSHA minimum standard;

(E) Office interventions or ergonomic equipment, including but not limited to chairs, anti-fatigue mats, standing desks, etc.;

(F) Any personal protective equipment (PPE) required to meet minimum industry standards;

(G) Passive Devices;

(H) Basic equipment replacements;

(I) Heavy equipment, including, but not limited to skid steers, front end loaders, bobcats, mules, forklifts, scissor lifts etc.;

(J) Powered hand tools;

(K) Equipment which would provide the Applicant with a competitive industry advantage;

(L) Rented or leased equipment;

(M) Any and all first aid equipment, including Automated External Defibrillators (AED's);

(N) Lighting;

(O) Vehicle lifts;

(P) Vehicles: all driven vehicles, including but not limited to cars, trucks, utility vehicles, gators, tractors, ATV's, four wheelers, personal watercraft;

(Q) Health or safety subscriptions, including but not limited to magazine and video libraries; or,

(R) Any equipment or training purchased prior to the application submission and/or prior to contract execution;

(c) Approval Process. Once an application has been approved, the Department will enter into a contract with the Applicant, to be written by a Risk Manager and signed by the Attorney General. The contract will state that:

(i) One hundred percent (100%) of the funds for the program not including matching funds shall be remitted to the Applicant after the contract is fully executed.

(ii) Funds will be paid directly to the Applicant.

(iii) Funds expended through the Program must be used within ninety (90) days of contract execution, unless an extension has been granted by the Administrator and/or his/her designee.

(d) Denial of Application. **S**hould an application for funding be denied, the Applicant may request an appeal or reconsideration within thirty (30) days. The request must:

(i) Be submitted to the Panel in writing.

(ii) Clearly outline why the Panel should reconsider the application.

(iii) State whether or not the Applicant would like a meeting scheduled to discuss the appeal with the Panel.

Section 5. Applicant Reporting. An Applicant who has been approved for funding through the Program shall submit reports, in a format provided by the Department, as outlined in the Program contract and W.S. 9-2-2608(b).

Section 6. Remittance of Unused Program Funds. The Applicant shall repay the Department any portion of funding not used for the approved training and/or equipment, as delineated by the Program Contract.

CHAPTER 12
FISCAL PROVISIONS

Section 1. Rehabilitation Expenses-Funds Transfer. Expenses incurred for administrative costs under W.S. § 27-14-408 shall be paid by the Division of Vocational Rehabilitation (DVR) of the Department of Workforce Services. The funds for program expenses shall be advanced by the Workers' Compensation Division on not more than a quarterly basis. The amount to be advanced shall be determined by the established caseload average expenses. If the client is eligible under state criteria the Workers' Compensation Division will advance the total expenses incurred within the limits allowed under W.S. § 27-14-408(e)(ii). If the client meets federal criteria, the Workers' Compensation Division will advance the nonfederal share of expenses up to the required state matching rate under the Federal Rehabilitation Act within the limits allowed under W.S. § 27-14-408(e)(ii).

(a) DVR shall develop an Individualized Plan for Employment, which will itemize or identify all costs of the Plan not to exceed $30,000.00. The total cost of each Plan will be charged to the employer's workers' compensation account in the following manner:

(i) 100% of the stipend paid to an injured worker for living expenses; and

(ii) 21.3% of any additional expenses which may include, but are not limited to, tuition, books, supplies, equipment, and program expenditures.

CHAPTER 13

PRESUMPTION OF DISABILITY FOR CERTAIN DISEASES

Section 1. Authority.

(a) These rules are promulgated pursuant to authority granted in Wyoming Statute § 27-14-616.

(b) These rules only apply to claims submitted under Wyoming Statutes §§ 27-15-101 – 27-15-103.

Section 2. Hearing Requirements.

(a) All requests for hearings will follow W.S. §27-14-601, W.S. § 27-14-602 and W.S. § 27-14-616.

RULES OF THE WYOMING OFFICE OF ADMINISTRATIVE HEARINGS APPLICABLE TO WORKERS' COMPENSATION CASES

The Wyoming Office of Administrative Hearings ("OAH") has jurisdiction over any workers' compensation case that is not medically contested. The following section contains rules promulgated by the OAH applicable to workers' compensation hearings held before it. These rules are distinct from rules promulgated by the Medical Commission or those promulgated by the Wyoming Safety and Compensation Division. For a fuller discussion of the OAH see the Treatise at Chapter 6.9.

CHAPTER 5

SPECIAL RULES RELATING TO WORKERS' COMPENSATION

Section 1. **General Construction.** These special rules relating to workers' compensation contested case proceedings before the Office are intended to supplement the foregoing provisions of Chapter 2. To the extent that any difference exists, the special rule takes precedence over any foregoing provision.

Section 2. **Filing and Service of Papers.** In all workers' compensation contested cases, the parties shall file all original documents, pleadings, and motions with the Workers' Compensation Division, with true and complete copies of the particular document, pleading, or motion properly served on all other parties or their attorneys, and this Office. Wyo. Stat. Ann. §§ 27-14-601(n) and 27-14-602.

Section 3. **Appointed Attorney.**

(a) The hearing examiner may appoint an attorney to represent an employee or claimant.

(b) Upon entry of a final order, an appointed attorney may request payment of reasonable fees and costs. All requests for fees and costs shall be verified and shall detail time spent and work performed. Permitted fees include:

(i) attorney's fees billed at an hourly rate of one hundred fifty dollars ($150.00);

(ii) paralegal and legal assistant fees billed at an hourly rate of forty dollars ($40.00). Reimbursable paralegal and legal assistant fees are those tasks requiring legal skill and knowledge. Clerical and secretarial tasks are not reimbursable and shall not be billed at a paralegal or legal assistant rate;

(iii) costs: appointed attorneys may request reimbursement of actual expenses reasonably incurred, with respective invoices/bills attached (e.g. expert witness fees, costs to obtain pertinent medical records, reasonable and customary postage costs, and subpoena costs). Copying costs shall be paid at no more than fifteen cents (15¢) per copy. If reasonably incurred, attorney's travel time shall be paid at one-half the hourly rate for attorney's fees; and

(iv) prevailing employer's attorney fees and costs billed at the rates established in this section in any contested case where the issue is the compensability of an injury.

(c) All requests for fees and costs shall be submitted to the Office within ninety (90) days of the final order. Any request for fees and costs not timely submitted shall be denied unless good cause is shown. Requests for fees and expenses of appointed attorneys shall include the attorney's certification that the fee statement is true and correct. The request shall additionally indicate the source (i.e., from the workers' compensation account, from amounts

awarded to the employee or claimant, or from the employer) from which the fees and expenses are proposed to be paid. Requests shall be properly served on all parties.

(d) No fee shall be awarded in any case in which the hearing examiner determines the claim to be frivolous or without legal or factual justification.

Section 4. **Record of Proceedings.** The presiding hearing officer shall assure that a record of the proceeding is kept pursuant to Wyoming Statute § 16-3-107(p). The cost of reporting the contested case evidentiary hearing shall be paid in accordance with Wyoming Statute § 27-14-602(c).

Section 5. **Referral to the Medical Commission.**

(a) Upon agreement of all the parties to a case, the hearing examiner may refer a medically contested case to the Medical Commission for hearing and final decision of all issues in the case.

(b) Upon agreement of all the parties to a case, the hearing examiner may refer a case to the Medical Commission for advice on specified medical issues. The hearing examiner will make the final decision on all issues in the case, and referrals for advice will be made only after the evidence in the case is closed. The parties shall have an opportunity to file written exceptions to the advice received from the Medical Commission and any exceptions, along with the advice received, shall become part of the record in the case.

Section 6. **Hearing Deadline.** In all workers' compensation cases, the contested case hearing shall be conducted, and the official record closed, no more than eleven (11) months after the first order setting hearing is issued. The hearing examiner shall issue final findings of fact, conclusions of law, and order no more than thirty (30) days after the record is closed.