



THE STATE CHAMBER OF OKLAHOMA
LEGISLATIVE ADVOCATES FOR BUSINESS

330 NE 10th Street
Oklahoma City, OK 73104
(405) 235-3669 - phone (405) 235-3670 - fax

**Overview of Committee Substitute
SB 1973 – February 15, 2010
Senator Glenn Coffee**

SECTION 1 – Pages 2-3

New Law: Allows any labor organization to opt out of the Workers' Compensation Act "...upon assurance by the organization and approval of the Administrator of the Workers' Compensation Court of a system within the organization for payment of benefits for injuries to employees arising out of and in the course of employment."

SECTION 2 – Page 3

New Law: Requires any insurer transacting workers' compensation insurance in Oklahoma to maintain an insurance adjuster within the state of Oklahoma.

SECTION 3 – Pages 3-7

Amendatory: Reduces the number of w.c. judges from ten to eight (eliminating positions #9 and #10); basing five in Oklahoma City and three in Tulsa; changes their term of office from six years to eight years, and allowing them only one term; current judges will be allowed to apply for one more eight-year term; all judges shall be confirmed by the Senate; all judges must have at least five years of workers' compensation experience; eliminates the Court en banc and replaces it with a "panel of Special Magistrates"

SECTION 4 – Pages 7-8

Amendatory: Allows the Administrator of the Workers' Compensation Court to serve for four years maximum, subject to Senate confirmation.

SECTION 5 – Pages 9-11

New Law: Creates the position of Medical Director of the Workers' Compensation Court (subject to the Presiding Judge of the W.C. Court and the Chief Justice of the Supreme Court) and sets out tasks – oversee medical maintenance of claimants; institute administrative procedures to enable evaluation of medical care in w.c. cases; inquire in cases where medical treatment or physical rehabilitation appears to be deficient or incomplete; advise on complaints of adequate medical care; gather data; conduct studies on medical aspects of w.c. cases; expedite submission and processing of medical reports; and, any other function delegated.

SECTION 6 – Pages 11-24

Amendatory: Definitions Section –

16. “Major cause” means ~~the predominate cause of the resulting injury or illness~~ more than fifty percent (50%) of the cause. A finding of major cause shall be established by a preponderance of the evidence;

17. “Objective medical evidence” means evidence which meets the criteria of Federal Rule of Evidence 702 and all U.S. Supreme Court case law applicable thereto. Objective findings are those findings which cannot come under the voluntary control of the patient. When determining physical or anatomical impairment, neither a physician, any other medical provider, a judge of the Workers' Compensation Court, nor the courts may consider complaints of pain. For the purpose of making physical or anatomical impairment ratings to the spine, straight-leg-raising tests or range-of-motion tests shall not be considered objective findings. Objective evidence necessary to prove physical or anatomical impairment in occupational hearing loss cases may be established by medically recognized and accepted clinical diagnostic methodologies, including, but not limited to, audiological tests that measure air and bone conduction thresholds and speech discrimination ability. Any difference in the baseline hearing levels must be confirmed with a subsequent test within the next four (4) weeks but not before five (5) days and being adjusted for presbycusis. Medical opinions addressing compensability and permanent impairment must be stated within a reasonable degree of medical certainty.

SECTION 7 – Pages 24-30

Amendatory: Eliminated the Court en banc and replaces it with a “panel of Special Magistrates”. Such panel shall consist of three judges appointed by the Supreme Court, none of whom shall have served as a judge of the Workers' Compensation Court, but who shall have at least five years of w.c. experience. All of the authorities and powers of the old court en banc are retained by the new panel of Special Magistrates.

SECTION 8 – Pages 30-33

Amendatory: Makes mediation mandatory. Sets out how such mediation is to be requested and handled. States that “Mediation completed pursuant to the dispute resolution procedures of a certified workplace medical plan shall satisfy the requirements of this section.”

SECTION 9 – Pages 33-40

Amendatory: Sets out a new type of injury which is exempt from the Workers' Compensation Act:

“5. An injury which occurs outside the course of employment. Employment shall be deemed to commence when an employee arrives at the employer's place of employment to report for work and shall terminate when the employee leaves the employer's place of employment, excluding areas not under the control of the employer; provided, however, when the employee is required by the employer to be away from the employer's place of employment, the employee shall be deemed to be in the course of employment when the employee is engaged in the direct performance of duties assigned or directed by the employer; but the employment of employee paid travel time by an employer for time spent traveling to and from a job site or of any employee who utilizes an employer-authorized vehicle shall commence and terminate with the time spent traveling to and from a job site or the authorized operation of a vehicle on business authorized by the employer. Travel by a policeman, fireman, or a member of a first aid or rescue squad, in responding to and returning from an emergency, shall be deemed to be in the course of employment.

Employment shall also be deemed to commence when an employee is traveling in a ridesharing arrangement between his or her place of residence or terminal near such place and his or her place of employment, if one of the following conditions is satisfied: the vehicle used in the ridesharing arrangement is owned, leased or contracted for by the employer, or the employee is required by the employer to travel in a ridesharing arrangement as a condition of employment. "Ridesharing" means the transportation of persons in a motor vehicle, with a maximum carrying capacity of not more than fifteen (15) passengers, including the driver, where such transportation is incidental to the purpose of the driver. This term shall include such ridesharing arrangements known as carpools and vanpools.”

SECTION 10 – Pages 40-42

Amendatory: Clarifies exclusive remedy.

“Section 12. The liability prescribed in Section 11 of this title shall be exclusive and in place of all other liability of the employer and any of his employees, any architect, professional engineer, or land surveyor retained to perform professional services on a construction project, at common law or otherwise, for such injury, loss of services, or death, to the employee, or the spouse, personal representative, parents, or dependents of the employee, or any other person, except in the case of an intentional tort, or where the employer has failed to secure the payment of compensation for the injured employee as provided for in this title. An intentional tort shall exist only when the employee is injured as a result of willful, deliberate, specific intent of the employer to cause such injury. The issue of whether an act is an intentional tort shall be a question of law for the court.”

SECTION 11 – Pages 42-52

Amendatory to Section 14 of Title 85: Deals with restrictions on light duty work. Eliminates the requirement by the treating physician to specify what restrictions must be followed by the employee upon his/her return to work; Changes how such light duty is to be offered and the ramifications if it's not offered by the employer or turned down by the employee:

~~“...If an injured employee, only partially disabled, refuses employment consistent with any restrictions ordered by the treating physician, the employee shall not be entitled to temporary benefits during the continuance of such refusal unless in the opinion of the treating physician such refusal was justifiable~~ In the event that the treating physician releases a claimant for light duty work and provides written restrictions from normal work duties, the employer shall make a good faith effort to provide a light duty position at the same rate of pay that the claimant was receiving on the date of the injury. If such light duty is offered to the claimant, and the claimant refuses to accept the light duty assignment, the claimant is not entitled to temporary total disability;”

States that “the good faith requirement set forth herein shall not constitute an independent cause of action.”

Adds a new paragraph dealing with penalties:

J. The Administrator shall impose administrative penalties for abusive practices and shall waive payment for medical services to any treating physician who is not in compliance with the provisions of this section. Noncompliance with the provisions of this section by an employee and without good cause shall cause the employee to forfeit his or her permanent award.

SECTION 12 – Pages 52-98

Amendatory to Section 22 of Title 85: Changes duration of Permanent Total Disability: from “during the continuance of such total disability” to “until such time as the employee becomes eligible for Medicare.”

Changes maximum for Permanent Partial Disability from “50% of the state’s average weekly wage” to “50% of the state’s average weekly wage in effect October 2008” and institutes a new schedule of benefits:

Thumb: For the loss of thumb, sixty-six (66) weeks.

First Finger: For the loss of the first finger, commonly called the index finger, thirty-nine (39) weeks.

Second Finger: For the loss of a second finger, thirty-three (33) weeks.

Third Finger: For the loss of a third finger, twenty-two (22) weeks.

Fourth Finger: For the loss of a fourth finger, commonly called the little finger, seventeen (17) weeks.

Phalange of Thumb or Finger: The loss of the first phalange of the thumb or finger shall be considered equal to the loss of one-half (1/2) of such thumb or finger, and compensation shall be

one-half (1/2) of the amount above specified; the loss of more than one phalange shall be considered as the loss of the entire thumb or finger; provided, however, that in no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

Great Toe: For the loss of a great toe, thirty-three (33) weeks.

Other Toes: For the loss of one of the toes other than the great toe, eleven (11) weeks.

Phalange of Toe: The loss of the first phalange of any toe shall be considered to be equal to the loss of one-half (1/2) of the amount specified. The loss of more than one phalange shall be considered as the loss of the entire toe.

Hand: For the loss of a hand, two hundred twenty (220) weeks.

Arm: For the loss of an arm, two hundred seventy-five (275) weeks.

Foot: For the loss of a foot, two hundred twenty (220) weeks.

Leg: For the loss of a leg, two hundred seventy-five (275) weeks.

Eye: For the loss of an eye, two hundred seventy-five (275) weeks.

Deafness: Deafness from industrial cause, including occupations which are hazardous to hearing, accident or sudden trauma, three hundred thirty (330) weeks, and total deafness of one ear from industrial cause, including occupations which are hazardous to hearing, accident or sudden trauma, one hundred ten (110) weeks. Except as otherwise provided herein, any examining physician shall only evaluate deafness or hearing impairment in accordance with the latest publication of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" in effect at the time of the injury. The Physician Advisory Committee may, pursuant to Section 201.1 of this title, recommend the adoption of a method or system to evaluate permanent impairment that shall be used in place of or in combination with the American Medical Association's "Guides to the Evaluation of Permanent Impairment". Such recommendation shall be made to the Administrator of the Workers' Compensation Court who may adopt the recommendation in part or in whole. The adopted method or system shall be submitted by the Administrator to the Governor, the Speaker of the House of Representatives and President Pro Tempore of the Senate within the first ten (10) legislative days of a regular session of the Legislature. Such method or system to evaluate permanent impairment that shall be used in place of or in combination with the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be subject to disapproval in whole or in part by joint or concurrent resolution of the Legislature during the legislative session in which submitted. Such method or system shall be operative one hundred twenty (120) days after the last day of the month in which the Administrator submits the adopted method or system to the Legislature if the Legislature takes no action or one hundred twenty (120) days after the last day of the month in which the Legislature disapproves it in part. If adopted, permanent impairment shall be evaluated only in accordance with the latest version of the alternative method or system in effect at the time of injury. Except as otherwise provided in Section 11 of this title, all evaluations shall include an apportionment of injury causation. However, revisions to the guides made by the American Medical Association which are published after January 1, 1989, and before January 1, 1995, shall be operative one hundred twenty (120) days after the last day of the month of publication. Revisions to the guides made by the American Medical Association which are published after December 31, 1994, may be adopted in whole or in part by the Administrator following recommendation by the Physician Advisory Committee. Revisions adopted by the Administrator shall be submitted by the Administrator to the Governor, the Speaker of the House of Representatives and President Pro Tempore of the Senate within the first ten (10) legislative

days of a regular session of the Legislature. Such revisions shall be subject to disapproval in whole or in part by joint or concurrent resolution of the Legislature during the legislative session in which submitted. Revisions shall be operative one hundred twenty (120) days after the last day of the month in which the Administrator submits the revisions to the Legislature if the Legislature takes no action or one hundred twenty (120) days after the last day of the month in which the Legislature disapproves them in part. The examining physician shall not follow the guides based on race or ethnic origin. The examining physician shall not deviate from such guides or any alternative thereof except as may be specifically provided for in the guides or modifications to the guides or except as may be specifically provided for in any alternative or modifications thereto adopted by the Administrator of the Workers' Compensation Court as provided in Section 201.1 of this title. The guides or modifications thereto or alternative system or method of evaluating permanent impairment or modifications thereto shall be the exclusive basis for testimony and conclusions with regard to deafness or hearing impairment.

Loss of Use: Permanent loss of use of a thumb, finger, toe, arm, hand, foot, leg or eye shall be considered as the equivalent of the loss of such thumb, finger, toe, hand, arm, foot, leg or eye.

For the permanent partial loss of use of a member, loss of hearing or sight of an eye, seventy percent (70%) of the employee's average weekly wage during that portion of the number of weeks in the foregoing schedule provided for the loss of such member or sight of an eye which the partial loss of use thereof bears to the total loss of use of such member, loss of hearing or sight of an eye.

Amputations: Amputation between the elbow and the wrist shall be considered as the equivalent of the loss of a hand. Amputation between the knee and the ankle shall be considered as the loss of a foot. Amputation at or above the elbow shall be considered as the loss of an arm. Amputation at or above the knee shall be considered as the loss of a leg.

The compensation for the foregoing specific injuries shall be in lieu of all other compensation except the benefits provided in Section 14 of this title and Section 16 of this title.

In case of an injury resulting in serious and permanent disfigurement, compensation shall be payable in an amount to be determined by the Court, but not in excess of Twenty Thousand Dollars (\$20,000.00) for an injury occurring before November 1, 2005, and not in excess of Fifty Thousand Dollars (\$50,000.00) for an injury occurring on or after November 1, 2005; provided, that compensation for permanent disfigurement shall not be in addition to the other compensation provided for in this section but shall be taken into consideration in fixing the compensation otherwise provided.

Hernia: In case of an injury resulting in hernia, temporary total compensation for six (6) weeks, and all necessary medical costs including, but not limited to, the cost of an operation shall be payable. A claimant who has had surgery for a hernia may petition the court for one extension of temporary total compensation and the court may order such an extension, not to exceed six (6) additional weeks, if the treating physician indicates such an extension is appropriate, or as agreed to by all parties.

Soft Tissue Injury: In case of a nonsurgical soft tissue injury, temporary total compensation shall not exceed eight (8) weeks. A claimant who has been recommended by a treating physician for surgery for a soft tissue injury may petition the Court for one extension of temporary total compensation and the court may order such an extension, not to exceed sixteen (16) additional weeks, if the treating physician indicates that such an extension is appropriate or as agreed to by all parties. In the event the surgery is not performed, the benefits for the extension period shall be terminated. For purposes of this section, "soft tissue injury" means

damage to one or more of the tissues that surround bones and joints. "Soft tissue injury" includes, but is not limited to: sprains, strains, contusions, tendonitis, and muscle tears. Cumulative trauma is to be considered a soft tissue injury. "Soft tissue injury" does not include any of the following:

(1) Injury to or disease of the spine, spinal disks, spinal nerves or spinal cord, where corrective surgery is performed;

(2) Brain or closed-head injury as evidenced by:

- a. sensory or motor disturbances,
- b. communication disturbances,
- c. complex integrated disturbances of cerebral function,
- d. episodic neurological disorders, or
- e. other brain and closed-head injury conditions at least as severe in nature as any condition provided in subdivisions a through d of this division; or

(3) Total knee replacement.

In all cases of soft tissue injury, the employee shall only be entitled to appropriate and necessary medical care and temporary total disability as set out in paragraph 2 of this section, unless there is objective medical evidence of a permanent anatomical abnormality. In determining the existence of such an abnormality, the Court may consider if there is credible medical evidence that the ability of the employee to earn wages at the same level as before the injury has been permanently impaired.

Other Cases: In all other classes of disabilities, excluding only those heretofore referred to in this paragraph, which disabilities result in loss of use of any portion of an employee's body, and which disabilities are partial in character but permanent in quality, disability shall mean the percentage of permanent impairment. The compensation ordered paid shall be seventy percent (70%) of the employee's average weekly wage for the number of weeks which the partial disability of the employee bears to five hundred (500) weeks. No permanent disability shall be awarded unless there is objective medical evidence, as defined in Section 3 of this title, of a permanent anatomical abnormality. In determining the existence of such an abnormality, the Court may consider if there is credible medical evidence that the ability of the employee to earn wages at the same level as before the injury has been permanently impaired.

SECTION 13 – Pages 98-101

Amendatory: Requires physicians to use the “current edition of the AMA Guides to Permanent Impairment” and eliminates the choice of using “or modifications thereto”.

SECTION 14 – Pages 101-110

Amendatory: Requires the Administrator of the Workers' Compensation Court to ensure all findings shall be based upon the most recent edition of the American Medical Association's “Guides to the Evaluation of Permanent Impairment.”

Deletes the ability of the Physician Advisory Committee to recommend deviations from the AMA Guides.

Changes how treatment guidelines are to be used. Eliminates the ability to use “nationally recognized practice standards” or those promulgated by the “Occupational Practice Guidelines by the American College of Occupational and Environmental Medicine”, and requires the use of the “Official Disability Guidelines promulgated by the Work Loss Data Institute.”

SECTION 15 – Pages 110-113

New Law: Requires the Court to adopt rules “requiring express written authorization from the employer's insurer to the treating physician forty-eight (48) hours prior to the recommended treatment or services for an employee's injuries including, but not limited to:

1. Spinal surgery;
2. Work-hardening or work-conditioning services;
3. Inpatient, nonemergency hospitalization, including any procedure and length of stay;
4. Transfers between facilities;
5. Physical and occupational therapy;
6. Outpatient services expected to exceed One Thousand Dollars (\$1,000.00) in billed charges for a single date of service or ambulatory surgical services, as defined by Court rule; and
7. Any investigational or experimental services or devices.

B. Treatment and service for a medical emergency do not require express written prior authorization. Upon emergency hospital admission, notice must be given to the insurer within twenty-four (24) hours or the next business day.

C. The procedures for requesting prior authorization shall be as follows:

1. Within three (3) working days of the treating physician's request for prior authorization, the insurer's designee shall give notification to the physician, by telephone or transmission of a facsimile, of the decision to grant or deny prior authorization. When the insurer approves prior authorization, the insurer shall send written approval, or if denying prior authorization, shall send written documentation identifying the reasons for denial to the injured employee, the injured employee's representative if known, and the treating physician, or the treating physician's designee, within twenty-four (24) hours after notification of denial or approval;

2. Prior to the date of proposed treatment or services, the treating physician, or his or her designee, shall give notification to the insurer, by telephone or transmission of a facsimile, of the recommended treatment or service. Notification shall include the medical information to substantiate the need for the treatment or service recommended. If requested to do so by the insurer, the treating physician shall also give notification of the location and estimated date of the recommended treatment or service, and the name of the health care provider performing the treatment or service, if other than the treating physician. Designee includes, but is not limited to, office staff and hospital staff; and

3. The Workers' Compensation Court shall promulgate rules for an insurer's failure to respond to a prior authorization request.

D. If a dispute arises over denial of prior authorization by the insurer, the treating physician or the injured employee may proceed to the Administrator. An insurer is not liable for payment for treatments and services requiring express written prior authorization, unless prior

authorization is sought by the claimant or treating physician and either obtained from the insurer or ordered by the Court.

If a specified treatment or service has prior authorization as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service.

The Court may not prohibit an insurer and a treating physician from voluntarily discussing treatment and services, either prospectively or concurrently, and may not prohibit an insurer from certifying or agreeing to pay for health care consistent with those agreements. The insurer is liable for treatment and services that are voluntarily given prior authorization and may not dispute the certified or agreed authorized treatment and services at a later date.

SECTION 16 – Page 113

Effective Date is November 1, 2010.