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Worker's Compensation Guide

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Wisconsin Worker's Compensation Guide

This Guide is designed to help employees and employers understand the Worker's Compensation system of Wisconsin. It should be used only as a guide and not as a definitive source for answers to legal questions.

Not every issue is discussed, however. If more information is needed, please contact the Worker's Compensation Division at one of the following locations:

Worker's Compensation Division Offices		
Madison (Main)	**Milwaukee**	**Appleton**
Worker's Compensation Division Room C100 201 E. Washington Avenue P.O. Box 7901 Madison, WI 53707-7901 (608) 266-1340 (608) 267-0394 (Fax)	Milwaukee Office State Office Building 819 N. Sixth St, Room 330 Milwaukee, WI 53203 (414) 227-4381 (414) 227-4012 (Fax)	Appleton Office Associated Bank Building 1500 N. Casaloma Drive, Suite 310 Appleton, WI 54913-8220 (920) 832-5450 (920) 832-5355 (Fax)

Equal Opportunity Statement

DWD is an equal opportunity employer and service provider. If you have a civil rights question or have a disability and need information in an alternate format, or need it translated to another language, please contact The Worker's Compensation Division at 608-266-1340 voice or (866)265-3142 TTY.

TABLE OF CONTENTS

INTRODUCTION

The purpose of this publication is to inform employees, employers and the public about Wisconsin's worker's compensation law and explain how the system works.

Knowledge of rights and obligations under the law helps to ensure fair, prompt and proper payment of benefits. Such payment helps injured workers, employers and the public.

If problems arise during a claim, an employee should contact the Worker's Compensation Division of the Department of Workforce Development at one of the locations shown on the first page of this guide.

Return to Table of Contents

WHO IS COVERED BY THE WORKER'S COMPENSATION LAW?

All employees working for an employer (other than farmers) with three or more workers are protected immediately by the Worker's Compensation Act. Employers with fewer than three workers come under the law if they pay wages of $500 or more in

any quarter of a calendar year. Their workers are covered 10 days after the end of that quarter. Farm workers are covered if the farm employer has six or more employees on 20 or more days in a calendar year.

Nearly all workers in Wisconsin are covered. This includes both public and private employers. Nearly all private and public employees in Wisconsin are covered under the Act, including employees who are family members (except for farmers in some cases), minors, part-time employees and corporate officers.

There are a few classes of workers who are covered by federal laws and are not covered by the Act. Employees of the federal government (such as postal workers, employees at a veteran's administration hospital, or members of the armed forces) are covered by federal laws. People who work on interstate railroads are covered by the Federal Employers Liability Act. Seamen on navigable waters are covered by the Merchant Marine Act of 1920, and people loading and unloading vessels are covered by the Longshoremen's and Harbor Worker's Compensation Act.

The only employee exceptions to the Act's insurance requirement are: (1) domestic servants, (2) any person whose employment is not in the trade, business, profession or occupation of the employer, (3) some farm employees, (4) volunteers, including volunteers of non-profit organizations that receive money or other things of value totaling not more than $10.00 per week, (5) religious sect members that qualify and are certified for an exemption, (6) employees of Native American tribal enterprises (including casinos), unless the tribe elects to waive its sovereign immunity and voluntarily become subject to the Act. Virtually all other workers and employers are subject to the Act.

Return to Table of Contents

WHAT IS THE UNINSURED EMPLOYERS FUND?

The Uninsured Employers Fund (UEF) pays worker's compensation benefits on valid worker's compensation claims filed by employees who are injured while working for illegally uninsured Wisconsin employers. When a compensable claim is filed, the UEF pays the injured employee worker's compensation benefits as if the uninsured employer had been insured.

How is the UEF funded?

It is funded through penalties assessed against employers for illegally operating a business without worker's compensation insurance. The penalties are mandatory and non-negotiable. In addition, the department pursues reimbursement from each uninsured employer of benefit payments made by the UEF under s. 102.81(1), Wis. Stats., to the employee of that uninsured employer or to the employee's dependents. The UEF uses aggressive collection action (including warrants, levies, garnishment and execution against property) to secure satisfaction of penalty assessments and reimbursement of claims paid by the fund.

When was the UEF implemented?

The UEF applies only to injuries occurring on or after July 1, 1996. Uninsured Employers Fund claims filed for injuries occurring prior to July 1, 1996 are not valid and will be denied.

How is a UEF claim application filed?

To file a claim, an injured worker must complete an Uninsured Employers Fund Claim Application and provide the required documentation. In addition, a claimant is

expected to provide assistance to the department or its agent, including copies of relevant payroll checks, check stubs, bank records, wage statements, tax returns or other similar documentation in determining whether their employer is liable for the injury. A claimant is also required to document any medical treatment, vocational rehabilitation services and other bills or expenses related to a claim.

Will the department verify the information provided in a UEF claim application?

Yes, the claim will be thoroughly investigated. In verifying information submitted in support of a claim for compensation, the department or its agent may share information related to a claim with other government agencies, including those responsible for tax collection, unemployment insurance, medical assistance, vocational rehabilitation, family support or general relief.

What if an alleged uninsured employer refuses to cooperate with the department?

An employer who is alleged to be uninsured is required to cooperate with the department or its agent in the investigation of a claim by providing any records related to payroll, personnel, taxes, ownership of the business or its assets or other documents the department or its agent from the employer to determine the employer's liability under s. 102.03 of the Wisconsin Statutes. If an employer fails to provide requested information, the department may presume the employer is an uninsured employer and assess the appropriate penalties.

Once a UEF claim application is filed, how long does it take to process the claim?

Within 14 days after receiving a completed UEF claim application, the department or its agent will mail the first indemnity payment to the injured employee, deny the claim or explain to the employee who filed the claim the reason that the claim is still under review. The department or its agent will report to the employee regarding the status of the claim at least once every 30 days from the date of the first notification that the claim is under review until the first indemnity payment is made or the claim is denied.

Who can I contact for more information regarding the UEF?

Call or write the Wisconsin Worker's Compensation Division, Bureau of Insurance Programs. Our mailing address is P.O. Box 7901, Madison, Wisconsin 53707-7901. Our telephone number is (608) 266-1340 or you can reach us by fax at (608) 266-6827.

Return to Table of Contents

INJURIES COVERED BY THE LAW

The worker's compensation law of Wisconsin defines an injury as any mental or physical harm due to workplace accidents or diseases, including accidental damage to artificial limbs, dental appliances and teeth. Injuries covered include:

- **Physical harm** or injury such as bruises, burns, cuts, fractures, crushing injuries, hernias, sprains, strains, stiffness, amputation, loss or paralysis of part of the body, sudden loss of hearing, sudden loss of vision and disfigurement.
- **Mental harm** including nervous disorders, hysteria, and traumatic neurosis. The effects of brain hemorrhage caused by an industrial accident may also result in such harm. If the injury is mental harm or emotional stress without a physical

trauma, the injured employee must show that it resulted from a situation of greater dimensions than the day-to-day mental stresses and tensions which all employees experience.

- **Accidental injury** such as physical or traumatic mental harm occurring suddenly and unexpectedly as a result of some employment-related activity.
- **Occupational disease** is chronic physical or mental harm caused by exposure over a period of time to some employment-related substance, condition or activity. Occupational disease includes loss of hearing and deterioration of bodily functions. Examples of common types of occupational disease are dermatitis (skin trouble), infection, silicosis, tuberculosis, pneumonia, lead poisoning, and respiratory disease. In addition, occupational disease includes deterioration of bodily function caused by working conditions over a period of time. For instance, hernias and back trouble caused by repetitive motion or repeated strain over a period of time are considered occupational diseases under the law.

Occupational Deafness. Benefits are payable if prolonged exposure to noise causes permanent partial or total loss of hearing.

Eye glasses and hearing aids may be replaced only when a personal injury entitles the employee to medical treatment or payment of worker's compensation benefits. If a pair of glasses drops to the floor, with no personal injury, there is no payment or replacement.

Return to Table of Contents

THE INJURY OR DISEASE MUST ARISE OUT OF "EMPLOYMENT" - WHAT IT MEANS

Worker's compensation benefits are payable, "Where, at the time of injury, the employee is performing service growing out of and incidental to his or her employment." The employee must prove that the injury happened while engaged in some activity related to employment.

On The Job Injuries

The most frequent types of accidents occurring on the job are through the impact of a falling or moving object, slips or falls, or strains or overexertion.

Injured While Going To And From Work

Usually, the only time an employee can be compensated for an injury which happens on the way to or from work is if it occurs on company-owned property, or under conditions cited in the law. Company sponsored cars and vanpools are not covered.

Injured On Company Steps Or On Company Owned Parking Lot

Injuries occurring on steps leading to the company, or on a customary path through the employer's property, or in a company-owned or designated parking lot are compensable.

Injured While Attending To Personal Needs

Generally, an employee who is injured at work while attending to personal needs, such as smoking, eating, getting refreshments or going to the lavatory, is paid worker's compensation. Injuries off the employer's premises during a break or lunch hour are usually not covered.

An employee injured on the employer's premises during the lunch hour, wash-up time or while changing clothes is covered by the law.

Injured While Doing Something Of A Strictly Private Nature

When an employee is injured in the performance of an act which is undertaken for a strictly private purpose or to satisfy his or her own curiosity, and it is apparent the job has been abandoned for the time being, the employee is not covered.

For example, an employee who while driving on the job runs a private errand and deviates from the ordinary driving route would not be compensated.

Injuries While Off Company Property, But Still On The Job

An injury occurring away from the company premises, but while the employee is still performing service for the employer and under the employer's direction and control, is compensable. If the employee is being transported by the employer when injured, he or she will be entitled to benefits whether or not the incident occurred on the employer's property. An employee whose employment requires travel is considered to be performing services at all times while on a trip. The employee is covered while traveling in airplanes, cabs, or while in eating places and hotels, provided there has been no deviation for a personal purpose.

Traffic Accidents Are Compensable

A traffic accident while on company business will be compensated. An employee on company business who has a heart attack while driving, resulting in an auto accident, is compensated for the injuries caused by the accident but may not be compensated for the heart problem. A delivery person injured in a traffic accident or while unloading merchandise at a different company will be compensated.

Injured During Horseplay Or Fighting

The circumstances surrounding horseplay or fighting determines if an injured worker should be compensated. If the injured employee started the horseplay or was the aggressor in the fight, it is unlikely that the employee will be paid compensation. On the other hand, if an employee is injured as the result of horseplay started by others, or was attacked without provocation, he or she may be awarded compensation.

Injured Because Of Self-Inflicted Wound

The law provides that if an injury is intentionally self-inflicted, it is not compensable (with suicide as the extreme case).

Return to Table of Contents

GIVING PROPER NOTICE OF INJURY TO THE EMPLOYER

When a person is injured or suffers a disease that is work related, the immediate goal is to take care of the condition through proper first aid treatment or medical attention. Remember, the injury and the need for medical attention must be reported to the employer to establish a worker's compensation claim. Even minor injuries should be reported because they may develop into something more serious.

As a general rule, an injury should be reported. A very late report may cause an employer to suspect that the accident occurred at home or, perhaps, not at all. Notice can be given verbally or in writing. It should include 1) the time, 2) the date, 3) type of injury or illness, 4) part of the body involved, 5) the circumstances surrounding the

injury or the first appearance of disease and 6) the need for medical attention. If the notice is verbal, the employee may want to keep a written record of the information and the person notified in case a question comes up later.

Time Limit Of Two Years

An injured employee should give notice to the employer within 30 days of any injury. In the case of an occupational disease, the employee should give notice within 30 days of the time the employee knows about the disability and its relation to the employment. However, if notice is not given within 30 days, it is still possible to give notice any time within two years of the date the injury occurred, the onset of the disease, or the date the worker first realized that such injury or disease was caused by his or her work.

If the employer receives notice within two years and the employer was not misled by the fact that earlier notice was not given, benefits may be payable. The two-year limit does not apply if the employer knew or should have known of the injury.

Return to Table of Contents

TWELVE-YEAR STATUTE OF LIMITATIONS

When an employee has stopped receiving weekly compensation benefits for temporary or permanent disability after an accidental injury, the claim may be reopened at any time within 12 years from the date compensation was last paid. This 12-year period does not apply, however, where a compromise agreement has been made and approved by the department or where a final award has been issued after a hearing.

A final award closes the claim after the time allowed for appeal unless the award is set aside on an appeal. A compromise closes the claim. Within one year after the department's approval of the compromise, any party to the compromise may ask the department to set aside or modify the compromise. The department may or may not grant the request. Few are ever reopened.

When medical treatment will be required beyond the 12-year period and there has not been a compromise or final award, the employee may file an application for hearing to keep the claim open until a hearing is held and a final order issued. For injuries that occurred before May 13, 1980, the statute of limitations was shorter. Information about the statute of limitations on a specific date of injury before May 13, 1980 can be obtained by contacting the division.

In cases of occupational disease and some serious traumatic injuries there is no statute of limitations. The employee may make a claim against the employer or its insurance company within 12 years from the date of injury or the date on which compensation was last paid. If this 12-year period has expired, the employee may make a claim for benefits due to occupational disease against the Work Injury Supplemental Benefit Fund, which is funded completely by specific case assessments on employers and insurance companies. For certain barred traumatic injuries, the employer or its insurance company continues to be liable for benefits after the statues of limitations has run.

See other information on page 29.

Return to Table of Contents

KEEPING A WRITTEN RECORD ABOUT THE INJURY

Complications can arise in a worker's compensation claim, and the amount of benefits is then determined by the specific facts of the case. It is important that the injured employee keep a record from the beginning. If the case goes to hearing, it is important that the employee's testimony is consistent with the earlier accounts of the accident such as his or her report to the doctor.

Critical Information To Document

The date of injury or first indication of an occupational disease. **The date is very important because benefit levels are based on the date of injury.**

The accident's cause, such as being struck by an object, overexerting, strain, sprain, etc.

The nature of the injury or disease, such as cut, sprain, hernia, etc.

The part of the body affected, such as finger, low back or respiratory system.

The kind of action that was taking place, such as lifting, carrying, etc.

The source of injury, such as machinery, object, hot or flammable substance, etc.

The weight of the object causing the injury.

Physical symptoms, such as sharp pain, stiffness, loss of motion, rash, etc.

How long the symptoms lasted; if and when they recurred.

Names of any witnesses who saw the accident or who the injured employee spoke to immediately following the injury.

The doctors seen and the date of each visit.

All money spent on doctors, examinations, treatment, medicines and transportation. Receipts and bills are important documentation.

All days or parts of days lost from work because of the disability.

A written record of any statement made to the employer or the insurance company representative.

Copies of any agreement or final receipt signed for a worker's compensation claim.

Return to Table of Contents

RELATED MEDICAL, HOSPITAL, SURGICAL EXPENSES AND OTHER TREATMENT EXPENSES

An employee who is injured at work or suffers from an occupational disease is entitled to have all bills paid for all medical, surgical and hospital treatment relating to the injury including: doctor bills, hospital bills, medicines, medical and surgical supplies, crutches and artificial limbs, training in the use of artificial limbs, and lost time and traveling expenses for treatment or examination.

All reasonable and necessary medical expenses must be paid by the employer whether or not weekly benefits are also due for temporary or permanent disability. If an injury requires medical treatment and there has been no lost time, no lost wages and no disability, the employee is still entitled to have medical treatment costs paid. Necessary treatment expenses must be paid unless the claim has been settled through a compromise agreement approved by the division.

Return to Table of Contents

SELECTION OF A DOCTOR

When a worker reports an injury, the employer shall offer the worker the right to select a doctor of the worker's choice for treatment. The employee may select any physician, psychologist, chiropractor, dentist, physician assistant, advanced practice nurse prescriber or podiatrist who is licensed to practice in Wisconsin. If the injury creates an emergency situation, the employer may make whatever arrangements are necessary for immediate treatment. Once the emergency passes, the worker has the right to select a doctor for future treatment.

Employee Allowed First And Second Choice Of Doctor

If the employee is not satisfied with the first doctor, one more choice is allowed; however, the worker must notify the employer of this second choice. The law recognizes that if the employee does not have confidence in the first doctor, recovery may be delayed. If the attending doctor refers the employee to a specialist or a series of specialists, this referral is still considered to be treatment by one doctor. If several doctors in one partnership or clinic are seen, these are all considered one doctor. After changing doctors once, any further change may be made only by mutual agreement between the employee, employer and insurance carrier.

Failure to notify the employer of the initial selection or of a change of doctors can lead to a disputed claim and the possibility of the injured employee having to pay for the entire cost of treatment.

Certain Treatment Not Allowed

Expenses will not be paid for treatment by a physical therapist, masseur or masseuse, or pain clinic unless the treatment is ordered by a doctor or unless the employer or insurance company specifically agrees in advance to pay for such treatment.

Any Doctor In an Emergency

In an emergency, an employee can go to any doctor for treatment.

Examination By Employer's Doctor

On written request, an employee should submit promptly to a reasonable examination by any doctor (physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber or podiatrist) named by the employer or insurance company. The written request must notify the employee of the date, time and place of examination and give the examining doctor's name and area of specialization. The request must also advise the employee of the procedure for changing the date, time and place of the examination. It must also advise of the employee’s right to have a doctor of his or her own choice present at the examination, and of the employee’s right to receive a copy of the doctor's report immediately upon receipt by the employer or insurance carrier. The employee may also have a translator present if help is needed speaking or understanding English.

Refusal Of Treatment

No compensation is payable for the death or disability of an employee if the death was caused by, or the disability aggravated by, an unreasonable refusal or neglect to submit to or follow reasonable medical or surgical treatment. However, an employee may refuse surgery which might endanger life or limb.

Out-of-State Treatment

With the consent of the insurer, the employee may treat with a medical practitioner not licensed in Wisconsin. The insurer's consent is not necessary if the out-of-state treatment is based on a referral from a practitioner licensed in Wisconsin.

Return to Table of Contents

WEEKLY BENEFITS PAID FOR TEMPORARY AND PERMANENT DISABILITY

In addition to medical, hospital and doctors' expenses, the law provides for the payment of weekly benefits for temporary and permanent disability.

Three-Day Waiting Period For Temporary Disability

To eliminate minor claims for temporary disability, the law requires a three-day waiting period for all disabilities lasting seven days or less. (Sundays are not included in the three days unless the employee usually works on Sundays.) Temporary disability benefits are never paid for the day of injury.

No Waiting Period Required If Out Over Seven Days

If, because of the injury, the employee is unable to work at any time after the 7th day of injury, compensation is paid for the entire period including the three-day waiting period. Payment for the lost time will include all days of disability up to that date, but not including the date of injury. If an injury causes both temporary and permanent disability, there is no waiting period and temporary benefits start from the first day. For example, amputations causing a day or two loss of work payments are required for temporary disability and the PPD disability caused by the amputation.

Temporary Total Disability (TTD)

Almost all worker's compensation cases involving lost time initially are for TTD which covers the period immediately after injury. This is the period of treatment and healing before it can be determined whether or not there is any permanent disability.

TTD benefits are paid: 1) when the employee is unable to work and has a total loss of wages; 2) when the employee is still recovering and is able to do some type of work, but the employer cannot provide work within the limitations the doctor has set.

Duration: TTD benefits are paid until the employee's condition has become stabilized and treatment and convalescence are not likely to result in additional improvement.

Amount: TTD benefits amount to two-thirds of the employee's average weekly wage subject to a maximum amount specified by law. For 2009, the maximum weekly rate for worker's compensation is two-thirds of $1212.00 or $808.00. This applies to normal full-time work. Wages and rates may vary for part-time employment.

Temporary Partial Disability (TPD)

TPD benefits are paid when an employee is working at a lesser paying job or is working fewer hours because of the temporary effects of an industrial accident or disease. Benefits are paid when the employee is offered a wage or work-hour reduction because of the disabling effects of the injury or disease during the healing period. TPD benefits are paid in proportion to the wage reduction.

Duration: TPD benefits are paid while the employee is working at a lesser paying

job or working part-time until the employee's condition becomes stabilized, and treatment as well as convalescence is not likely to result in additional improvement.

Amount: TPD benefits will vary. The employee gets the same percentage of TPD benefits that the percentage wage loss is when compared to his or her wage at the time of injury.

Permanent Partial Disability (PPD)

The healing period lasts until the employee is as well as he or she is expected to get as determined by competent medical evidence. If at that time the employee has limitations which are expected to remain unchanged in the future, he or she is entitled to benefits for permanent disability.

Permanent disabilities, including loss or partial loss of particular parts of the body, or physical or mental capacities are compensated after the temporary injury has healed. The duration of PPD is determined in one of two ways:

Number Of Weeks Paid According To A Schedule Of Losses

The law contains a schedule for various kinds of injuries with a corresponding number of weeks for which benefits are allowed. This schedule states the number of weeks benefits will be allowed for each condition. For example: loss of a hand at the wrist - 400 weeks; loss of foot at the ankle - 250 weeks; loss of the thumb at the proximal joint - 120 weeks, etc. Ten-percent loss of use of the hand at the wrist would amount to 40 weeks of benefits (10% of 400 is 40).

Nonscheduled Injuries Are Paid As A Percentage of 1,000 Weeks

For permanent injuries which are not listed on the schedule of injuries, such as internal injuries to the head, back or torso, a medical estimate has to be made as to the amount of permanent loss. The amount estimated is then taken as a percentage of 1,000 weeks. For example: an employee who suffered a herniated disc to the back receives a doctor's estimate of 10% PPD. The employee is entitled to 100 weeks of PPD benefits (10% of 1,000 weeks). Claims for loss of earning capacity can be made only in cases of nonscheduled injuries.

Nonscheduled injuries take into account the employee's ability to perform in the labor market after the permanent physical disability has been determined. Benefits help make up some of the loss of ability to perform in the labor market.

If an employee returns to work for the same employer at no more than a 15% wage loss, compensation is payable only for the physical disability. However, if the employer cannot continue to provide suitable employment or if the worker is physically unable to do the job, the claim for a loss of earning capacity may be reopened.

Amount: Permanent partial benefits for both scheduled and nonscheduled injuries are computed at two-thirds of a maximum average permanent partial weekly wage provided for in the law at the time of injury.

(For details see the Worker's Compensation Web Site Publication List, under WKC-8486-P, Monetary Conversion Tables of Disability.

Permanent Total Disability (PTD)

In case of an extremely serious injury which prevents the employee from performing any gainful employment, the law provides that weekly benefits be paid for life. The

law defines a permanent total injury as the loss of both eyes, the loss of both arms, the loss of both legs, the loss of an arm and a leg and other extreme conditions determined by the division to prevent the injured employee from working.

Duration: PTD payments are paid for life.

Amount: PTD benefits amount to two-thirds of the employee's average weekly rate subject to the maximum amount specified by law.

Weekly Benefit Rates

Compensation for lost wages is based on two thirds of an injured worker's wage at the time of injury up to the maximum rate set for the year of injury.

Return to Table of Contents

PAYMENTS ALLOWED FOR SPECIAL CIRCUMSTANCES

By law, there are separate benefits for occupational deafness, disfigurement, non-disabling exposures such as silicosis, multiple injuries and for handicapped workers.

Disfigurement

If an employee is so permanently disfigured as to cause potential or probable wage loss, the division may allow a sum it deems just for compensation, not exceeding the employee's average annual earnings as defined by law. The division considers the employee's age, education, training and previous experience and earnings, present occupation and possible future occupational change in determining the potential for wage loss and the sum awarded.

Non-disabling Toxic Or Hazardous Exposure

An employee may work with toxic or hazardous materials or conditions that cause some physical changes which are not yet disabling but might become disabling with further exposure. That employee may be entitled to benefits if he or she leaves that job through discharge, transfer or simply quitting. To be entitled to benefits, the employee must show that it was inadvisable to continue in that job and that by leaving the job the employee had a wage loss. The benefits are paid as the wage loss occurs. The maximum for these benefits is set by law.

Multiple Injury Variations

If an accident causes more than one permanent injury (such as loss of two or more fingers), the number of weeks of permanent partial benefits are increased for each additional equal or lesser disability in a series of increasing steps as established by statute. An increased allowance is also made for some injuries to the dominant hand or arm.

Workers With Disabilities

The Work Injury Supplemental Benefit Fund (Second Injury Program) was created to reduce discrimination in hiring workers with a disability. If a worker with a disability is injured on the job, the employer may not have to bear the full financial burden of paying for the effects of the combined disability and the injury.

The previous disability does not have to be the result of a work-related injury. The pre-existing disability can include such conditions as loss of vision, loss of hearing, diabetes and heart problems. The present work-related injury must be severe enough

to entitle the employee to 200 or more weeks of compensation for permanent partial disability. The previous disability must be enough to have entitled the employee to 200 or more weeks of compensation for permanent partial disability had it been caused by a work-related injury. The Worker's Compensation Division will notify an injured worker if the disability from the work injury qualifies him or her to make a claim for second injury benefits under this provision.

Return to Table of Contents

PAYMENT FOR TRAINING AND REHABILITATION OF INJURED WORKERS

Wisconsin law recognizes the obligation to train injured workers to again become productive members of the community.

Training In The Use Of Artificial Limbs Provided

In cases of amputation after injury, temporary disability benefits extend during any reasonable period it takes to be trained in the efficient use of artificial limbs. The cost and length of training depends on the employee's progress in using such devices.

Vocational Rehabilitation

If employees suffer from any serious work-related injury or disease that makes it difficult or impossible to do the work previously performed, they may be eligible for vocational rehabilitation services. These services may come from the Division of Vocational Rehabilitation or from private sector vocational rehabilitation specialists referred to them by their insurance carrier or the Worker's Compensation Division. The return to work services may include career planning, job placement or retraining of up to 80 weeks. Additional benefits could include the cost of transportation and maintenance if retraining occurs outside the employee's home community. Any employee who has a permanent disability and cannot return to his or her job should contact the local Division of Vocational Rehabilitation. The employee may also contact the Worker's Compensation/Rehabilitation Unit for further information.

Return to Table of Contents

DEATH BENEFITS PAID TO SPOUSE AND DEPENDENTS AND BURIAL EXPENSES PROVIDED

If a work-related accident or occupational disease causes death, or if a worker dies while entitled to PTD benefits, the law provides for the payment of compensation to a spouse, parent or a relative. Extra benefits are paid to dependent children.

Benefits To The Surviving Spouse

If there is a surviving wife or husband, benefits are paid to the spouse, and all other relatives are excluded (except children who get additional benefits). Compensation varies according to the employee's wage up to the maximum wage in effect at the time of injury. The maximum death benefit is four times the average annual earnings. The benefits are payable monthly. If there is a spouse and dependent children, the division may reassign death benefits to the children if the spouse remarries.

Extra Benefits

Dependent children under 18 years of age living with the employee at the time of

injury may receive additional benefits. If the child is mentally or physically incapacitated, benefits may be paid past age 18. The amount of benefits varies with the age of each child. The younger the child, the greater the total benefit.

Death Benefits Other Than To Spouse Or Children

If there is no surviving spouse or child and the employee was totally supporting a parent or other relatives, such parent or relatives are entitled to the full death benefit. If parents are not dependent, but have maintained friendly relations with the deceased, they are allowed $6,500 if the injury occurred on or after January 1, 1990. If the employee contributed $500 to the support of parents in the year before death, the parents may be awarded additional death benefits up to the greater of four times the contributions in the preceding year or one-half of the normal death benefit.

Burial Expenses

In all cases where death results from a work-related accident or disease, the employer or the insurance company must pay burial expenses up to the limits in the law.

Return to Table of Contents

INCREASED OR DECREASED COMPENSATION (SAFETY VIOLATION)

There are several provisions in the law for increasing or decreasing weekly benefits and death benefits which are important to the enforcement of Wisconsin's safety code and child labor laws.

The "Safe Place" Statute

State law imposes an absolute duty on employers to do everything reasonably necessary to furnish a safe place to work and to protect the life, health, safety and welfare of their employees. If employers fail to meet safety standards, the division can increase the amount of worker's compensation benefits they must pay.

15% Increase For Employer Violation

If injury is caused by an employer's violation of the "safe place" statute or of a safety order, or because of failure of an employer to reasonably enforce compliance by employees with a safety order, 15% increased compensation is payable to the employee or dependents up to a statutory maximum. When employees claim such violations, they should report accidents to the Worker's Compensation Division which may make its own investigation.

15% Decrease For An Employee's Violation Or Intoxication

If an employee fails to use a safety device or to obey a reasonable safety rule, compensation may be decreased by 15% up to a state maximum. The safety device must be provided and adequately maintained and its use must be reasonably enforced by the employer or compensation will not be reduced. Likewise, a safety rule must be enforced and the employee must have notice of the rule before compensation would be reduced. If an injury occurs because of an employee's intoxication by alcohol or illegal drugs, compensation may be decreased by 15%.

Return to Table of Contents

ILLEGAL EMPLOYMENT OF MINORS

If a minor is working without a work permit and is injured, the employer must pay to the state treasurer for deposit into the fund created under Wis. Stat. S. 102.65 an amount equal to the benefits payable to the injured worker. The additional amount must be paid by the employer, rather than the insurance company, as a penalty. If an injured minor is illegally employed in an occupation which is prohibited to minors, the amount payable to the state treasurer is double that payable to the injured employee.

Return to Table of Contents

EARLY RETURN TO WORK ... IT WORKS FOR YOU!!

After an injury at work, an employee often must wait before returning to the job. The employee may be reluctant to start working again for fear of pain, re-injury or not being able to perform as well. If a different job is required because of the injury, there may also be a concern about trying something new.

Sometimes employers are not willing to bring able workers back to their original jobs, or some related work, for many of the same reasons. It is helpful if employers have some type of limited duty, or alternate work, to help workers gradually get used to being back in the workforce

It is to everyone's advantage to return to work as soon as possible after injury - within medical restrictions - because returning to suitable work helps employees more readily recover from injuries.

In addition to these benefits of early return to work, there also are financial advantages. Under the law, if the return to work is at a lower pay rate, benefits for TPD still are payable. TPD benefits are not taxable income. If the employer offers work within the limits set by a doctor, and the worker refuses the job offer, the employer or insurance company owes only the TPD. They do not owe for TTD.

The employee thus gains by returning to work, and may actually lose money by not returning when a doctor so advises.

There are other good reasons for an early return to work including:

- If employers have some type of return to work program, the majority of workers will return to their jobs early in their recovery period.
- Most injured workers WANT to go back to work.

Return To Work

When is the employee able to return to work? Opinions may differ as to when the employee is sufficiently recovered to return to work. If the employee does not feel up to it, but has been advised by the doctor to return to work, an attempt should be made to return to the job. The worker will be in a stronger position to obtain additional benefits if a return is attempted rather than refused.

A doctor may advise an employee to return to work during healing in some lighter, restricted work, different from the work performed before the injury. It often is to the worker's advantage to return early, within medical work limitations.

Unreasonable Refusal To Rehire

If an employer unreasonably refuses to rehire an employee following an injury, the

Worker's Compensation Division may award the employee the wage loss during the period of refusal, up to one year's wages. In determining whether or not refusal to re-employ is unreasonable, the division must consider whether suitable employment is available within the employee's physical and mental limitations. The availability of work may be affected by seniority provisions in effect at the work site.

Return to Table of Contents

FILING A WORKER'S COMPENSATION CLAIM WHERE THERE IS NO DISPUTE

A major purpose of the worker's compensation law is to ensure prompt and proper payment of claims. Administrative rules hasten the process and protect the parties involved. Under Wisconsin law, the employer or insurance company takes the initiative by paying benefits in non-disputed cases. The division insures that correct payments are made by requiring complete reports from employers, insurance companies and doctors, and by careful examination of the evidence.

Procedure For A Non-disputed Claim

The employee gives immediate notice of injury to the employer. Notice must be within two years.

When the employee is injured or learns of an occupational disease, he or she gets needed medical attention. The employee sees a doctor as soon as possible and continues treatment as necessary.

The employer files reports with its insurance company or internal claims department if self-insured.

The employer files a report within seven days after the injury with the insurance carrier or the carrier's administrator. By the 14th day, the insurer or its administrator will submit to the division a report of injury either via the internet or by electronic submission.

The Division sends the employee an information brochure.

The insurance company obtains a medical report on the nature of the injury or disease from the doctor or employer.

The most common cause of delay or interruption of compensation payments is lack of medical information from the attending doctors. If an interruption in compensation payment occurs, it is advisable for an injured employee to call the doctor's office to find when the last medical report was sent to the employer or worker's compensation insurer and what was said in that report.

The insurance company contacts the employee for details of the accident and the extent of injury or illness. The worker should give a complete statement, particularly of the physical symptoms connected with the disability. If there are any doubts about the statement, the employee need not sign it. The insurance company must have a certain amount of information to handle the claim, and this is the basic purpose of the statement. Incomplete or inaccurate information may cause the company to deny the claim and withhold benefits. The worker must be given a copy of the signed statement.

If there is agreement about the claim, the insurance company or self-insured employer will promptly begin paying benefits to the employee for lost wages. The insurance company or employer is also responsible for paying authorized, reasonable, necessary medical and associated costs directly to the health care provider.

The employer or insurance company sends the Division a follow-up report within 30 days showing that payment of benefits has begun, or explaining the reasons for denial.

The employee receives the first check, usually within 15 days after the date of injury. If payment is not received, the worker should call the employer or its insurance company to find out if a problem exists. If there is a problem with the claim, the employee can write or call any of the Division offices listed at the front of this publication.

At the end of the period of disability, the insurance company usually writes a letter informing the employee that payments will be stopped as of a certain date.

An employee may safely sign a receipt for payment because the claim remains open for 12 years from the date of last payment.

The employer and insurance company make out a "supplementary" report, sending one copy to the Division, and one copy to the employee when final payment has been made.

A report from a health care practitioner must accompany the final report, and a copy must be given to the employee if there are more than three weeks of temporary disability or any permanent disability, or if the injured has undergone surgery to treat the work injury.

Return to Table of Contents

STIPULATION-OF-FACTS AGREEMENT AND COMPROMISE AGREEMENT

Many questions can arise in a worker's compensation claim before the employer or insurance company is willing to pay or is ordered to pay benefits by the division. Questions include whether the injury or disease arose out of and because of work, whether it was aggravated by non-work causes, whether it caused a permanent condition and the extent of permanent disability. Such questions may be disputed by the insurance company, employer, doctors or the employee.

There are two types of agreements that can be reached if both parties (employee and employer) prefer to settle without a hearing: 1) a stipulation-of-fact agreement and 2) a compromise agreement. Both types must be submitted to the division for review. The division will affirm, set aside or modify the agreement and direct payment in the form of an order or award.

Stipulation-Of-Facts Agreement

A stipulation-of-facts agreement is beneficial in cases where it is advantageous to both sides to pin down or identify the facts. This agreement commits each side to something that they might not want to otherwise concede. For instance, it will state the percentage of PPD to eliminate further controversy over this point. In cases where there will be a lengthy payment period, it obligates both sides to accept the agreed upon number of weeks. The worker (or dependents in cases involving death) should make sure all facts are stated to the worker's satisfaction as to percentage of permanent disability and number of weeks of payment. The insurance company cannot claim at a later date that the disability actually amounted to a lesser amount unless it can bring proof of that fact.

Compromise Agreement

In some cases, if there is doubt that the claim is due to or aggravated by the

employment, or if there is a dispute about the extent of disability, or if there is uncertainty on both sides about how the case would turn out as a result of a hearing, a compromise agreement may be made. Under this type of agreement, the employee is not allowed to ask to reopen the claim after one year from the date of the agreement. Unless an actual dispute arises, the parties should not attempt to make a compromise agreement, but should stipulate to the facts without using the word "compromise." For all practical purposes the case cannot be reopened once an order on compromise is issued.

Return to Table of Contents

DISPUTED CLAIMS AND HEARINGS

A disputed claim occurs when an employee, surviving spouse or dependents believe they are entitled to worker's compensation benefits, and the employer or insurance company denies liability.

An employer's or insurance company's unwillingness to pay benefits may arise from an honest difference of opinion among witnesses or a conflict of medical testimony between doctors. If there is no settlement, a hearing is held before an Administrative Law Judge (ALJ).

The ALJ is to resolve the dispute on the basis of the relevant facts in the case. The ALJ's decision is based on the testimony of all parties, as well as doctor's reports, other documents, or other pertinent testimony submitted in the case. In most instances, the insurance company or employer is represented by an attorney and has expert witnesses. Typically, there is only one hearing. All further appeals are based on the record created in this hearing.

Application For Hearing

When an employee or employer wants to request a hearing, three copies of a form entitled "Application For Hearing" (WKC-7) must be filed with the division. The form can also be obtained from the division.

The division sends one copy of the WKC-7 to the employer or insurance company for an answer. If an employee is not represented at the time of a scheduled hearing, the ALJ will ask the questions to record all testimony and evidence that is available at the time of hearing. The division and the ALJ cannot prepare the claim in advance, cannot see that the proper evidence is available at the time of hearing, or act as legal counsel to represent any of the parties.

Pre-hearing Conference

After an Application For Hearing is filed, the division may schedule a pre-hearing conference. The purpose is to permit the parties to discuss the claim informally with an ALJ. The ALJ will try to have the parties agree on documents and reports which may be introduced at a hearing and to reduce the number of issues that are in dispute. As the issues are reduced, it is often possible for the parties to come to an agreement that will eliminate the need for a hearing.

Hearing Is Scheduled

Once the division sets a hearing date, both parties are notified at least 10 days in advance. If the worker is not ready for the hearing, the division should be notified immediately. Hearings are semi-judicial proceedings. Witnesses are sworn in as in a courtroom and either party may cross-examine. Exhibits consisting of documents and reports are entered into the formal hearing record. A court reporter records all

testimony.

Consulting With Division Staff

At any time, an employee (or dependent), an employer or insurance company representative, can consult with a representative of the division in person at any of its offices, in writing or via telephone contact concerning a claim.

Legal Representation And Legal Fees

Either party may be represented by an attorney; most are represented. If an attorney is hired, he or she should be experienced in worker's compensation litigation. An attorney retained by a worker is entitled to legal fees of up to 20% of the amount of benefits in dispute or, if there is no net gain over the amount the employer offered, the attorney is entitled to up to $250 as determined by the ALJ.

Physical Examinations And Medical Testimony

One of the most common types of cases to go to hearing involves a conflict of medical testimony. There may already have been a number of examinations and reports at the time of hearing. (The employer has the right to ask that the employee be examined and re-examined a reasonable number of times.) Both employee and employer have the right to obtain medical reports submitted on their behalf, or to have health care practitioners appear as witnesses at the hearing. Doctor reports may be submitted on the "Practitioner's Report On Accident Or Industrial Disease In Lieu Of Testimony" (WKC-16-B).

A physician, psychologist, chiropractor, podiatrist or dentist should submit the form to the division at least 15 days before the hearing, so it can be used as direct testimony, just as if the doctor were there in person. Personal appearances by medical witnesses at a hearing can be very costly.

Treating Doctors As Witnesses

If no WKC-16-B is filed or if the employee or the employee’s attorney feels it is advisable, the employee may bring a doctor or doctors to testify at the hearing. The employee must pay for the doctor's appearance. The doctor's fee to appear at the hearing is not part of the treatment costs.

ALJ's Award

The ALJ will gather all the facts at the hearing. Law judges can order an examination by a doctor not connected with the case, if that is necessary. After the final hearing, the ALJ issues a decision that either confirms or denies the claim. If the decision confirms the claim, an order will be issued stating the amount of disability and how much compensation is to be paid.

Either party has the right to appeal the ALJ's Order. The appeals follow this order:

Labor and Industry Review Commission (LIRC);

Circuit Court;

Court of Appeals; and

Wisconsin Supreme Court.

Appeal For Commission Review

If a party wishes to appeal the ALJ's Order, a “Petition For Commission Review” (WKC-28) must be filed within 21 days of the mailing date of the ALJ's Order. On this form

the appealing party states points of disagreement. The three-member Labor and Industry Review Commission (LIRC) will review the hearing record. LIRC can affirm, set aside or modify the ALJ Order. All parties will receive a copy of the LIRC decision.

Appeal To Circuit Court

After LIRC has decided the case, any further appeal is to Circuit Court. Such appeal must be made within 30 days. A lawyer should be consulted to handle the case, since only questions of law are taken up by Circuit Court. If the appealing party loses the court case, he or she may be liable to pay court costs. If the appealing party wins, the court can assign costs as it sees fit among both parties.

The Court Of Appeals And The Supreme Court

Usually, only exceptional cases are appealed to the Court of Appeals and eventually to the Supreme Court. A lawyer should be consulted since only questions of law are taken by the court of appeals and the Wisconsin Supreme Court.

Return to Table of Contents

THIRD-PARTY SUITS

If a person is hurt by negligence of a third party (such as outside contractor doing work in the plant), the injured person may receive worker's compensation benefits and also sue the third party in a civil action. The worker will receive at least one-third of the net amount recovered from the third party. All costs of collection, including attorney's fees, are taken out before the proceeds are divided.

The insurance company or employer is then repaid the amount paid as compensation to the injured employee, and if any balance remains, it is paid to the employee. Legal action against a third party is usually by joint action of the employer and/or the insurance company and the injured employee. Employers or injured employees may not always be aware of a third party suit and should consult an attorney if there is any doubt. Each party must give the other parties reasonable notice of such action.

Return to Table of Contents

STATUTE OF LIMITATIONS

The statute of limitations in effect on the date of injury determines the maximum time within which a claim must be made

For many years the Worker's Compensation Act provided that a claim could not be made more than six years after the date of injury or from the date of last payment of compensation. Since then, there have been changes.

The statute was amended to remove any statute of limitation for injuries caused by ionized radiation.

Effective January 1, 1974, the statute of limitations for bringing a claim for lung disease or for exposure to toxic substances was extended to 12 years.

Effective December 30, 1975, a significant change was made to remove the statute of limitations completely for claims for occupational disease. The amendment provided that valid claims made after the usual period for the statute of limitations would be paid from a state fund. This is still in effect for occupational diseases.

Effective January 1, 1978, the basic statute of limitations within which a claim

may be made against an employer or insurance company was extended from 6 years to 10 years.

Effective May 13, 1980, the basic statute of limitations was extended from 10 years to 12 years.

Effective January 1, 2002, there is no longer a statute of limitations for some serious traumatic injuries. Effective April 1, 2006 valid claims based on these serious traumatic injuries made after the usual period for the statute of limitations are paid by the employer or insurance carrier. The serious traumatic injuries include:

- Loss or total impairment of a hand or any part of the rest of the arm proximal to the hand.
- Loss or total impairment of a foot or any part of the rest of the leg proximal to the foot.
- Any loss of vision.
- Any permanent brain injury.
- Any injury causing the need for a total or partial knee or hip replacement.

Return to Table of Contents

CONCLUSION

The Worker's Compensation Division is available as a resource to provide additional information on questions you may have about the worker's compensation law. If you have questions on a particular case, please contact the Madison office.

Because worker's compensation case files contain information of a sensitive nature, access to these files is limited to the parties (employee, employer, insurer) and their attorneys or authorized agents.

Division staff will not conduct random searches to determine if injuries to specific employees have been reported. Files may not be immediately available if staff are working with them or if they must be retrieved from the State Records Center. Please be patient, it may take up to several weeks to retrieve a file in use or from the State Records Center. To assure their integrity, files may be examined only under the supervision of division staff.

You may obtain copies of any records you have the right to inspect. The following fee schedule (subject to change at any time) was in effect when this publication was printed.

- $0.10 per copy if you do the photocopying yourself at the division's Madison office.
- $0.20 per copy if division staff make the copies. Please plan on 15 work days for completion.
- $3.00 for postage and handling if the copies are to be mailed to you.
- Certified copies: $2.00 certification fee plus $0.20 per page.

Return to Table of Contents

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