Survey of Other State Laws

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Column1	For workers on time loss, are physicians or other providers required to see or communicate with them on a schedule or in a set timeframe - e.g. once every 30 days, every two weeks, once per month? If so, what is the required schedule?	Do time loss benefits have to be authorized in specific increments, e.g., 14 days at a time? If so, what are the increments?	Can a provider authorize time loss without an end date?	Can a claim be closed if the worker does not follow their treatment plan?	Does an injured worker have any specific incentives to complete their treatment plan?
Arizona	At least once every 30 days for an active workers' comp claim.	An injured worker is paid every 14 days if on a no work status from a physician until they are released back to full duty work. If the injured worker is released to light duty work then they are paid every 30 days minus any earnings that they earned working light duty work.	A Provider referring to a physician can continue the Injured worker on a no work status with supported documentation for on-going active treatment.	A claim can only be closed with supporting medical documentation for time loss claims and/or Medical only claims with a no response to a 20 day letter regarding if they are still seeking medical treatment.	No, there is no specific incentive for an injured worker to complete their treatment plans.
California	There is no set timeframe. The physician should issue the Doctor's First Report of Injury, setting forth medical information and "work status" within 5 working days following initial evaluation. (See Title 8, California Code of Regulations §9785.) Thereafter, the injured worker's primary treating physician treating issues a Progress Report (PR-2) within 20 days of specified circumstances. There is no set time frame for the physician to see or communicate with the injured worker who is temporarily disabled. Frequency would be determined by the medical condition and standards of care, including any recommendations in the Medical Treatment Utilization Schedule ACOEM Guidelines related to the condition. There are specified triggers for the physician to issue a report to the claims administrator so that appropriate benefits may be provided in a timely manner. Note that section 9785, subdivision (f)(8) provides that "When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination." Note that section 9785, subdivision (f)(3) requires the physician to report within 20 days if "[t]he employee's condition permits return to modified or regular work." In summary, there is not a set time frame for seeing or communicating with the injured worker who is on temporary disability status. The medical considerations and reporting	There is no requirement for temporary disability to be authorized in specified increments. Recommendations in the MTUS ACOEM Treatment Guidelines may impact the "increments" that are medically appropriate to be off work in light of the injured worker's diagnosis and treatment plan. Although there is no set increment for authorized time off work, the temporary disability indemnity payments are made "every two weeks on the day designated with the first payment." (California Labor Code section 4650(c).)	There is no specific statute or regulation addressing this; however it would be expected that the physician provide a medically appropriate estimate of the time off work and indicate when a re-evaluation would be planned. Additionally, the physician is expected to report when the patient may return to modified duties. When the injured worker's medical condition is permanent and stationary, the physician would issue a report releasing the worker to return to work (unless already returned to work or permanently totally disabled), and would indicate any ongoing work restrictions. Although there are no specific rules limiting a provider from authorizing an endless amount of time loss, there are caps on the amount of payable temporary disability indemnity. California Labor Code section 4656(c) states, "aggregate disability payments for a single injury occurring on or after April 19, 2004, causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of TD payment." The statute allows up to 240 compensable weeks within five years for specified serious injuries or conditions, and for firefighter/peace officer where the cancer presumption	A claim cannot be unilaterally "closed" if the worker does not follow their treatment plan. However, if the injured worker does not follow recommended / authorized treatment which results in extended temporary disability, the employer/insurer may petition the Workers' Compensation Appeals Board to suspend benefits. California Labor Code section 4056 states as follows: "No compensation is payable in case of the death or disability of an employee when his death is caused, or when and so far as his disability is caused, continued, or aggravated, by an unreasonable refusal to submit to medical treatment, or to any surgical treatment, if the risk of the treatment is, in the opinion of the appeals board, based upon expert medical or surgical advice, inconsiderable in view of the seriousness of the injury."	No.
Colorado	There is no set schedule in rule or act. Some of the individual carriers have policies, but those are not enforced by our Division of Worker's Compensation.	No	Yes	Sort of. I'm not positive if you're asking about full claim closure or just termination of the wage replacement benefits (temporary disability benefits), so I'm giving you the answer for both, along with links to the specified rules. Colorado Workers' Compensation Rules of Procedure (WCRP) Rule 6-1 lays out how temporary disability benefits can be shut down. In subsection (4), benefits can be terminated if an injured worker fails to respond to a written offer of modified employment. Subsection (5) allows suspension of benefits when there is failure to attend a rescheduled (so they've missed one appointment already) medical appointment and the worker is notified of that rescheduled appointment by written notice with a signed certificate of service stating that benefits will be suspended if the worker fails to appear. I should note, however, that if the worker's benefits are suspended under this rule and the worker later goes back to the doctor, the suspended benefits can be collected by the injured worker. WCRP Rule 7-1(B) allows for a final admission of liability to be filed based upon claim abandonment, but there cannot be temporary benefits being paid, the worker has to have missed at least 2 consecutive medical appointments, and they have to fail to respond within 30 days to a letter from the adjuster inquiring if additional treatment is necessary AND warning of the consequences of failing to respond. If the claimant responds/objects to that final admission, the claim must go back on a general admission of liability.	I'm not positive what you're asking here, so I am going to assume we do not have something like that in CO. As I previously mentioned, if there is a modified job offer or failure to attend medical appointments, wage replacement benefits can be cut off and/or suspended. There is also a 24-month Division Independent Medical Examination (DIME) process which can force claims to closure. It's provided for by Act, in CRS 8-42-107(8)(b)(II). You can find the process laid out in WCRP Rule 11-4. The short version of that process is, 24 months from date of injury, if the authorized provider has not placed the worker at maximum medical improvement (MMI), the carrier can send the worker to an independent physician for examination. If that independent provider says the injured worker is at MMI, then the report is sent to the authorized provider. If the authorized provider still says not at MMI, then the carrier can request a 24 month DIME. In Colorado, the DIME process is requested from our DOWC. The DIME Unit sends a list of 3 doctors, each party strikes one, and the remaining doctor performs an examination. If that doctor says MMI, then the carrier can move forward. If not, then treatment just needs to continue.

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Florida	[Florida] Administrative Rule 69L-7.730 requires the treating physician to complete and return form DWC-25 (Florida Workers' Compensation Uniform Medical Treatment/Status Report Form) to the insurer, and employer upon request, by close of business on the next business day following the first visit and following each subsequent visit or a maximum of 30 calendar days from the date of the prior DWC-25 form submission. In instances where the form is submitted without the occurrence of any actionable event, receipt of new information or patient re-examination, it is anticipated that the provider will submit the form reflecting an unchanged patient status. The DWC-25 is the required reporting form for physicians to recommend medical treatment/services and report the medical status of the injured employee to insurers/employers including the establishment of the date of Maximum Medical Improvement (MMI) and assignment of Permanent Impairment Rating (PIR), when applicable, pursuant to Sections 440.13(4)(a) and 440.15(3)(d), F.S. The form shall be submitted by the provider to the insurer, and to the employer upon request, upon the occurrence of any actionable event (change in treatment plan, regime, therapies, prescriptions, or functional limitations or restrictions) and following the injured employees achieving Maximum Medical Improvement, in accordance with the conditions and timeframes established in this rule.	Per Florida Statute 440.20(2)(a), the carrier must pay the first installment of compensation for total disability or death benefits or deny compensability no later than the 14th calendar day after the employer receives notification of the injury or death, when the disability is immediate and continuous for 8 calendar days. If the first 7 days after the disability are nonconsecutive or delayed, the first installment of compensation is due on the 6th day after the first 8 calendar days of disability. After the first week paid installment of indemnity benefits, indemnity benefits are paid in bi-weekly installments until suspended, exhausted or settled.	The injured worker can be placed on a no work status by the authorized treating physician (as deemed necessary) as it relates to the compensable work injury/illness for treatment that is medically necessary, remedial treatment and care. This includes required recovery periods as it relates to the nature of the injury.	Indemnity benefits can be suspended for medical noncompliance.	Indemnity benefits are paid at 66 2/3 % of the Average Weekly Wage (AWW). No compensation is payable if the injured worker is engaged in, or is physically capable of engaging in, at least sedentary duty work.
Georgia	In Georgia there is not a set timeframe, but is as when "medically reasonably necessary" and the employer or employee can request a return visit to see the authorized treating physician whenever either desires.	Authorized lost time benefits have to be paid on a weekly basis beginning 21 days after a date of injury with compensable lost time.	Yes	Not without a Georgia State Board of Workers' Compensation Order, or if a statute of limitation has run, or by agreement of the parties.	Only his or her personal motivation to recover as fully and completely from their physical injuries as soon as possible and by their own motivation to have a successful return to work as soon as possible.
Hawaii	There is no set timeframe or schedule please review 12-15-32 of the Hawaii Administrative Rules Workers' Compensation Medical Fee Schedule (link provided below): https://labor.hawaii.gov/dcd/files/2012/11/MFS-RULES-WEB.pdf	I am not sure what your question is referring to, but if you are referring to the time increment of when they are paid for time loss benefits, you may refer to Section 386-31 (link provided below): https://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0386/HRS_0386-0031.htm1 and Section 386-53 (link provided below): https://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0386/HRS_0386-0053.htm	Most providers provide a time loss end date. However, if they don't, I would think that the insurance adjuster would generally contact the provider to obtain an end date (example: next appointment).	There is no specific statute or administrative rule that a claim can be closed if the worker does not follow their treatment plan. If a case is closed, it can be reopened. You may review section 386-89 HRS Reopening of cases: https://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0386/HRS_0386-0089.htm	There is no specific statute or administrative rule that provide incentives for an injured worker to complete their treatment plan.
Idaho	Reasonable and/or necessary follow-up is determined by the treating physician.	Income benefits are to be paid weekly by statute, although we do allow bi-weekly payments.	Our regulations do not require an end date.	Benefits may be suspended if the injured worker fails to submit to or obstructs an examination by the physician or surgeon until such failure or obstruction ceases.	Nothing other than getting well and returning to gainful employment.
Illinois	By statute and / or Rule, there is no set time frame required for communication. Rather, it is the physician/patient relationship that will dictate the method and timing of communication.	Presuming that you are asking about the continuation of disability payments, as based upon a physician note, there is no required increment. However, there is a requirement that any physician off work slip be delivered to the employer in a timely manner. As the world has changed with Covid, so too has the delivery method of off work slips.	If there is no end date on an off work slip, it is usually subject to the caveat of "until further order" of the physician. In the truest sense of the word, the answer to your question is "yes."	As with all questions, the conclusion is not answered simply. If the claim reaches 3 years, subsequent to the last payment of compensation, without a filing at the IWCC, it is moot. Anytime prior to that, the claim is not simply closed. Employers may terminate benefits for non-compliance. If you need further discussion on this issue, or any other please call me.	The easy answer is yes, he or she wants to return to work and keep her or his job. There are many who feel that there is no incentive, short of that.
Indiana	No. We do not micromanage how insurers handle care provided to injured workers unless there is an issue about it.	No	Yes. Provider may keep the person off work until the next follow up appointment, for example.	Yes. In Indiana we actually have a Suspension of Benefits provision which can be invoked by the payer whenever the worker does not comply with medical care plan or light work restriction. If this goes on long enough, the payer can try to get the claim dismissed. Some workers are just NOT going to comply, such as with a surgical order, so the claim will be dismissed if conservative care does not work. There will be a PPI, but it will take into consideration the fact that surgery was not done.	Yes. Not getting their TTD suspended or their PPI refused. Getting the care they need to heal.
Maine	No. Injured workers seek treatment as needed.	No	Providers do not authorize payments for time lost from work.	Maine's statute does not specifically authorize an insurer/self-insurer to close a claim on this basis.	Other than an injured worker's desire to heal and return to work as soon as possible, no. Maine's statute does not contain any provisions specifically tailored to treatment plans.
Maryland	There is not a set timeframe, although disability slips should cover reasonable amounts of time and thus, presumably visits should occur within reasonable amounts of time.	There is not a specific increment for time loss benefits.	Please see no. 1 above. The provider may authorize time loss without an end date but that does not necessarily equate to the injured worker receiving time loss benefits ad infinitum.	Treatment and benefits may be terminated/suspended but the overall claim is not necessarily "closed".	Other than getting better and returning to the workforce…there is not an incentive to finish treatment, although the quicker an injured worker finishes treatment the less likely he/she will be involved in litigation.

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Michigan	We do not regulate communication between the provider and the worker. Providers must provide information to the carrier to support that the treatment that they are providing is for the work injury. This is customarily done by supplying the physician notes or diagnostic study reports.	Michigan is a wage loss state. The injured worker must show a loss of wage-earning capacity as a result of the work injury and that their ongoing disability is causing the wage loss. Our statute describes benefits as weekly with a formal definition of the weekly compensation rate as 80% of the after-tax weekly wage.	? Yes, however, most carriers expect to see disability slips that state the worker will be off work for a period of time, i.e., able to return to work in 4 weeks, etc.	Both wage-loss and medical benefits in Michigan are potentially life long. This means that if you meet the definition of disability and it results in wage-loss then you are entitled to weekly benefits. Similarly, if the medical treatment that is provided is reasonable and related to the work injury then it remains the carrier's responsibility. It is commonplace for carriers to close files, but their liability can only be fully terminated through an Agreement to Redeem that must be approved by a Workers' Compensation Magistrate.	While there is an argument that non-compliance with medical treatment could result in the termination of weekly wage-loss benefits, it is a rare occurrence and cannot be sustained if the treatment is invasive in any way. So truly the only incentive is recovery from the work injury.
Minnesota	No	No. Minnesota rules do require that health care providers complete a report of work ability (form here) within 10 days of request by an insurer or self-insured employer or at the following intervals: (1) every visit if visits are less frequent than once every two weeks; (2) every two weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; or (3) upon expiration of the ending or review date of the restriction specified in a previous report of work ability. Minn. R. 5221.0410, subp. 6 (A)(3). The form includes information on an employee's work restrictions and is used by payers to authorize benefits. The treatment parameters for treatment of post-traumatic stress disorder (PTSD) require a psychotherapy provider to complete a report of work ability every two weeks while a patient is receiving psychotherapy treatment. Minn. R. 5221.6700, subp. 5(C).	No, Minnesota rules state "open-ended durations of disability or restriction may not be given." Minn. R. 5221.0410, subp. 6 (A)(3).	No. However, workers' compensation benefits may be suspended if the employee refuses reasonable medical treatment, subject to reinstatement from the time the employee accepts treatment. The Minnesota Supreme Court has stated that workers whether an employee's refusal of treatment is reasonable requires "a weighing of the probability of the treatment's successfully reducing the disability by a significant amount, against the risk of the treatment to the [employee]." The Court has also stated that generally, an employee's unreasonable refusal to submit to corrective surgery justifies suspension of payment of benefits. Reasonableness is based on a number of factors, including the dangerousness of the operation, the likelihood of success, and the pain and discomfort possible from the surgery.	No, but refusal of reasonable treatment puts their benefits in jeopardy as explained in number 4 above.
Montana	No	Typically bi-week (39-71-740).	Providers are required to fill out the Medical Status Form (39-71-1036). One of the things that is required to be addressed on the form is the anticipated date of release.	Insurers may suspend compensation benefits pending the receipt of medical information when an IW unreasonably fails to keep scheduled medical appointments (39-71-607).	I don't understand this question. The incentive is they get better. The disincentive is that they can have their benefits terminated, see #2 above, if they do not comply.
Nebraska	In Nebraska, there is no set time frame for physician examinations. Situations are analyzed on a case by case basis.	No. Time loss benefits do not have to be authorized in specific increments.	There are no statutory (or court rule) requirements that a medical provider place an end date as to time loss. This is another issue that would be analyzed on a case by case basis. If an employee or employer took issue with an open-ended release from work, they could request a hearing in front of one of the judges to address the duration of time loss due to the work accident.	We have two points to make in response to this question. First, a claim can only be closed by complying with statutory procedures for settlement releases or court-approved settlements. See Nebraska revised Statutes § § 48-138 and 48-139. Second, while a claim can't be closed if a worker doesn't follow their treatment plan, and that failure rises to the level described in our statutes, the employer may be able to obtain an order suspending, reducing, or limiting benefits.Nebraska Revised Statutes § 48-120(2)(c) provides that " If the injured employee unreasonably refuses or neglects to avail himself or herself of medical or surgical treatment furnished by the employer, except as herein and otherwise provided, the employer is not liable for an aggravation of such injury due to such refusal and neglect and the compensation court or judge thereof may suspend, reduce, or limit the compensation otherwise payable under the Nebraska Workers' Compensation Act "	There are no statutory incentives for an injured worker to complete their treatment plan, nor do applicable court rules establish such incentives. The usual incentives, such as a desire to support oneself / family and return to productive activity, would apply.
Nevada	NAC 616C.055 Reports required 3. The following reports are required on a scheduled basis: (a) A monthly report prepared by the treating physician or chiropractic physician during the period of disability. The report must contain a narrative summary of the condition of the injured employee, his or her progress, and the physician's or chiropractic physician's plan of future treatment and prognosis. The report is due on or before the 10th day of each month following the month in which the treatment or evaluation is rendered.	NRS 616C.475 Amount and duration of compensation; limitations; cessation of payments; requirements for certification of disability; offer of light-duty employment. [Effective January 1, 2022.] 3. If a claim for the period of temporary total disability is allowed, the first payment pursuant to this section must be issued by the insurer within 14 working days after receipt of the initial certification of disability and regularly thereafter.	NRS 616C.475 Amount and duration of compensation; limitations; cessation of payments; requirements for certification of disability; offer of light-duty employment. [Effective January 1, 2022.] 7. A certification of disability issued by a physician or chiropractic physician must: (a) Include the period of disability and a description of any physical limitations or restrictions imposed upon the work of the employee; (b) Specify whether the limitations or restrictions are permanent or temporary; and (c) Be signed by the treating physician or chiropractic physician authorized pursuant to NRS 616B.527 or appropriately chosen pursuant to subsection 4 or 5 of NRS 616C.090.	Yes, there can be several scenarios for claim closure. However, if they do not follow up for medical treatment, the Insurer/TPA may issue the Intent to Close claim letter, with appeal rights, which expire in 70 days, (+3 days for mailing), whether receiving TTD/TPD benefits or not. NRS 616C.140 Medical examination of claimant; effect of refusal to submit to examination; communications not privileged. [Effective January 1, 2022.] 5. If the employee refuses to submit to an examination ordered or requested pursuant to subsection 1 or 2 or obstructs the examination, the right of the employee to compensation is suspended until the examination has taken place, and no compensation is payable during or for the period of suspension.	Yes, if they are receiving temporary total disability (TTD) or temporary partial disability (TPD) benefits and do not follow up for medical treatment, benefits can be suspended until treatment resumes. NRS 616C.230 Grounds for denial, reduction or suspension of compensation; evidence of and examination for use of alcohol or controlled substance. [Effective January 1, 2022.] 4. If any employee persists in an unsanitary or injurious practice that imperils or retards his or her recovery, or refuses to submit to such medical or surgical treatment as is necessary to promote his or her recovery, the employee's compensation may be reduced or suspended. 5. An injured employee's compensation, other than accident benefits, must be suspended if: (a) A physician or chiropractic physician determines that the employee is unable to undergo treatment, testing or examination for the industrial injury solely because of a condition or injury that did not arise out of and in the course of employment; and (b) It is within the ability of the employee to correct the nonindustrial condition or injury. The compensation must be suspended until the injured employee is able to resume treatment, testing or examination for the industrial injury. The insurer may elect to pay for the treatment of the nonindustrial condition or injury.

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New Hampshire	There is no requirement in New Hampshire's Workers Compensation Law that requires a medical provider to treat an injured worker on a statutorily specified schedule.	No. Workers Compensation insurance carriers liable to make payment of lost time for a disability period must do so for the pendency of the disability period and there is no statutory requirement for reauthorization from the Department.	There is no requirement under New Hampshire's workers compensation law that requires an end date if that provider has determined the injured worker is not released to return to work as a result if his or her injuries.	Relative to indemnity payments, an insurance carriers may not reduce or terminate indemnity benefits to an injured worker without approval from the Department of Labor, per New Hampshire's Workers Compensation Law at RSA 281-A:48. Any insurance carrier seeking to terminate or reduce indemnity benefits would need to petition for and Department approval to do so, and provide documentation supporting that the injured worker has had a change of condition. Relative to medical benefits, an insurance carrier may deny medical expenses presented if those expenses are not reasonable, necessary and related to the underlying injury, even if the case has been approved for lump sum settlement.	There are not specific provisions in New Hampshire's Workers Compensation Law relative to incentives and/or treatment plan completeness/compliance.
New York	When a claimant's disability has not been classified as permanent, there is no presumption or inference of a continuing disability, and the claimant's attending physicians have the burden of submitting up-to-date medical evidence that the disability is continuing (see 12 NYCRR 325-1.3[b][3]; Matter of Virtuoso v Glen Campbell Chevrolet, Inc., 66 AD3d 1141 [2009]). Pursuant to 12 NYCRR 325-1.3(b)(3), the claimant's attending physician is required to submit progress reports of ongoing medically necessary treatment and "the intervals between [those] follow-up visits shall be no more than 90 days."	In New York State, Workers' Compensation benefits are ordered to be paid by a Workers' Compensation Law Judge (WCLJ). There is no specific time frame for such benefits. Typically, a WCLJ will determine the degree of the claimant's disability (based on medical evidence introduced) and order benefits to be paid at the appropriate rate for the period from either the date of injury or date of a prior order to the date of the present order and direct the carrier to continue to pay benefits for an indefinite period at the same or a different rate. The carrier or claimant may, at any time thereafter, seek a change in the benefit rate based on new medical evidence. A carrier may only unilaterally suspend continuing payments in limited circumstances, such as when the record contains evidence of the claimant's return to work, based on two weeks of payroll records; when the claimant's treating physician has provided an opinion of no disability; or when the carrier obtains and submits "proof of incarceration upon [the claimant's] conviction of a felony" (12 NYCRR 300.23[b][3][i]-[iv]).	Medical providers have no authority to authorize Workers' Compensation benefits in New York State. Providers and carrier's medical consultants provide medical evidence to the WCLJ, who then makes a legal determination as to a claimant's temporary or permanent degree of disability and the amount(s) and period(s) of benefits (if any) to be paid.	The New York State Workers' Compensation Law has no provision for "treatment plans."	Workers' Compensation benefits are initially paid on a temporary basis depending on the WCLJ's finding of the temporary degree of disability until such time as the WCLJ determines, based on medical evidence provided, that the claimant has reached maximum medical improvement (MMI), i.e., that the claimant has recovered from the work injury or illness to the greatest extent that is expected, and no further improvement is reasonably expected. Upon a determination of MMI, the WCLJ will make a finding as to the degree of permanent disability (if any) and award benefits (if any) in accordance with that finding.
North Carolina	No	No	Yes	No	Failure to comply with medical treatment could result in suspension of workers' compensation benefits during the period of non-compliance, if ordered by the Industrial Commission.
North Dakota	Not directly. Disability must be certified by the employee's healthcare provider. NDCC 65-05-08.1. A schedule is not statutorily specified.	No	There is no statutory prohibition.	? If an employee fails to follow a treatment plan, indemnity benefits may terminate. The termination can be for the remainder of the claim. Medical benefits however, are unaffected. NDCC 65-05-28(4).	If an injured worker does not complete the plan, they risk moving into medical non-compliance and losing indemnity benefits. NDCC 65-05-28(4).
Ohio	No	No	No	No	No
Pennsylvania	No	No, this is controlled by statues that state they must be paid per their regular pay schedules.	Yes	Not unilaterally, a petition must be filed.	Not statutorily.
Rhode Island	No time schedule.	No specific increments	Yes	Yes	No, but benefits can be suspended if not followed.
South Dakota	It is set up by the case management plan or by the claimant and employer/insurer	It is set up by the case management plan or by the claimant and employer/insurer	It is set up by the case management plan or by the claimant and employer/insurer	A claim can be suspended if a claimant refuses to avail themselves to treatment. (SD 62-4-43)	Once they are at MMI they receive PPD payments according to SDCL 62-4-6.
Texas	There is no such provision in the Texas Labor code	No. Once the injured employee accrues benefits (related to TTD or PPD (050/070), they will continue weekly until the injured employee is released to return to work full duty or light duty earning same preinjury wages. There are other events that can suspend the weekly benefits such as certification of MMI, incarceration, IC denial (if timely and complete denial filed), death unrelated to injury, etc.	Rule 129.5(d)(2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the injured employee).	I would first like to point out that the Texas Labor Code provides for lifetime income benefits for certain severe injuries and provides for lifetime medical benefits for all injuries. For those reasons, a claim cannot be considered "closed" until all benefits are exhausted including lifetime medical benefits which end when the employee dies. That said, no there is no such provision in the Texas Labor code.	There are no incentives in the Texas Labor Code.
Utah	There is no set schedule for physicians to treat patients who are receiving loss time benefits in Utah.	A provider does not have to authorize time loss in specific increments in Utah. There are requirements for timely payment of the benefits by the carrier, which is codified based on benefit type.	A provider can authorize time loss without an end date.	A claim can be denied in whole, or in part, if an injured worker does not follow a treatment plan that is considered reasonable and necessary.	Only benefit continuation.
Vermont	No	No. The only caveat here is that after 90 days of TTD the carrier has to refer the injured worker to voc rehab screening, and after 104 weeks of TTD the carrier is required to review the claim and provide either an expected end date of disability, or file a notice to discontinue if the worker is at end medical result.	No	Yes. Failure to follow a medical treatment plan or failure to cooperate with a voc rehab counselor are grounds for termination of TTD.	Not in the affirmative. Rather, the worker risks discontinuance of temporary benefits for not completing the treatment plan.
Virginia	There is no required schedule.	No, they do not have authorized in specific increments.	Yes.	If the claimant refuses treatment/treatment plan the Claims Administrator can file to terminate benefits by filing an Employer's Application for Hearing.	Return to gainful employment.

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Surveys sent by the Workers' Compensation Division to other state contacts. Responses are listed verbatim as received.

Column1	For workers on time loss, are physicians or other providers required to see or communicate with them on a schedule or in a set timeframe - e.g. once every 30 days, every two weeks, once per month? If so, what is the required schedule?	Do time loss benefits have to be authorized in specific increments, e.g., 14 days at a time? If so, what are the increments?	Can a provider authorize time loss without an end date?	Can a claim be closed if the worker does not follow their treatment plan?	Does an injured worker have any specific incentives to complete their treatment plan?
Wisconsin	In Wisconsin physicians and other health care providers are not required by statute or administrative rule to see or communicate with injured workers on a schedule or set timeframe.	There is no statute or administrative rule that requires compensation for temporary disability (compensation for lost time) to be authorized in specific increments.	Physicians and other competent practitioners may authorize time off work for injured employees without a specific end date.	Section 102.42 (6), Wis. Stats., covers treatment rejected by an employee. A summary of this subsection provides that no compensation shall be payable for death or disability of an employee, if the death or disability is aggravated, caused or continued by an unreasonable refusal or neglect by the employee to submit to or follow any competent and reasonable treatment when found by the department or division to be necessary. This provision does not apply to employees who elected Christian Science treatment in lieu of medical treatment.	There are no specific incentives in our law or administrative rules for an injured employee to complete the treatment plan. The primary incentive is for the employee is to successfully recover from the injury and return to work.
Wyoming	Wyoming Statute 27-14-404(g) states only a healthcare provider may certify temporary total disability (TTD) benefits. The length of time of the initial certification or recertification of TTD shall be established by the department after considering the recommendation of the health care provider and current medical literature. The employee, employer, or division may request recertification at intervals of not less than sixty (60) days. The division does require the injured worker to see their physician every 60 days while receiving TTD benefits.	Wyoming Statute 27-14-403 (c) requires Temporary Total Disability (TTD) benefits to be paid twice a month, with half paid on or about the fifteenth of the month and the other half paid on or about the thirtieth of the month.	The division considers certification to be incomplete without an end date. When this occurs, we return the temporary total disability application to the injured worker and the physician to request an end date.	Wyoming Statute 27-14-404 (h) states temporary total disability benefits shall be suspended if the injured worker fails to appear at an appointment with his health care provider. Payment shall be suspended until the employee appears at a subsequent rescheduled appointment. Payment shall not be suspended for failing to appear at an appointment if the injured worker notifies the division before the appointment or within twenty-four (24) hours after missing the appointment if it's determined that the injured worker made all reasonable efforts to keep the appointment. If the division has not paid a claim in 120 days, the claim will be inactivated and no further benefits will be paid unless future treatment billed to the division is determined to be related to the original injury.	Wyoming Statute 27-14-403(k) allows the division to offer a three percent (3%) incentive on temporary total disability benefits if the injured worker receives all of their care in Wyoming. The division does not offer an incentive to complete a treatment plan.