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Workers' Compensation Board Government Evaluation Act Program Evaluation Report. 2010

Maine Workers' Compensation Board

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**Maine
Workers' Compensation Board**

**Government Evaluation Act
Program Evaluation Report**

February 1, 2010

Maine Workers' Compensation Board
BOARD MEMBERS

BOARD CHAIR

Paul R. Dionne, Executive Director

MANAGEMENT REPRESENTATIVES

James A. Mingo
Term Expires: 3-24-2011

Mitchell P. Sammons
Term Expires: 3-24-2012

Sophia Leotsakos-Wilson
Term Expires: 3-24-2013

LABOR REPRESENTATIVES

Anthony Monfiletto
Term Expires: 3-24-2011

Daniel Lawson
Term Expires: 3-24-2012

Ginette Rivard
Term Expires: 3-24-2013

TITLE 3 §956. PROGRAM EVALUATION REPORT

TITLE 3 §956. PROGRAM EVALUATION REPORT

1. Report required. Each agency and independent agency shall prepare and submit to the Legislature, through the committee of jurisdiction, a program evaluation report by a date specified by the committee.

[1995, c. 488, §2 (NEW) .]

2. Program evaluation report; contents. Each report must include the following information in a concise but complete manner:

A. Enabling or authorizing law or other relevant mandate, including any federal mandates; [1995, c. 488, §2 (NEW) .]

B. A description of each program administered by the agency or independent agency, including the following for each program:

(1) Established priorities, including the goals and objectives in meeting each priority;

(2) Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving the goals and objectives; and

(3) An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives; [1995, c. 488, §2 (NEW) .]

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility; [1995, c. 488, §2 (NEW) .]

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation; [1995, c. 488, §2 (NEW) .]

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years; [1995, c. 488, §2 (NEW) .]

F. When applicable, the regulatory agenda and the summary of rules adopted; [1995, c. 488, §2 (NEW) .]

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements; [1999, c. 661, §1 (AMD) .]

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes; [1995, c. 488, §2 (NEW) .]

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives; [1995, c. 488, §2 (NEW) .]

J. Identification of emerging issues for the agency or program in the coming years; [1999, c. 661, §1 (AMD) .]

K. Any other information specifically requested by the committee of jurisdiction; [2001, c. 321, Pt. A, §1 (AMD) .]

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; [2001, c. 495, §1 (AMD) .]

M. Agency policies for collecting, managing and using personal information over the Internet and

nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement; and [2001, c. 495, §2 (AMD).]

N. A list of reports, applications and other similar paperwork required to be filed with the agency by the public. The list must include:

- (1) The statutory authority for each filing requirement;
- (2) The date each filing requirement was adopted or last amended by the agency;
- (3) The frequency that filing is required;
- (4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and
- (5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication. [2001, c. 495, §3 (NEW).]

[2001, c. 495, §1-3 (AMD) .]

SECTION HISTORY

1995, c. 488, §2 (NEW). 1999, c. 661, §§1,2 (AMD). 2001, c. 321, §§A1-3 (AMD). 2001, c. 495, §§1-3 (AMD).

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WORKERS' COMPENSATION BOARD

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A. ENABLING LEGISLATION AND HISTORY OF MAINE WORKERS' COMPENSATION

I. ENABLING LEGISLATION.

39-A M.R.S. § 101, et seq. (Maine Workers' Compensation Act of 1992)

On January 1, 1993, Title 39, which contained the Workers' Compensation Act of 1991 and all prior workers' compensation acts, was repealed and replaced with Title 39-A, the Workers' Compensation Act of 1992.

II. REVISIONS TO ENABLING LEGISLATION.

The following are some of the revisions made to the Act since 1993.

- **§ 102(11)(B-1).** Tightened the criteria for wood harvesters to obtain a predetermination of independent contractor status.
- **§ 113.** Permits reciprocal agreements to exempt certain nonresident employees from coverage under the Act.
- **§ 151-A.** Added the Board's mission statement.
- **§ 153(9).** Established the monitoring, audit & enforcement (MAE) program.
- **§ 153-A.** Established the worker advocate program.
- **§ 201(6).** Clarified rights and benefits in cases which post-1993 work injuries aggravate, accelerate, or combine with work-injuries that occurred prior to January 1, 1993.
- **§ 213(1-A).** Defines "permanent impairment" for the purpose of determining entitlement to partial incapacity benefits.
- **§ 224.** Clarified annual adjustments made pursuant to former Title 39, §§ 55 and 55-A.
- **§ 328-A.** Created rebuttable presumption of work-relatedness for emergency rescue or public safety workers who contract certain communicable diseases.
- **§§ 355-A, 355-B, 355-C, and 356.** Created the Supplemental Benefits Oversight Committee.
- **§§ 151, Sub-§1.** Established the Executive Director as a gubernatorial appointment and member and Chair of the Board of Directors. Changed the composition of the Board from eight to seven members.

III. STATE AGENCY HISTORY.

The original agency, the Industrial Accident Board, began operations on January 1, 1916. In 1978, it became the Workers' Compensation Commission. In 1993, it became the Workers' Compensation Board.

A. The Early Years of Workers' Compensation.

A transition from common law into the statutory system we know today occurred during the late teens and early 1920's. Earlier, an injured worker had to sue his employer and prove fault to obtain compensation. Workers' compensation was conceived as an alternative to tort. Instead of litigating fault, injured workers would receive a statutorily determined compensation for lost wages and medical treatment. Employers gave up legal defenses such as assumption of risk or contributory negligence. Injured workers gave up the possibility of damages, beyond lost wages and medical treatment, such as pain and suffering and punitive damages. This historic bargain, as it is sometimes called, remains a fundamental feature of workers' compensation. Perhaps because of the time period, financing and administration of benefit payments remained in the private sector, either through insurance policies or self-insurance. Workers' compensation disputes still occur in a no fault system. For example, disputes arise as to whether the disability is related to work; how much money is due the injured worker; and, how much earning capacity has been permanently lost. Maine, like other states, established an agency to process these disputes and perform other administrative duties. Disputes were simpler. Injured workers rarely had lawyers. Expensive, long term, and medically complicated claims, such as carpal tunnel syndrome or back strain, were decades away.

B. Adjudicators as Fact Finders.

In 1929, the Maine Federation of Labor and an early employer group listed as "Associated Industries" opposed Commissioner William Hall's re-nomination. Testimony from both groups referred to reversals of his decisions by the Maine Supreme Court. This early feature of Maine's system, direct review of decisions by the Supreme Court, still exists today. The Supreme Court decides issues regarding legal interpretation, and does not conduct a whole new trial. In Maine, the state agency adjudicator has historically been the final fact finder.

Until 1993, Commissioners were gubernatorial appointments, subject to confirmation by the legislative committee on judiciary. The need for independence of its quasi-judicial function was one of the reasons why it was established as an independent agency, rather than as a part of a larger administrative department within the executive branch. The smaller scale of state government in 1916 no doubt also played a role.

C. Transition to the Modern Era.

In 1974, workers' compensation coverage became mandatory. This and other significant changes to the statute were passed without an increase in appropriation for the Industrial Accident Commission. In 1964 insurance carriers reported about \$3 million in direct losses paid. By 1974 that had grown to about \$14 million of direct losses

paid. By 1979, direct losses paid by carriers totaled a little over \$55 million. By 1984, it had grown to almost \$128 million. These figures do not reflect benefits paid through self-insurance. This exponential growth of the system resulted from legislative changes during the late 1970's and set the stage for a series of workers compensation crises that occurred throughout the 1980's and into the early 1990's.

During the early 1970's time limits were removed for both total and partial wage loss benefits. Inflation adjustments were added. The maximum benefit was set at 200% of the state average weekly wage. Also, laws were passed making it easier for injured workers to secure the services of an attorney. The availability of legal representation greatly enhanced an injured worker's likelihood of receiving benefits, especially in a complex case. And, statutory changes and evolving medical knowledge brought a new type of claim into the system. The law no longer required a specific accident. Doctors began to connect injuries such as carpal tunnel syndrome and back problems to work and thus brought these injuries within the coverage of workers' compensation.

Such injuries required benefit payments for longer periods than most accidental injuries. These claims were more likely to involve litigation. Over the course of a decade, rising costs quickly transformed workers compensation into a contentious political issue in the late 1980's and early 1990's.

In 1980, Commissioners became full-time and an informal conference process was added to attempt to resolve disputes early in the claim cycle, before a formal hearing.

Additionally, regional offices were established in Portland, Lewiston, Bangor, Augusta, and Caribou, supported by the central administrative office in Augusta.

In 1987, three full-time Commissioners were added, bringing the total to 11, in addition to the Chair. Today, the Board has eight Hearing Officers.

The workers' compensation environment of the 1980's and early 1990's was an extraordinary time in Maine's political history. Contentious legislative sessions regarding workers' compensation occurred in 1982, 1985, 1987, 1991, and 1992. In 1991, then Governor John McKernan tied his veto of the State Budget to changes in the workers' compensation statute. State Government was shut down for about three weeks.

In 1992, a Blue Ribbon Commission made a series of recommendations which were ultimately enacted. Inflation adjustments for both partial and total benefits were eliminated. The maximum benefit was set at 90% of state average weekly wage. A limit of 260 weeks of benefits was established for partial disability. These changes represented substantial reductions in benefits for injured workers, particularly those with long term disabilities. Additionally, the section of the statute concerning access to legal representation was changed making it more difficult for injured workers to secure the services of private attorneys.

Maine Employers' Mutual Insurance Company was established. It replaced the assigned risk pool and offered a permanent source of coverage. Despite differing views on the nature of the problems within the preceding and current system, virtually all observers agree that MEMIC has played a critical role in stabilizing the workers' compensation environment in Maine.

Based on the recommendation of the Blue Ribbon Commission, the Workers' Compensation Board was created directly involving labor and management in the administration of the State agency.

The Board of Directors originally consisted of four Labor members and four Management members, appointed by the Governor based on nomination lists submitted by the Maine AFL-CIO and Maine Chamber of Commerce. The eight Directors hired an Executive Director to run the agency. In 2004 legislation was enacted to reduce the Board to three Labor Directors and three Management members. The Executive Director became a gubernatorial appointment, confirmed by the Senate and serving at the will of the Governor.

The Board of Directors appoints Hearing Officers to adjudicate Formal Hearings. A two step process replaced informal conferences, troubleshooting, and mediation.

In 1997, legislation was enacted which provided more structure to case monitoring operations of the Board and created the MAE program. Also in 1997, a worker advocate program, created by the Board, was expanded by the Legislature.

In terms of both regulatory and dispute resolution operations the Board has experienced significant accomplishments. In terms of its traditional operation, dispute resolution, the Board can show an efficient informal process. Between troubleshooting and mediation, approximately 75% of initial disputes are resolved within 80 days from the date a denial is filed. An efficient formal hearing process had reduced timelines to an acceptable 7.3 months for processing cases in 2000. Gridlock by the Board of Directors regarding appointment of Hearing Officers occurred in 2003 and 2004, resulting in slightly longer time frames at the formal level, about 10.5 months in 2004. The problem was exacerbated by the Law Court decision in *Lydon v. Sprinkler Systems* significantly reducing the number of independent medical examiners (IME) from 30 to 11. The gridlock of the appointment of hearing officers was broken as hearing officers were appointed to seven year terms, and the IME problem has improved significantly through the addition of more Independent Medical Examiners.

In an apples to apples comparison, matching the complexity of the dispute and the type of litigation, the Board's average time frame of about nine months for formal hearings is rapid, compared to other states, and especially if compared to court systems for comparable personal injury cases.

The agency was criticized for not doing more with its data gathering and regulatory operations during the late 1980's and early 1990's. But the benefit of a relational database installed in 1996, and a modern programming language, the agency is making progress. Filings of first reports and first payment documents are systematically tracked. Significant administrative penalties have been pursued in several cases. The computer applications and the abuse unit are doing a better job of identifying employers, typically small employers, with no coverage. No coverage hearings are regularly scheduled. The Board has mandated the electronic filing of First Reports with an effective date of July 1, 2005. The Board has also mandated the electronic filing of denials, with an effective date of June 2006, and for payments, with an anticipated implementation date of December 2010.

During the late 1990's, the Board of Directors began to deadlock on significant issues such as the appointment of Hearing Officers, the adjustments to the benefit structure under section 213, and the agency budget. By 2002, this had become a matter of Legislative concern. Finally, in 2004, legislation was proposed by Governor Baldacci and enacted to make the Board's Executive Director a tie-breaking member of the Board and its Chair. The Executive Director became a gubernatorial appointment, subject to confirmation by the legislative Committee on Labor and the Senate, serving at the pleasure of the Governor. With the new arrangement, gridlock due to tie votes is no longer an issue. The Executive Director casts deciding votes when necessary. However, the objective is still to foster cooperation between the Labor and Management caucuses, which has occurred more frequently since 2004.

Chapter 208, A Resolve to Appoint Members To and Establish Terms for the Workers' Compensation Board, was enacted during the second session (2008) of the 123rd Legislature. The purpose of the Resolve was to change the membership on the Board while maintaining continuity. The Governor appointed new members during the first session (2009) of the 124th Legislature. The Governor's appointments were confirmed by the Legislature.

B. DESCRIPTION OF PROGRAMS

B1. EXECUTIVE SUMMARY

The State Government Evaluation Act “provides for a system of periodic review of agencies and independent agencies of State Government in order to evaluate their efficiency and performance. The financial and programmatic review must include, but is not limited to, a review of agency management and organization, program delivery, agency goals and objectives, statutory mandates and fiscal accountability.”

WORKERS' COMPENSATION BOARD

The Governor worked diligently with both labor and management to ensure the passage of Public Law 2004 Chapter 608 which became effective April 8, 2004. The intent of the legislation was to break the Board's gridlock on key issues and return a sense of normalcy to the Board's operations. The legislation changed the structure of the Board from eight members to seven. Three members represent labor and three represent management. The seventh member is the Executive Director, who serves as Chair of the Board and at the pleasure of the Governor. Since the effective date of the legislation, the Board has resolved all of the gridlock issues and functions in an effective manner in setting policy for Board business. Some of the difficult issues the Board has acted on, or will act on, include: hearing officer appointments; hearing officer terms; budgetary and assessment matters; Section 213 actuarial studies; electronic filing mandates; by-law revisions; legislation; compliance issues; independent medical examiners; worker advocate resources and reclassifications; dispute resolution issues; increase in compliance benchmarks; independent contractors; an independent audit by Blake, Hurley, McCallum, and Conley; a Facility Fee Schedule; data gathering project; and Employee Misclassification.

The importance of the Governor's legislation (Chapter 608) cannot be overly emphasized. The State of Maine has gradually improved its national rating regarding the costs of workers' compensation and an effective and efficient Board help to perpetuate this positive trend. Decisions are less regularly made by the Chair in a tie-breaking manner, which means, in large part, that the parties of interest are reaching consensus more often on decisions that impact their constituencies.

The composition of the Board was changed as a result of recent legislation. In order to maintain continuity, a member from both Labor (Anthony Monfiletto) and Management (James Mingo) were nominated by the Governor and confirmed by the Legislature. The Executive Director/Chair (Paul Dionne) was also nominated by the Governor and confirmed by the Legislature. Two new Labor Members (Ginette Rivard and Dan Lawson) and two new Management Members (Sophia Leotsakos Wilson and Mitch Sammons) were nominated by the Governor and confirmed by the Legislature. The new Board is handling difficult issues efficiently and professionally. As an example, the

Board, upon the recommendation of the Executive Director, approved a transfer of \$3 million to offset the assessment to employers.

It was not too long ago that Maine was one of the costliest states in the nation in regard to workers' compensation costs. A recent article in the *Workers' Compensation Policy Review* compared the costs of benefits for 47 states and highlighted Maine's achievements during the past few years: "The experience in Maine ... clearly demonstrates that significant reduction in cash, medical, and total benefits are possible."

The various reports comparing Maine to the other states in regard to the costs of workers' compensation indicate that Maine has improved significantly in lowering its costs. "Maine is one of the states with the largest decrease in benefit costs" ; "Maine is at the national average for cash benefits, medical benefits, and total cash and medical benefits" ; "Maine's rank was 30th among 45 states and Maine's rank was 3rd among the New England states with only Massachusetts and Rhode Island faring better than Maine."

Maine has gone from one of the costliest states in the nation to one that is moving to the level of average costs for both premiums and benefits and has positioned itself to continue this trend. Maine appears to have struck a balance between reasonable costs and reasonable benefits, all within the Governor's policy of keeping Maine fair-minded and competitive.

The Board submitted two bills for consideration during the First Regular Session of the 124th Legislature, both were enacted into law.

The first bill changes the assessment process so that assessment collections which exceed 10% of the maximum assessment are used to reduce the annual assessment on insured employers.

The second bill clarifies that Maine Insurance Guaranty Association (MIGA) is required to pay all penalties for non-compliance of the Maine Workers' Compensation Act, with the exception of the penalty in Section 359(2) provided for in Title 39-A.

The Board will submit at least three bills for consideration during the Second Regular Session of the 124th Legislature.

One will ensure that penalties for not maintaining required workers' compensation coverage are applied equally to all business entities;

Another will enhance the Abuse Unit's ability to coordinate enforcement with other agencies;

And, the third bill will reverse the Law Court's holding in *Nichols v. S.D. Warren* clarifying that certain insurance benefits are not subject to offset.

An independent accountant report prepared by Blake, Hurley, McCallum & Conley gave the Board a clean bill of health for the past 10 years in regard to its assessment and budgetary procedures. It also advanced recommendations to improve the process, most of which have been implemented by the Board. One of the recommendations that has not been dealt with was to legislatively change the "assessment statute to require

to Maine businesses. And, the Board has reduced the assessment to employers by \$3 million. All of which contribute to one of the more stable workers' compensation systems in the country.

In the past seven years, the Maine Workers' compensation Board has transitioned from an agency whose purpose was mainly dispute resolution to one which provides effective regulation, improved compliance, strong advocacy for injured workers, and is now assuming a major role in employee misclassification.

insurance companies to pay assessments on the same basis as the self-insureds" (cash basis in lieu of rate basis). The change would simplify the process and reduce administrative costs, but would be very cumbersome for the insurance companies to implement.

The Workers' Compensation Board has made significant progress in regard to a Facility Fee Schedule to contain health care costs. In 2007, the Board contracted with Ingenix to review hospital inpatient, outpatient, and ambulatory surgical center charges and costs. Four meetings have been held with the consensus-based rulemaking group. Although that group was able to reach consensus on the methodology, it was unable to agree on the base rate. The objectives of the Fee Schedule include: providing access to quality care for injured workers, ensuring that providers are paid fairly, reducing and containing healthcare costs, and, creating clarity in rules and simplicity for maintenance.

The Facility Fee Schedule should not be viewed as a one-time event, accordingly, Board Staff has recommendations for future courses of action:

- Medicare updates should be reviewed and adjusted annually;
- Payment rates should be recalculated and adjusted annually;
- Expenditures should be analyzed annually;
- Ingenix should be retained for one year to review and analyze the data and make recommendations to the Board as to adjustments to the Facility Fee Schedule.

The Board agreed on a rule for the Facility Fee Schedule which was sent out for public hearing. Comments were submitted by the various interest groups and considered by the Board. In November 2009, the Board agreed to obtain new data and consider its impact, if any, on the base rate for payment. As a result, the Board missed the adoption deadline date of December 24, 2009 for passage of the rule. The Board will consider the new data and send a rule back out for public hearing in 2010.

Employee misclassification is another issue dealt with by the Board in 2009. This is a huge problem in Maine as well as nationally. The Governor issued an Executive Order in January 2009 appointing a Task Force to analyze the problem in Maine and to make recommendations to the Governor.

The Task Force has met regularly over the past 12 months and has held three, well-attended, public hearings in Bangor, Portland, and Lewiston. The Workers' Compensation Board has two members on the Task Force and has provided a Report to the Task Force and the Legislature. The Report recommends internal changes, such as reclassification and reallocation of positions which would improve oversight significantly at very little costs. The Report also recommends that the Task Force consider the feasibility of creating an Employee Misclassification Unit and determine whether this would lead to increased revenues and decreased premiums.

Overall, dispute resolution is performing at peak levels. Compliance with the Workers' Compensation Act is high. Frequency of claims is down. Compensation rates have dropped 47 percent since 1993. The Superintendent of Insurance has approved a 7 percent rate reduction for 2010. MEMIC has recently declared a \$15 million dividend

B2. INTRODUCTION

The original agency, known as the Industrial Accident Board, began operations on January 1, 1916. It became the Workers' Compensation Commission in 1978. It became the Workers' Compensation Board in 1993.

The major programs of the Board fall into six categories: (1) Dispute Resolution; (2) Compliance – Monitoring, Auditing, and Enforcement (MAE) Program; (3) Worker Advocate Program; (4) Independent Medical Examiners/Medical Fee Schedule; (5) Technology; (6) Central and Regional Office support; and (7) potentially Employee Misclassification.

The implementation of Standard Operating Procedures (SOPs) has resulted in the elimination of backlogs and an efficient dispute resolution system. But a Law Court decision in regard to the Independent Medical Examiner program has reversed some of the progress. The Law Court holding in *Lydon v. Sprinkler Systems* has resulted in a reduction in the number of independent medical examiners causing delays to the formal hearing process. Cases without an IME are processed within 8 months, while cases with an IME are taking over 11 months to process through the formal hearing system. The Board's ability to attract doctors in the appropriate specialties to serve as independent medical examiners has been difficult and in order to ameliorate the problem the Board in 2009 raised the fee schedules for the IMEs. The number of IMEs has fluctuated greatly. The number was 30 pre- *Lydon*; 11 post- *Lydon*; and 24 currently.

The MAE Program has dramatically improved compliance throughout the industry both as to payments and filings. The basic goals of the programs are to (1) provide timely and reliable data to policy-makers; (2) monitor and audit payments and filings; (3) identify insurers, self-insurers and third-party administrators that are not complying with minimum standards. Compliance is near 90% in all categories, a huge improvement since the inception of the MAE Program.

The Worker Advocate Program has given injured workers access to advocates improving their likelihood of receiving statutory benefits. Nearly 50% of injured workers are represented by advocates at the mediation level and over 30% are represented by advocates at the formal hearing level.

The Board has recently mandated the electronic filing of First Reports of Injury (July 1, 2006), Notices of Controversy (April to June 2006), Memorandums of Payment and related documents (May 1, 2009), and Proof of Coverage (May 1, 2009).

The Board is not a General Fund agency and receives its revenue to fund its operations through an assessment on Maine's employers. The Legislature established the assessment as a revenue source to fund the Board, but capped the assessment, limiting the amount of revenue which can be assessed.

The Board's assessment was adequate to fund the Board's operations until FY97. In 1997, the Board implemented legislation that expanded the Worker Advocate Program and created the MAE Program. The cost of these programs has been in excess of the amount allocated for the task. The cost of these programs, increases in employee salaries and benefits, and general inflation created budgetary problems for the Board, in light of the maximum assessment set by law. In spite of the obstacles, the Board found the wherewithal to reduce the assessment to Maine's employers for the next two years by \$3 million.

The Legislature, recognized the urgency of the Board's situation in FY02, taking two steps: (1) authorizing the use of \$700,000 from the Board's reserve account; and (2) authorizing a one-time increase in the maximum assessment of \$300,000 to provide temporary assistance to the Worker Advocate Program. The Legislature also recognized the urgency of the Board's situation in FY03, taking the following steps: (1) authorizing the use of reserve funds in the amount of \$1,300,000; (2) increasing the assessment to fund a hearing officer position in Caribou in the amount of \$125,000; and (3) allocating funds from reserves to fund actuarial studies and arbitration services to determine permanent impairment thresholds, and to fund a MAE Program position in the amount of \$135,000. These were short-term solutions and during the 2003 Legislative Term the Legislature increased the Board's assessment cap to \$8,350,000 in FY 04 and \$8,525,000 in FY 05. The Legislature also provided for greater discretion in the use of the Board's reserve account. Through the use of the reserve account, the Board was able to fund the FY-06-07 budget. The Legislature increased the Board's assessment for FY 07-08 to \$9,820,178, for FY 08-09 to \$10,000,000, for FY 09-10 to \$10,400,000, for FY 10-11 to \$10,800,000, and for FY 11-12 to \$11,200,000, and requested an audit of the Board's performance for the past 10 years and a review of the Worker Advocate and Monitoring, Audit, & Enforcement Programs to determine if they were adequately funded.

The Blake Hurley McCallum & Conley audit and program report was submitted to the Governor, the 123rd Second Regular Session of the Legislature, the Workers' Compensation Board, and the Department of Administrative and Financial Services in January of 2008 relating to the Board's fiscal operations for the past 10 years. The Board received a clean bill of health for both its budgetary and assessment procedures along with a number of recommendations to further improve the efficiency of the Board's fiscal operations.

The Board is attempting to improve efficiency and lower costs through administrative efforts ranging from mandating electronic data interchange, enforcing performance standards in the dispute resolution process, and enforcing compliance through the MAE program and the Abuse Investigation Unit.

In 2004 the Governor introduced a Bill, which was enacted by the Legislature as Chapter 608 and entitled "*An Act to Promote Decision-Making Within the Workers' Compensation Board.*" The purpose of the legislation was to break the gridlock that adversely affected the Board. The legislation reduced the size of the Board from eight to seven members and empowered the Governor to appoint an executive director, to serve as chair and chief executive officer of the Board. The Board has since resolved most of

the gridlock issues and functions in a more effective manner in setting policy for the Board's business.

The Board worked diligently during the course of 2008-2009 with a consensus based rulemaking group to formulate a facility fee schedule to help contain healthcare costs for hospitals and ambulatory care centers. Staff recommended a proposed rule to the Board in January 2009. Due to the recent availability of new data the Board has delayed action on the rule, but is intent on formulating a rule in 2010. The objectives of the Fee Schedule include: reducing and containing the increase of healthcare costs; providing access to quality care for injured workers; ensuring that providers are paid fairly; and, creating clarity in rules and simplicity for maintenance.

Staff is also playing a very active role in the Governor's Misclassification Task Force and has forwarded its recommendations to the Board, the Legislature, and the Governor's Task Force.

Prior to the inception of the Maine Workers' Compensation Act (January 1, 1993), Maine was one of the costliest states in the nation in regard to workers' compensation costs. Recent studies demonstrate a dramatic improvement for Maine in comparison to other states. Maine has gone from one of the costliest states in the nation to one that is at average costs for both premiums and benefits, all within the Governor's policy of making the system fair and competitive for the employees and employers of Maine.

B3. DISPUTE RESOLUTION

I. INTRODUCTION.

The Workers' Compensation Board has regional offices throughout the State, in Caribou, Bangor, Augusta, Lewiston and Portland that handle dispute resolution functions. The regional offices handle troubleshooting, mediation and formal hearings.

II. THREE TIERS OF DISPUTE RESOLUTION.

On January 1, 1993, Title 39, which contained the Workers' Compensation Act of 1991 and all prior workers' compensation acts, was repealed and replaced with Title 39-A, the Workers' Compensation Act of 1992. The new Title 39-A created a three tiered dispute resolution process.

First, at the troubleshooting stage, a claims resolution specialist informally attempts to resolve disputes by contacting the employer and the employee and identifying the issues. Many times, additional information, often medical reports, must be obtained in order to discuss possible resolutions. If a resolution of the dispute is not reached after reviewing the necessary information, the claim is referred to mediation.

Second, at the mediation stage, a case is scheduled before one of the Board's mediators. The parties attend the mediation at a regional office or through teleconference. At mediation, the employee, the employer, the insurance adjuster and any employee or employer representatives such as attorneys or advocates meet with the mediator in an attempt to reach a voluntary resolution of the claim. The mediator requests each party to state its position and tries to find common ground. At times, the mediator meets with each side separately to sort out the issues. If the case is resolved at mediation, the mediator writes out the terms of the agreement, which is signed by the parties. If the case is not resolved at mediation, it is referred for formal hearing.

Third, at the formal hearing stage, the parties are required to exchange information and medical reports and answer specific questions that pertain to the claim. After the information has been exchanged, the parties file with the Board a "Joint Scheduling Memorandum," which lists the witnesses who will testify and estimates the time needed for hearing. Depositions of medical witnesses oftentimes scheduled to elicit or dispute expert testimony. At the hearing, witnesses for both sides testify and evidence is submitted. In most cases, the parties are represented either by an attorney or a worker advocate. Following the hearing, position papers are submitted and the hearing officer issues a decision.

The number of cases entering each phase for the period 1999 thru 2009 is shown in the table below:

Cases Entering Dispute Resolution			
Year	Trouble Shooting	Mediation	Formal Hearing
2000	9,442	3,642	2,433
2001	10,132	3,830	2,725
2002	9,677	3,507	2,481
2003	9,996	3,582	2,532
2004	9,356	3,303	2,458
2005	8,784	3,003	2,088
2006	8,962	2,652	1,915
2007	8,749	2,499	1,765
2008	8,384	2,428	1,680
2009	7,960	2,220	1,602

The raw counts of cases entering each stage are not logical subsets. The Board has done occasional studies of subsets to evaluate the results of each stage. In general, of 100 disputes entering Trouble Shooting approximately half (50) will go on to Mediation. Of the 50 going to Mediation, approximately half (25) will continue to the Formal Hearing stage.

III. TROUBLESHOOTING STATISTICAL SUMMARY

The following table shows, the number of filings and dispositions at Mediation, the average timeframes, and number of cases pending at the end of each year for the period 1999 thru 2009.

Trouble Shooting Cases Assigned, Disposed, and Pending				
Year	Assigned	Disposed	Pending 12/31	Av Days at TS
2000	9,442	9,426	763	25
2001	10,132	10,139	756	24
2002	9,677	9,466	967	23
2003	9,996	10,269	838	27
2004	9,356	9,588	606	27
2005	8,784	8,724	666	27
2006	8,962	8,927	701	27
2007	8,749	8,719	731	27
2008	8,439	8,439	676	30
2009	7,960	7,913	723	29

IV. MEDIATION STATISTICAL SUMMARY.

The following table shows the number of filings and dispositions at Mediation, the average timeframes, and number of cases pending at the end of each year for the period 1999 thru 2009.

Mediations Cases Assigned, Disposed, and Pending				
Year	Assigned	Disposed	Pending 12/31	Av Days At MDN
2000	3,642	3,551	666	53
2001	3,830	3,745	751	51
2002	3,507	3,655	603	54
2003	3,582	3,331	854	60
2004	3,303	3,395	666	62
2005	3,003	3,084	585	59
2006	2,652	2,741	496	61
2007	2,499	2,532	463	58
2008	2,428	2,488	443	55
2009	2,220	2,239	424	57

V. FORMAL HEARING STATISTICAL SUMMARY.

The following table shows the number of filings and dispositions at Formal Hearing, the average timeframes, and number of cases pending at the end of each year for the period 1999 thru 2000.

Formal Hearing Cases Assigned, Disposed, and Pending				
Year	Assigned	Disposed	Pending 12/31	Av Months to Decree
2000	2,433	2,417	1,110	7.4
2001	2,725	2,592	1,243	6.8
2002	2,481	2,400	1,324	7.1
2003	2,532	2,194	1,662	9.5
2004	2,458	2,414	1,706	10.9
2005	2,088	2,266	1,528	11.7
2006	1,915	2,173	1,270	11.7
2007	1,765	1,907	1,128	10.7
2008	1,680	1,728	1,080	8.4
2009	1,602	1,546	1,136	9.1

VI. OTHER.

The number of cases entering the Mediation and Formal stages of dispute resolution has declined noticeably during the last few years. So much so, that the Board eliminated a hearing officer position. The Board will also consider reallocating positions from within dispute resolution to the Abuse Investigation Unit and the Employee Misclassification effort.

B4. OFFICE OF MONITORING, AUDIT, AND ENFORCEMENT

I. HISTORY

In 1997, the Maine Legislature, with the support of Governor Angus S. King, Jr., enacted Public Law 1997, Chapter 486 to establish the Office of Monitoring, Audit, and Enforcement (MAE) with the goals of: (1) providing timely and reliable data to policymakers; (2) monitoring and auditing payments and filings; and (3) identifying those insurers, self-administered employers, and third-party administrators (collectively "insurers") not complying with minimum standards.

II. MONITORING

With a key component of the monitoring program being the production of Quarterly and Annual Compliance Reports, a pilot project was undertaken in May 1997 to: (1) measure the Board's data collection and reporting capabilities; (2) report on the performance of insurers; and (3) let all interested parties know what to expect from the Compliance Reports. From this pilot, MAE was able to refine its policies, practices and processes. Since 1997, MAE has followed a course of continuous improvement to ensure that the Compliance Reports maintain high quality standards.

The 2008 Quarterly and Annual Compliance Reports were unanimously accepted by the Maine Worker's Compensation Board. The 2008 quarterly compliance in Table 1 represents static results based upon data received by the deadline for each quarter. The 2008 Annual Compliance Report represents dynamic results based upon data received by March 31, 2009. Tables 2 and 3 show continued improvement in the performance of insurers since the pilot project. This improvement results in improved claims-handling and faster initial indemnity payments.

A. Lost Time First Report Filings

The Board's benchmark for lost time first report filings within 7 days is 85%. **Benchmark Exceeded.** The Board received 14,160 lost time first reports. This represents 235 fewer reports than in 2007 and continues a long term decline in the number of lost time first reports. Eighty-nine percent (89%) of lost time first report filings were within 7 days, the highest compliance recorded for this indicator to date.

B. Initial Indemnity Payments

The Board's benchmark for initial indemnity payments within 14 days is 87%. **Benchmark Exceeded.** Eighty-nine percent (89%) of initial indemnity payments were within 14 days, the highest compliance recorded for this indicator to date.

C. Initial Memorandum of Payment (MOP) Filings

The Board's benchmark for initial MOP filings within 17 days is 85%.

Benchmark Exceeded. Eighty-eight percent (88%) of initial MOP filings were within 17 days, the highest compliance recorded for this indicator to date.

D. Initial Indemnity Notice of Controversy (NOC) Filings

The Board's benchmark for initial indemnity NOC filings within 14 days is 90%.

Benchmark Met. Ninety percent (90%) of initial indemnity NOC filings were within 14 days.

E. Utilization Analysis

Nineteen percent (19%) of all lost time first reports were "denied", a decrease of 0.5% from 2007. Forty percent (40%) of all claims for compensation were denied, a decline of 0.4% since 2007.

F. Initial Indemnity Payments > 44 Days

\$42,150 was issued to claimants in penalties under Section 205(3).

G. Late Filed Coverage Notices

\$82,700 was collected in penalties under Section 360(1)(B), and \$3,700 in penalties are awaiting resolution. These monies go to the State General Fund.

H. Caveats & Explanations

1. Lost Time First Report Filings

- Compliance with the lost time first report filing obligation exists when the lost time first report is filed (accepted Electronic Data Interchange transaction, with or without errors) within 7 days of the employer receiving notice or knowledge of an employee injury that has caused the employee to lose a day's work.
- When a medical only first report was received and later converted to a lost time first report, if the date of the employer's notice or knowledge of incapacity minus the received date was less than zero, the filing was considered in compliance.

2. Initial Indemnity Payments

- Compliance with the Initial Indemnity Payment obligation exists when the check is mailed within the later of: (a) 14 days after the employer's notice or knowledge of incapacity or (b) the first day of compensability plus 6 days.

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3. Initial Memorandum of Payment (MOP) Filings

- Compliance with the Initial Memorandum of Payment filing obligation exists when the MOP is received within 17 days of the employer's notice or knowledge of incapacity.

4. Initial Indemnity Notice of Controversy (NOC) Filings

- Measurement excludes filings submitted with full denial reason codes 3A-3H (No Coverage).

- Compliance with the Initial Indemnity Notice of Controversy filing obligation exists when the NOC is filed (accepted EDI transaction, with or without errors) within 14 days of the employer receiving notice or knowledge of the incapacity or death.

I. Corrective Action Plans (CAPs)

CAPs are implemented for insurers with chronic poor compliance. Elements of the CAPs are reviewed and updated each quarter to track compliance changes and ensure that the elements of the plan are being met.

The following insurers had CAPs in place for all or part of 2008:

Insurer (alphabetical)	Market Share by Premiums Written
ACE	1.2%
AIG	< 1%
Cambridge Integrated Services	Not Applicable - TPA
Claims Management, Inc. (Wal-Mart) (CAP lifted)	Not Applicable - TPA
CNA	1.2%
Crawford & Co.	Not Applicable - TPA
GAB Robins	Not Applicable - TPA
Gallagher Bassett Services, Inc.	Not Applicable - TPA
Hartford	3.5%
Meadowbrook	Not Applicable - MGA
Old Republic Insurance	< 1%
Sedgwick Claims Management	Not Applicable - TPA
Selective Insurance Company (CAP lifted)	< 1%
Specialty Risk Services	Not Applicable - TPA
Zurich	1.2%

New additions in 2008: GAB Robins, Meadowbrook, Old Republic, Sedgwick, and SRS.

Special recognition goes to Claims Management, Inc. and Selective Insurance Company for successfully meeting their CAP requirements and having their CAPs lifted.

Annual Compliance Summary

Table 1 2008 Quarterly Compliance Reports

Benchmark	Goal	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Lost Time First Report Filings Rec'd w/i 7 Days	85%	88%	89%	88%	88%
Initial Indemnity Payments Made w/i 14 Days	87%	88%	88%	87%	89%
Initial Memorandum of Payment Filings Rec'd w/i 17 Days	85%	87%	88%	87%	89%
Initial Indemnity Notice of Controversy Filings Rec'd w/i 14 Days	90%	88%	90%	91%	93%

Table 2 Annual Compliance

Benchmark	1997 ¹	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Lost Time First Report Filings Rec'd w/i 7 Days	37%	69%	78%	80%	82%	82%	86%	86%	84%	87%	89%
Initial Indemnity Payments Made w/i 14 Days	59%	79%	80%	83%	85%	86%	85%	87%	87%	87%	89%
Initial Memorandum of Payment Filings Rec'd w/i 17 Days	57%	75%	75%	77%	81%	82%	83%	84%	84%	85%	88%
Initial Indemnity Notice of Controversy Filings Rec'd w/i 14 Days ²							91%	92%	89% ³	89%	90%

Table 3 Percentage Change Over Time

Benchmark	Since 1997 ¹	Since 1999	Since 2000	Since 2001	Since 2002	Since 2003	Since 2004	Since 2005	Since 2006	Since 2007
Lost Time First Report Filings Rec'd w/i 7 Days	141%	28%	13%	11%	8%	8%	3%	3%	5%	2%
Initial Indemnity Payments Made w/i 14 Days	49%	12%	10%	7%	4%	4%	4%	2%	2%	1%
Initial Memorandum of Payment Filings Rec'd w/i 17 Days	55%	17%	18%	15%	9%	8%	7%	5%	5%	4%
Initial Indemnity Notice of Controversy Filings Rec'd w/i 14 Days ²							-1%	-2%	1%	1.5%

¹ Based on sample data.

² The Initial Indemnity Notice of Controversy filing benchmark was changed in 2007 from 17 days to 14 days.

³ Second quarter 2006 excluded.

III. AUDIT

The Board conducts compliance audits of insurers, self-insurers and third-party administrators to ensure that all obligations under the Workers' Compensation Act are met. The functions of the audit program include, but are not limited to: ensuring that all reporting requirements of the Board are met, auditing the timeliness of benefit payments, auditing the accuracy of indemnity payments, evaluating claims-handling techniques, and determining whether claims are unreasonably contested.

A. Compliance Audits

Since implementing the program, one hundred forty-seven (147) audit reports have been issued. In addition to the amounts paid to employees, dependents and service providers for compensation, interest, or other unpaid obligations, \$1,324,713 in penalties has been paid since 1999 (see Table 1). Audit reports and the corresponding consent decrees are available on the Board's website:

www.maine.gov/wcb/

In 2003, the Board successfully prosecuted Hanover Insurance Company for engaging in a pattern of questionable claims-handling techniques under §359(2) of the Workers' Compensation Act (see Section 12). Additionally, ACE Insurance Group, American International Group, Arch Insurance Group, Atlantic Mutual Insurance Company, Berkley Administrators of Connecticut, Broadspire Services, Cambridge Integrated Services, Claimetrics Management, Claims Management (Wal-Mart), CMI Octagon, CNA Insurance Group, Crawford & Company, ESIS, Fireman's Fund Insurance Group, Future Comp/TD Banknorth Insurance Agency, GAB Robins, Gallagher Bassett Services, Gates McDonald, Georgia Pacific, Harleysville Insurance Company, Hartford Insurance Group, Helmsman Management Services, Liberty Mutual Insurance Group, Meadowbrook, MEMIC, NGM Insurance Company, Old Republic Insurance Company, Royal & SunAlliance Insurance Group, Sedgwick Claims Management Services, Specialty Risk Services, The St. Paul Companies, Virginia Surety Company, Wausau Insurance Group, and Zurich Insurance Group have all signed consent decrees for engaging in a pattern of questionable claims-handling techniques under §359(2). The Board filed Certificates of Findings pursuant to this section with the Maine Bureau of Insurance for further action.

B. Complaints for Audit

The audit program also has a Complaint for Audit form and procedure that allow a complainant to request that the Board investigate a claim to determine if an audit under §359 and/or §360(2) is warranted. Since the form was implemented, two hundred ninety-seven (297) complaints have been received. As a result of these investigations, over \$255,000 in unpaid obligations and over \$155,000 in penalties have been paid (see Table 2).

Table 1 Completed Audits

Date	205 (3)	205 (4)	324 (2) EE	324 (2) State	359 (2)	360(1)	360 (2)	Total Penalties
1999	22,550	0	0	0	0	32,200	0	54,750
2000	20,750	0	1,000	2,100	8,000	16,100	0	47,950
2001	7,750	0	0	0	0	5,500	0	13,250
2002	10,350	0	1,150	1,725	0	16,725	0	29,950
2003	13,950	0	0	0	10,000	24,150	0	48,100
2004	10,350	0	100	300	29,500	16,375	0	56,625
2005	74,400	0	54,900	7,800	60,000	47,950	20,000	265,050
2006	68,450	0	52,953	8,400	50,000	68,625	10,000	258,428
2007	87,550	850	61,550	21,900	37,000	53,225	2,000	264,075
2008	107,150	1,500	10,175	0	64,000	45,675	0	228,500
2009	26,350	0	2,150	0	19,500	10,035	0	58,035
Total	\$449,600	\$2,350	\$183,978	\$42,225	\$278,000	\$336,560	\$32,000	\$1,324,713

Table 2 Complaints for Audit

Date	205(3)	205(4)	324(2) EE	324(2) State	360(1)	360(2)	Total Penalties	Statutory Obligations Paid
1999	0	0	0	0	0	0	0	0
2001	0	0	0	0	0	0	0	0
2002	0	0	0	0	0	0	0	0
2003	0	0	0	0	0	0	0	0
2004	3,000	0	0	0	0	0	3,000	85,739
2005	9,000	4,000	31,050	57,300	300	0	101,650	62,303
2006	4,700	0	25,600	3,150	0	0	33,450	52,278
2007	4,700	0	2,050	0	0	0	6,750	25,689
2008	12,000	0	1,500	0	0	0	13,500	25,891
2009	0	0	0	0	0	0	0	4,049
Total	\$33,400	\$4,000	\$60,200	\$60,450	\$300	\$0	\$158,350	\$255,948

IV. ENFORCEMENT

The Board's Abuse Investigation Unit handles enforcement of the Workers' Compensation Act. The report of the Abuse Investigation Unit appears at Section 12 of the Board's Annual Report.

B5. INDEPENDENT MEDICAL EXAMINATIONS (IMES); MEDICAL FEE SCHEDULE; FACILITY FEE SCHEDULE

I. INDEPENDENT MEDICAL EXAMINATIONS.ERROR! BOOKMARK NOT DEFINED.

Draft regulations for the implementation of Section 312 of the Workers' Compensation Act of 1992 were first presented to the Board of Directors April 7, 1994, with final approval on January 3, 1996. Section 312 provides, in part, as follows:

Examiner system. The board shall develop and implement an independent medical examiner system consistent with the requirements of this section. As part of this system, the board shall, in the exercise of its discretion, create, maintain and periodically validate a list of not more than 50 health care providers that it finds to be the most qualified and to be highly experienced and competent in their specific fields of expertise and in the treatment of work-related injuries to serve as independent medical examiners from each of the health care specialties that the board finds most commonly used by injured employees. The board shall establish a fee schedule for services rendered by independent medical examiners and adopt any rules considered necessary to effectuate the purposes of this section.

Duties. An independent medical examiner shall render medical findings on the medical condition of an employee and related issues as specified under this section. The independent medical examiner in a case may not be the employee's treating health care provider and may not have treated the employee with respect to the injury for which the claim is being made or the benefits are being paid. Nothing in this subsection precludes the selection of a provider authorized to receive reimbursement under section 206 to serve in the capacity of an independent medical examiner. Unless agreed upon by the parties, a physician who has examined an employee at the request of an insurance company, employer or employee in accordance with section 207 during the previous 52 weeks is not eligible to serve as an independent medical examiner.

Appointment. If the parties to a dispute cannot agree on an independent medical examiner of their own choosing, the board shall assign an independent medical examiner from the list of qualified examiners to render medical findings in any dispute relating to the medical condition of a claimant, including but not limited to disputes that involve the employee's medical condition, improvement or treatment, degree of impairment or ability to return to work.

Rules. The board may adopt rules pertaining to the procedures before the independent medical examiner, including the parties' ability to propound questions relating to the medical condition of the employee to be submitted to the independent medical examiner. The parties shall submit any medical records or other pertinent information to

the independent medical examiner. In addition to the review of records and information submitted by the parties, the independent medical examiner may examine the employee as often as the examiner determines necessary to render medical findings on the questions propounded by the parties.

Medical findings; fees. The independent medical examiner shall submit a written report to the board, the employer and the employee stating the examiner's medical findings on the issues raised by that case and providing a description of findings sufficient to explain the basis of those findings. It is presumed that the employer and employee received the report 3 working days after mailing. The fee for the examination and report must be paid by the employer.

Weight. The board shall adopt the medical findings of the independent medical examiner unless there is clear and convincing evidence to the contrary in the record that does not support the medical findings. Contrary evidence does not include medical evidence not considered by the independent medical examiner. The board shall state in writing the reasons for not accepting the medical findings of the independent medical examiner.

Annual review. The board shall create a review process to oversee on an annual basis the quality of performance and the timeliness of the submission of medical findings by the independent medical examiners.

Currently, the Board has 24 examiners on its Section 312 IME list. The Board continues to consider alternatives to increase the number of examiners on the list and decrease the amount of delay. The following physicians are currently on the Board's Section 312 IME list:

**ANESTHESIOLOGY/PAIN
MANAGEMENT**

BLAZIER, KENNETH
MERCY HOSPITAL, DEPT
OF ANESTHESIA
144 STATE STREET
PORTLAND ME 04102
TEL: 879-3385

LEONG, PETER Y
MERCY HOSPITAL, DEPT
OF ANESTHESIA
144 STATE STREET
PORTLAND ME 04102
TEL: 879-3385

CHIROPRACTIC

BALLEW, DAVID M., DC
BALLEW CHIROPRACTIC OFFICE
256 MAIN STREET
WATERVILLE, ME 04901
TEL: 873-1167

LYNCH, ROBERT P., DC
1200 BROADWAY
S PORTLAND, ME 04106
TEL: 799-2263

VANDERPLOEG, DOUGLAS DC
17 BACK MEADOW RD
DAMARISCOTTA, ME 04543
TEL: 563-8500

FAM/GEN/INT

GRIFFITH, WILLIAM L., MD
TOGUS VA MEDICAL CENTER
1 VA WAY
AUGUSTA, ME 04330
TEL: 623-8411 EXT 5243

SHAW, PETER K., MD
96 CAMPUS DR
SCARBOROUGH, ME 04102
TEL: 885-9905

GASTROENTEROLOGY

SULLIVAN, HAROLD H. MD
CASCO BAY
GASTROENTEROLOGY
25 LONG CREEK DRIVE
SOUTH PORTLAND, ME
04106
TEL: (207) 879-0094

INTERNAL MEDICINE

MEDRANO, RENATO
SOUTHERN MAINE
PHYSICAL THERAPY, P.A.
449 COTTAGE ROAD
SOUTH PORTLAND, ME
04106
TEL: 623-8411 EXT 4390

NEUROLOGY

BRIDGMAN, PETER, MD
51 HARPSWELL RD, STE 100
BRUNSWICK, ME 04011
TEL: 729-7800

NEUROPSYCHOLOGIST

RILEY, ROBERT, Psy.D.,
ABPP-CN
THE BRAIN CLINIC OF
CENTRAL MAINE, LLC
93 SECOND ST
HALLOWELL, ME 04347
TEL: 485-1646

ORTHOPEDIC SURGERY

CROTHERS III, OMAR D.,
M.D. (HIPS ONLY)
ORTHOPEDIC ASSOCS PTL
33 SEWALL ST.
PORTLAND, ME 04104
TELE: 828-2100

DONOVAN, MATTHEW MD
10 MARKETPLACE DR.
YORK, ME 03909
TEL: 363-6400

OSTEOPATH

CHARKOWICK, ROBERT
P.O. BOX 3154
AUGUSTA, ME 04330
TEL: 623-8411 ext. 5257

SULLIVAN, CHARLES W.
147 RIVERSIDE DR, SUITE1
AUGUSTA, ME 04330-4100
TEL: 623-6355

OTOLARYNGOLOGY

HAUGHWOUT, PETER MD
18 DOUGLAS ST
BRUNSWICK, ME 04011
TEL: 729-4085

PHYSIATRY

BAMBERGER, STEPHAN
MEDICAL REHAB
ASSOCIATES
12 INDUSTRIAL PARKWAY
BRUNSWICK, ME 04011
TEL: 725-7854

WOELFLEIN, KAREN
MEDICAL REHAB ASSOCS
12 INDUSTRIAL PARKWAY
BRUNSWICK, ME 04011
TEL: 725-7854

PHYSICAL MED & REHAB

HALL, JOHN
MAINE GENERAL MEDICAL CTR
SETON UNIT, 30 CHASE AVE
WATERVILLE, ME 04901
TEL: 872-4400

PODIATRY

MUCA, ERIC, D.P.M.
INTERMED SPECIALTY
GROUP
100 FODEN RD STE 200
PORTLAND, ME 04106
TEL: 523-8500

PSYCHIATRY

BARKIN, JEFFREY S., M.D.
97A EXCHANGE STREET
PORTLAND, ME 04101
TEL: 775-2244

LOBOZZO, DAVID B., MD
477 CONGRESS ST
PORTLAND, ME 04101
TEL: 773-1290

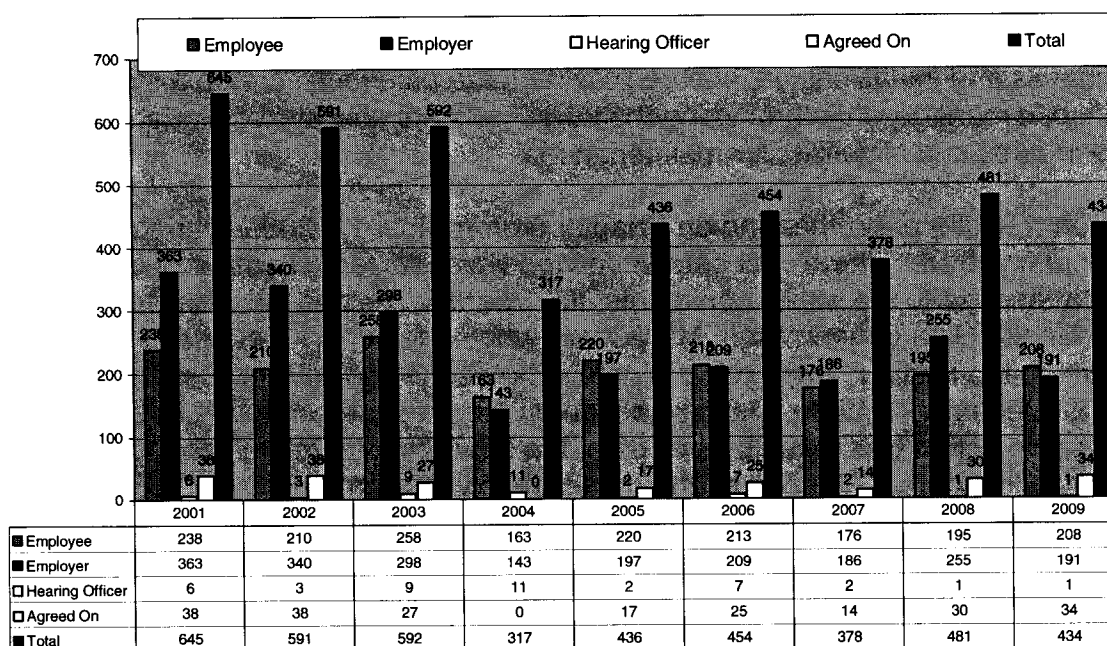
PSYCHOLOGY

MATRANGA, JEFF, PH.D.
2 BIG SKY LANE
WATERVILLE, ME 04901
TEL: 872-5800

PULMONARY

FUHRMANN, CALVIN P. MD
KENNEBUNK MEDICAL CTR
24 PORTLAND ROAD
KENNEBUNK, ME 04043
TEL: 985-3726

Independent Medical Exams 2001-2009



The above chart reflects the source of requests for independent medical examinations for the years 2001-2009.

II. MEDICAL FEE SCHEDULE.

The Board first published a Medical Fee Schedule on April 4, 1994. The Board is required pursuant to Section 209 to adopt rules establishing standards, schedules, and scales of maximum charges for individual services, procedures and courses of treatment. In order to ensure appropriate costs for health care services, the standards are to be adjusted annually to reflect appropriate changes in levels of reimbursement.

In August 1997, the Board adopted the Resource Based Relative Value System (RBRVS) as an efficient method to administer a fee schedule. On August 22, 2006, the Board voted to adopt the 2005 CPT Codes and RBRVS.

III. FACILITY FEE SCHEDULE.

In 2007, Maine WCB contracted with Ingenix to facilitate the creation of a facility fee rule for hospital inpatient, outpatient and ambulatory surgical care. After four meetings of the consensus-based rulemaking group, they were able to agree on a modified Medicare methodology because it is relatively transparent and widely understood, but they were unable to agree on several issues, including the base rate. The Board went to public

hearing on August 17, 2009, and the deadline for written comments was August 27, 2009.

The goal of the facility fee schedule is to: reduce inequities in the system; eliminate bottlenecks and inefficiencies; ensure providers are paid fairly; create a system that payers can manage while producing the lowest rational cost system wide; and create clarity in rules and simplicity for maintenance.

The Board held a public hearing on Chapter 5 on August 17, 2009. During the public comment timeframe, there was data submitted which raised a number of questions. In order to respond to the public comments, the Board requested additional data from the Maine Health Data Organization. MHDO was unable to supply the data in a timely fashion, so the Board is attempting to obtain the data from OnPoint Health. The Board had until December 24th to take final action on the proposed changes to Chapter 5. Because no action was taken by that date, the timeframe for implementing the proposed fee schedule expired. As soon as the data is received from MHDO or OnPoint Health, Ingenix will provide its analysis, and the Board will propose a new fee schedule.

The Board anticipates that the rule will generate significant savings with respect to these medical costs. A safety net is built in to have Ingenix analyze the facility fee rule one year after implementation to identify savings or correct any negative impact.

B6. WORKER ADVOCATE PROGRAM

I. INTRODUCTION.

The Worker Advocate Program provides legal representation to injured workers in administrative proceedings (mediations and formal hearings) before the Workers' Compensation Board. In order for a worker to qualify to receive assistance, the worker's injury must have occurred on or after January 1, 1993; the worker must have participated in the Board's troubleshooter program; the worker must not have informally resolved the dispute; and finally, the worker must demonstrate that they have not retained legal counsel.

Traditional legal representation is the core of the program, the Advocate staff have broad responsibilities to injured workers, which include: attending hearings and mediations; conducting negotiations; acting as an information resource; advocating for and assisting workers to obtain rehabilitation, return to work and employment security services; and communicating with insurers, employers and health care providers on behalf of the injured worker.

II. HISTORY.

In 1992 the Maine legislature re-wrote the Workers' Compensation Act. They repealed Title 39 and enacted Title 39-A. One of the most significant changes which impacted injured workers was the elimination of the "prevail" standard. Under "old" Title 39, attorneys who represented injured workers were entitled to Board ordered fees from employers/insurers if they obtained a benefit for their client, i.e., if they "prevailed". However, under the "new" act (beginning in January of 1993), the employer/insurer had no liability for legal fees regardless of whether the worker prevailed or not, and, in addition, fees paid by injured workers to their attorneys were limited to a maximum of 30% of accrued benefits and settlement fees no greater than 10%.

These changes, which undoubtedly reduced the cost of claims, made it very difficult for injured workers to obtain legal representation—unless they had a serious injury with a substantial amount of accrued benefits at stake. Estimates indicate that upwards of 40% of injured workers did not have legal representation after these changes were made to the statute. This presented some dramatic challenges for the administration of the workers' compensation system. By 1995, recognition of these issues prompted the Workers' Compensation Board of Directors to establish a pilot "Worker Advocate" program.

The pilot program was staffed by one non-attorney Advocate and was limited to the representation of injured workers at the mediation stage of dispute resolution. Based on

its initial success, the board expanded the pilot program to five non-attorney Advocates, one for each regional office; however, representation remained limited to mediations. Ultimately, in recognition of both the difficulties facing unrepresented workers and the success of the pilot program, the Legislature amended Title 39-A to formally create the Worker Advocate Program in 1997.

The new statute created a substantial expansion of the existing operations. Most significantly, the new program required Advocates to provide representation at formal hearings in addition to mediations. The additional responsibilities associated with this new representation require much greater skill and many more tasks than previously required of Advocates. Some of these new tasks include: participation in depositions, attendance at hearings, drafting required joint scheduling memorandums, drafting numerous types of motions, drafting complicated post-hearing memorandums, comprehending complex medical reports, conducting settlement negotiations, and analysis and utilization of statutory and case law.

III. THE CURRENT WORKER ADVOCATE PROGRAM

Currently the board has 12 Advocates working in five regional offices from Caribou to Portland. Advocates are generally required to represent all qualified employees who apply to the program—unlike private attorneys. The statute does provide some exceptions to this requirement of representation whereby the program may decline to provide assistance. However, the reality is that relatively few cases are refused.

Cases are referred to the Advocate Program only when there is a dispute—as indicated by the employee, employer, insurer, or a health care provider. When the Board is notified of a dispute, a Claims Resolution Specialist (known as a “troubleshooter”) tries to facilitate a voluntary resolution of the problem. If that is not successful, the Board determines if the employee qualifies for the assistance of the Advocate Program, and if so, makes the referral.

If troubleshooting is not successful, cases are scheduled for Mediation. To represent an injured worker at Mediation, the Advocate Program must first obtain medical records and factual information regarding the injury and the worker’s employment. Advocates must meet with the injured worker to learn of and review the issues; they must also acquire information from health care providers. Advocates are also often called upon to explain the legal process (including Board rules and the statute) to injured workers. They often must explain requirements regarding medical treatment and work and frequently must assist workers with unemployment and health insurance issues. They also provide injured workers with other forms of interim support, as needed. Many of these steps produce evidence and information necessary for subsequent formal litigation, if the case gets that far.

At Mediation, the parties meet with a Mediator, discuss the issues, and attempt to negotiate an agreement. The Mediator facilitates, but has no authority to require the parties to reach an agreement or to set the terms of an agreement. If the parties resolve

their issues, the terms of the agreement are recorded in a binding Mediation Record. A significant number of cases are resolved before, at, and after Mediation; of every 100 disputes reported to the Board, only about 25 go on to a formal hearing.

Cases that do not resolve at mediation typically do so because of the factual and/or legal complexity of the dispute. These cases typically involve situations where facts are unclear or as the result of differing interpretations of the statute and case law. If voluntary resolution of issues fails at mediation, the next step is litigation at the formal hearing level.

This formal process is initiated by an Advocate filing petitions to request a formal hearing (after assuring there is adequate medical and other evidence to support a claim). Before a hearing is conducted, the parties exchange relevant information through voluntary requests and formal discovery. Preparation for hearing entails preparation of and response to motions, preparation of the worker and other witnesses for their testimony, preparation of exhibits, analysis of applicable law and analysis of medical and other evidence. At the hearing, Advocates must elicit direct and cross examination testimony of the witnesses, introduce exhibits, make objections and motions, and, at the conclusion of the evidence taking, file position papers which summarize the facts and credibly argue the law in the way most favorable to the injured worker. Along the way, the Advocates also often attend depositions of medical providers, private investigators, and labor market experts. Eventually, either a decision is issued or the parties agree on either a voluntary resolution of the issues or a lump sum settlement. The average timeframe for the entire process is about 12 months, although it can be significantly shorter or longer depending on the complexity of medical evidence and the need for independent medical examinations.

IV. CASELOAD STATISTICS.

Injured workers in Maine have made substantial utilization of the Advocate program. Advocates represent injured workers at approximately 50% of all mediations (an average of 2,000 mediations per year). Given the relatively large number of Mediations handled by Advocates, it bears noting that from 1998 through 2008, the program consistently cleared no less than 95% of the cases assigned in a given year for Mediation. The following table reflects the number of cases at Mediation from 1999 through 2009.

Advocate Cases at Mediation

	A s s i g n e d	C a s e s D i s p o s e d	P e n d i n g D e c 3 1 s t	% o f A l l P e n d i n g
1 9 9 9	2,342	2,351	299	51%
2 0 0 1	2,249	2,247	348	51%
2 0 0 2	2,113	2,153	308	51%
2 0 0 3	1,981	1,899	390	46%
2 0 0 4	1,816	1,969	237	50%
2 0 0 5	1,915	1,841	311	53%
2 0 0 6	1,522	1,533	280	56%
2 0 0 7	1,397	1,434	243	52%
2 0 0 8	1,405	1,437	211	48%
2 0 0 9	1,205	1,195	221	52%

In 2009, the number of cases handled by Advocates at mediation represents a decrease of approximately 14%, as compared to the number of cases taken to mediation by Advocates in 2008 (which represented a slight increase over 2007). Nevertheless, the Advocate Division handled 52% of mediations (statewide) in 2009. This represents an 8% increase in market share over 2008 levels.

The Advocate program has also represented injured workers at 25 to 30% of all formal hearings before the Board (about 700 cases per year). In the majority of years, Advocates have cleared more formal cases than were pending at the start of the year. Given the much greater scope of responsibility inherent with formal hearing cases, Advocates have performed very well in their expanded role. The following table represents the number of cases handled by Advocates to formal hearing in years 2000 through 2009.

Advocate Cases at Formal Hearings

	A s s i g n e d	D i s p o s e d	P e n d i n g 1 2 / 3 1	% o f A l l P e n d i n g
2 0 0 0	597	594	313	28%
2 0 0 1	813	784	342	28%
2 0 0 2	642	682	468	35%
2 0 0 3	920	780	608	37%
2 0 0 4	689	810	487	29%
2 0 0 5	679	714	452	30%
2 0 0 6	628	715	361	29%
2 0 0 7	632	673	320	28%
2 0 0 8	599	610	309	29%
2 0 0 9	564	511	362	32%

In 2009, there was a marginal decrease in the number of cases handled by Advocates to formal hearing, as compared to the number of cases handled by Advocates to formal hearing in 2008. However, there are more Advocate cases currently pending at the Formal Hearing level than at any time since 2005.

It is also worth noting that the Advocate Division is currently handling 32% of all cases pending at the Formal Hearing level. This constitutes a 10% increase in market share over 2008 levels and a 14% increase in market share over 2007 levels. This is the highest level of market share since 2003.

V. SUMMARY.

The Advocate Program was created to meet a significant need in the administration of the Workers' Compensation system. The statutory expansion of program duties in 1997 created unmet needs in the program. In order to meet the obligations in the statute, the Workers' Compensation Board has diverted resources from other work to the Advocate program. Currently the program has 12 Advocates with a support staff of 16 (two of which are part-time) and a supervising Senior Staff Attorney. Services are provided in 5 offices; Caribou, Bangor, Augusta, Lewiston and Portland.

In its first 10 years, the Program has proven its value by providing much-needed assistance to Maine's injured workers, albeit with limited resources. As a result of the limited resources, the Advocate program has experienced periods of overly high case loads which has led to chronic staff turnover. In one 12-month period, (2006–2007) 42% of existing Advocate Program positions were vacant. Nothing has greater potential to impact the quality of the services rendered to injured workers than insufficient staff. In response to ongoing concerns, the 123rd Legislature provided additional support for the Advocate program. Qualifications for Advocates and paralegals were increased and, in conjunction, pay ranges were upgraded. [Public Law 2007 Ch 312]. The changes, which went into effect in September 2007, are intended to attract and retain staff and to bolster stability of this program—which is an integral part of the Workers' Compensation system in Maine.

B7. TECHNOLOGY

The Board over the past year has implemented a number of significant changes with respect to information systems and their delivery. Due to recent legislation, many of the information delivery platforms and application were centralized into the Office of Information Technology. The Board has completed the migration of its applications on Board servers to the OIT centralized enterprise services. This transition required changes to our Agency Business application as well as merging the Advocate client tracking system. These two tasks alone required significant time and expense to migrate to the OIT enterprise server. Additionally, all the desktops were replaced because they were over 5 years old and beginning to experience system degradation and malfunctions. Working with OIT we seemed to have resolved the issues regarding the slow network by adding lines to the slower offices.

The WCB, in cooperation with NCCI, implemented electronic submission for Proof of Coverage from the insurer community. The community has been asking for this electronic submission which will provide more accurate and timely filings. This will also enable the Claim staff to better supervise the timeliness and accuracy of payments to injured employees. The Board also convened a consensus based rulemaking group to develop a rule requiring the electronic filing of proof of workers' compensation coverage. The WCB has recently added a search feature to the WCB Website that will allow anyone the opportunity to check the WC insurance status online.

The Board has been using a tool called ISYS (word search application for Hearing Officers) which provide the ability to search by key word other Hearing Officer decisions, Board Statute, Board Rules, and other pertinent documents. This functionality has been expanded over the past year to other Board employees, including Advocates. The Board, at the request of the legal community, has partnered with Westlaw to provide access for the legal community to perform word search capabilities of Hearing Officer decisions. Lexis Nexis and West Publishing distribute the decisions to their clients.

The 121st Maine Legislature enacted legislation that required the Workers Compensation Board (WCB) to adopt rules mandating electronic filing. The legislation directed the Board to proceed by way of consensus based rulemaking. A committee was formed consisting of representatives from the insurance companies, self-insureds, WCB Directors and staff. Recommendations were forwarded to and unanimously approved by the Board of Directors.

The WCB agreed on a timetable for implementation. First Reports of Injury and Denial submissions have been completed. Staff is currently engaged in completing the remaining payments phase. An internal group is near completion for the Trading Partner Tables which will provide a roadmap of the various payment functions and time frames required for each business event. The next step is to get shareholder review and comment before programming the necessary functions. The carriers require at least 12 months once the State's specifications are posted before they can initiate a test.

Additionally, WCB Rules will be updated to take advantage of the new process. Testing is estimated to begin the Spring of '10.

A Rule mandating electronic submission of Proof of Coverage information was approved on August 22, 2009. All submissions for Proof of Coverage are now being submitted electronically.

B8. ABUSE INVESTIGATION UNIT

The Abuse Investigation Unit (AIU) is responsible for investigating violations of the Act by employers, employees or insurers including complaints of fraud and illegal or improper conduct. 39-A M.R.S. §153(5). The Unit conducts investigations from information received from internal and external sources. The AIU is also responsible for assessing fines regarding worker benefits, parties' agreements, mandatory workers' compensation insurance, and abuses of the Act (willful violations, fraud or intentional misrepresentations).

Board staff initiates cases against employers' that fail to carry mandatory workers' compensation insurance coverage. Cases are heard by Board-appointed presiding officers and can result in significant monetary penalties, loss of corporate status, suspension of a state-issued license, and/or referral to the Attorney General for criminal prosecution. The AIU also rules on petitions filed by parties for failure to pay medical expenses or lost-time benefits, and in instances when one party alleges another has failed to follow or has violated a Board order or other agreement regarding payment of benefits. The AIU may represent the Board when there is an allegation that an employer, insurer or third-party administrator has engaged in a pattern of questionable claims-handling or has repeatedly unreasonably contested claims.

The Unit is also responsible for administrative enforcement of laws when employers and insurers have to file specific forms. Potential violations are identified, and the AIU issues a complaint notifying employers and/or insurers of possible violations, conducts an investigation and, if a violation is identified, issues a decision that may impose a penalty.

Following is a list of the statutory provisions for which AIU is responsible.

- **Section 205(3):** when there is no ongoing dispute lost time benefits must be paid within 30 days of becoming due. Penalties of \$50 per day to a maximum of \$1,500 are payable to the injured worker for violations.
- **Section 205(4):** when there is no ongoing dispute medical bills are payable within 30 days of becoming due. Penalties of \$50 per day up to a maximum of \$1,500 are payable to a health care provider or the injured worker if there is a violation.
- **Section 324(2):** payments pursuant to a board order or agreement of the parties must be made within 10 days. Violations of this section may be penalized up to \$200 per day for each day of violation. The employee receives up to \$50 per day of any penalty assessed with the balance, if any, payable to the Board's Administrative Fund.
- **Section 360(1):** employers and insurers must provide information and/or file certain forms within deadlines specified. Penalties of up to \$100 per instance are payable to the General Fund.

- **Section 324(3):** entities conducting business in Maine, regardless of where they are based, must have workers' compensation insurance for any employees. Failure to carry coverage can result in penalties of up to \$10,000.00 or an amount equal to 108% of the unpaid premiums, **whichever is greater**. Violators are also subject to loss of corporate status, suspension of a state-issued license, and/or referral to the Attorney General for criminal prosecution. Penalties are paid to the Board's Employment Rehabilitation Fund.
- **Section 356(2):** benefits due to the work-related death of an employee are payable to the state when there are no surviving dependents as defined by the Act. An amount equal to 100 times the state average weekly wage is payable. AIU investigates possible cases and negotiates with insurers or litigates claims for payment.
- **Section 359(2):** any employer, insurer or third-party administrator found, after a hearing, to have a pattern of questionable claims-handling techniques or to have repeatedly unreasonably contested claims for compensation is liable for fines of up to \$25,000. Penalties are payable to the General Fund and violations are certified to the Superintendent of Insurance for further action.
- **Section 360(2):** individuals or businesses that commit a willful violation of the Workers' Compensation Act, fraud or intentional misrepresentation may be penalized. Individuals may be fined up to \$1,000 and businesses up to \$10,000 per violation and they may be ordered to pay compensation wrongfully withheld or repay benefits received. Penalties are payable to the General Fund.

Through the efforts of the Abuse Investigation Unit, the Board has contributed \$160,240 to the General Fund in 2009 from penalties assessed for late filed First Reports.

The AIU continues to work closely with the Attorney General's office regarding criminal prosecutions based on violations of Title 39-A. The failure to carry mandatory workers' compensation coverage is a Class D crime in Maine. 39-A M.R.S. § 324(3)(A). In 2005 the Attorney General's office began accepting cases for prosecution. Cases are identified using jointly developed criteria including the length of time a business operated without coverage and taking into consideration violators representative of a particular business or sector. The Attorney General's office also accepts cases from the Board for criminal prosecution based on violations of § 360(2). While violation of this section is not a crime, the actions taken resulting in violations (working while collecting compensation, misrepresenting the law or facts, perjury, fraud, etc.) may also constitute one or several different crimes under Maine Law. The Attorney General has obtained indictments regarding both provisions in all the cases presented to date, and has successfully obtained convictions with jail time and/or penalties and restitution.

B9. CLAIMS MANAGEMENT UNIT

The Claims Management Unit operates under a "case management" system. Individual claims managers process the file from start to finish. The insurance carriers, claims administrators, and self-insured employers benefit from having a single contact in the Claims Management Unit.

The Unit coordinates with the Monitoring Unit of the MAE Program to identify carriers that frequently file late forms or who may be consistently late in making required payments to injured workers. Case managers of the Claims Management Unit review the paperwork filed by carriers to ensure that payments to injured workers are accurate and that the proper forms are completed and filed with the Workers' Compensation Board. The Unit conducts training workshops regarding compliance and payments to injured workers upon request.

Greater implementation of Electronic Data Interchange (EDI) has created efficiencies in claims management, allowing managers to increase their claim management efforts, through the electronic filing of the First Report of Injury and Notice of Controversy.

In addition to EDI creating data entry efficiencies, the Unit is also undergoing full business analysis of its overall daily functions. The purpose is to upgrade computer programs and screens in order to streamline the workload, thereby making the daily performance of work more efficient; automate functions that can be done by the computer; and, reduce the time it takes to process claims and associated paperwork. All of these changes will provide time to address higher level and more serious problems and should benefit the entire workers' compensation community. It will also identify, through the computer, filing requirements and deadlines for carriers while notifying them automatically of problems or errors in this regard.

Claims staff search the database for a claim that matches the information on each form that is received, checking by Social Security Number, employee name and date of injury. This is information that is entered into the database after the Employer's First Report of Occupational Injury or Disease is filed with the Board. Claims Management Unit staff verify accuracy of payment information on each claim that is filed with the Workers' Compensation Board for claims that have been open since 1966. Cost of Living Adjustments (COLA) are done on claims beginning with dates of injury on January 1, 1972 through December 31, 1992. Claims staff check to see that the COLAs are calculated correctly. The filing of forms with incorrect information cause Claims staff to spend a lot of time researching files and doing mathematical calculations, which is necessary to ensure that correct payments are made to injured workers.

This Unit is responsible for annually producing the "State Average Weekly Notice" that contains the information necessary to make COLAs on claims, to calculate permanent impairment payments, and whether to include fringe benefits when calculating compensation rates. The SAWW is determined by the Department of Labor each year.

Claims staff use this information to do the mathematical calculations to determine the COLA multiplier and maximum benefit in effect for the following year.

Work is done by Claims staff to produce an annual Weekly Benefit Table. The Weekly Benefit Table is used by all members of the Workers' Compensation community who need to determine a compensation rate for an employee.

A brief description of the way various forms are processed is shown below:

Petitions – The file for the claim is located or created, the form is entered in the database, and the file is sent to the appropriate Claims Resolution Specialist in a regional office. A telephone call or e-mail message is directed to the person who filed the form if a claim cannot be found in the database. A request is made to provide an Employer's First Report of Occupational Injury or Disease so that a claim can be started.

Notices of Controversy - The initial form is filed electronically. Corrections to the form are submitted to the Board on paper forms and the changes are entered manually by Claims staff.

Answers to Petitions - The file for the claim is located, the Answer is entered into the database and sent to the file.

Wage Statements - The average weekly wage is calculated by Claims staff in accordance with direction given by Statute, Board Rules and Law Court decisions. The average weekly wage is entered into the database and the form is sent to the File Room.

Schedule of Dependent(s) and Filing Status Statements - The information on this form is entered into the database and the form is sent to the File Room.

Memorandum of Payment, Discontinuance or Modification of Compensation, Consent between Employer and Employee - The form is checked for accuracy, comparing dates, the rate, and the wage to information previously filed. The form is entered into the database and then sent to the File Room. A telephone call or e-mail message is directed to the person who filed the form if there is a problem. Explanations or amended forms are requested, when necessary.

21-Day Certificate or Reduction of Compensation - The form is checked for accuracy, comparing dates, the rate, and the wage. The form is entered in the database if everything is correct. In cases where it is determined by Claims staff that there has been an improper suspension or reduction, the file and form are sent to a Claims Resolution Specialist in a regional office.

Lump Sum Settlement – The information on this form is entered into the database and the form is sent to the File Room.

Statement of Compensation Paid – The information on this form is compared to information previously reported, the form is entered into the database, and the form is sent to the File Room. A large number of these forms are found to have errors which results in staff having to research the file to contact the person who filed the form, requesting corrected or missing forms.

The Claims Management Unit processed the following forms:

Filed between Jan. 1
And Oct. 31, 2009

Employer's First Report of Occupational Injury or Disease	31,488 electronic 54 paper filing
Notice of Controversy	8,081 electronic 4 paper filing
Petitions	3,265
Answers to Petitions	1,352
Wage Statement	7,678
Schedule of Dependent(s) and Filing Status Statement	8,085
All Payment Forms, including:	15,715
Memorandum of Payment	
Discontinuance or Modification of Compensation	
Consent Between Employer and Employee	
21-Day Certificate of Discontinuance or Reduction of Comp	
Lump Sum Settlement	
Statement of Compensation Paid	12,144

Currently the only forms which can be filed electronically are the Employer's First Report of Occupational Injury or Disease and the Notice of Controversy. All other forms are filed on paper and must be entered manually. Corrections to the Notice of Controversy cannot be made electronically and must be submitted manually.

B10. INSURANCE COVERAGE UNIT

The Unit researches the history of employer insurance coverage in order to certify the accuracy of these records. This is particularly important for many of the claims at formal hearing, especially where there is a controversy as to the liability for the payment of the claim. Since workers' compensation coverage in Maine is mandatory, the Unit routinely provides assistance to the public regarding insurance coverage requirements.

The Insurance Coverage Unit has new computer screens resulting from recent program upgrades. The new screens help to streamline data entry and enhance the ability to identify trends and problems with carriers. The program can link coverage and do employer updates more easily than in the past. This has resulted in a reduction of First Reports that can't be matched to an insurer. In the early 1990s, the Board would receive approximately 600 First Reports in which coverage could not be identified. In 2005 this figure had been reduced to 16, and in 2006 to 14. As a direct result of the computer upgrade and streamlining personnel in the Coverage Unit staff was reduced by four employees.

The Board's database was merged with the Department of Labor's roughly six years ago, resulting in greater collaboration with the Department of Labor and the Bureau of Insurance. The Unit processes proof of workers' compensation insurance coverage both manually and electronically. A staff member is assigned for processing applications for waivers to the Workers' Compensation Act.

The Unit supervisor is responsible for a multitude of duties including the approval of applications for predetermination of independent contractor status. The functions of the Unit consist of proof of coverage, waivers, and predeterminations. The goal of staff is to process 80% of the proof of coverage filings within 24 hours of receipt (the Board received and processed 45,641 proof of coverage filings between November 2007 and October 2008); 90% of waiver applications within 48 hours of receipt (the Board received and processed 1,652 waiver applications between November 2007 and October 2008); and 100% of predetermination applications within 14 days (the Board received 6,644 applications between November 2008 and October 2009). ALL GOALS WERE MET.

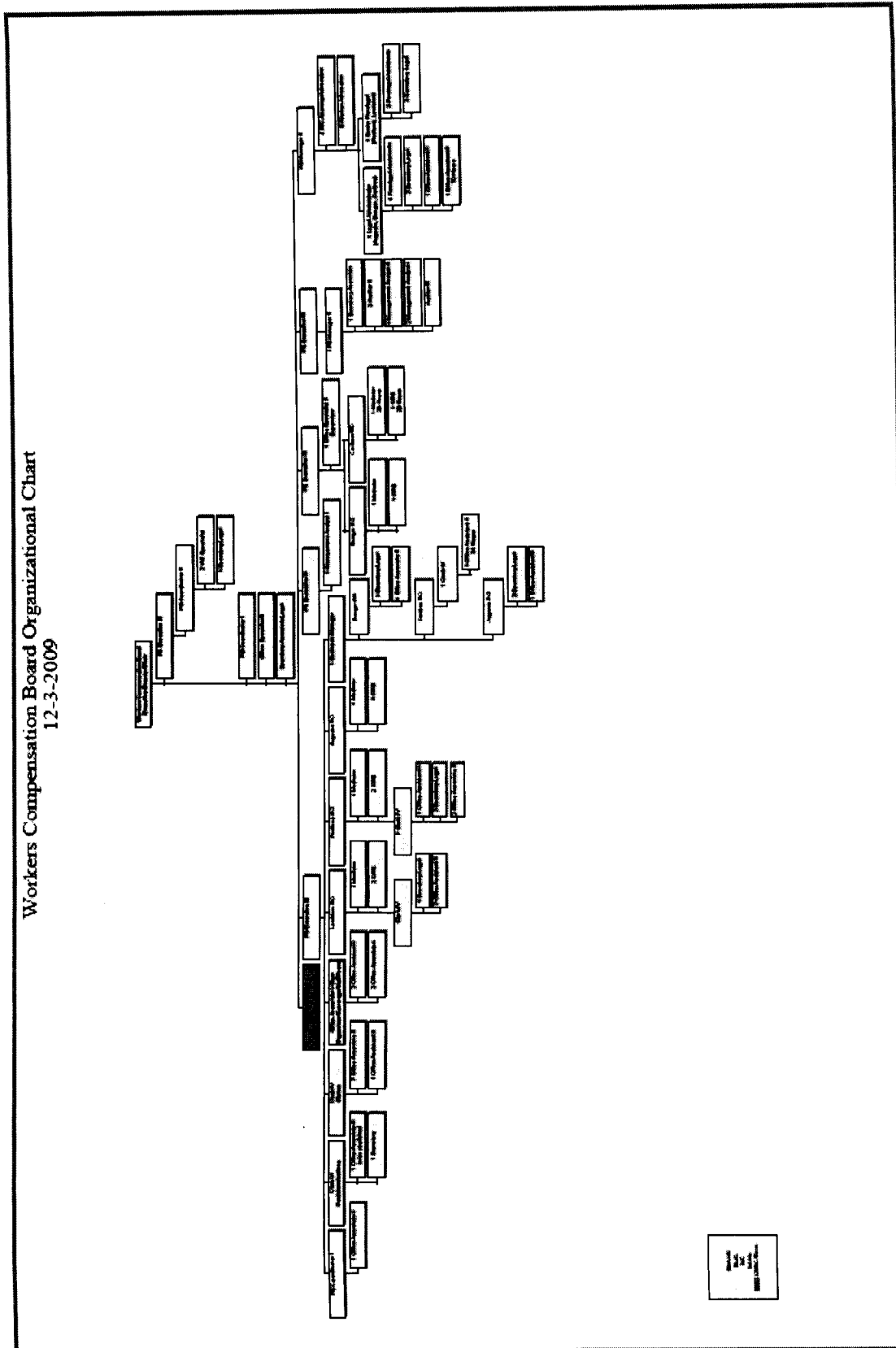
The Unit assists with problem claims including the identification of insurance coverage, the identification of employers, and identifying address changes for employers. This is done to properly process and assign claim files to the appropriate regional offices. The Coverage staff works closely with the Abuse Investigation Unit regarding problems associated with coverage enforcement. The Unit cooperates with the MAE program to identify carriers and self-insureds who consistently fail to file required information in a timely manner. And, it assists the Bureau of Labor Standards to maintain an accurate and up-to-date employer database, utilized by both departments.

**C. ORGANIZATIONAL STRUCTURE,
POSITION COUNT, JOB CLASSIFICATIONS**

Attachment I - Workers' Compensation Board, Organizational Flow-Chart

Attachment II - Workers' Compensation Board, Position Count, 108; Job Classifications

Note: The Board's position count is down from 122.5 in 2001.

[illegible]

**WORKERS' COMPENSATION BOARD
POSITION LISTING
FEBRUARY 2010**

2/2/10

POSITION NUMBER	POSITION TITLE
029000334	ADMIN ASST
029000309	ASST TO THE EX DIR W/C BOARD
029000046	AUDITOR II
029000063	AUDITOR II
029000361	AUDITOR II
029000001	AUDITOR III
029000375	BUSINESS MANAGER I
029000402	CLAIMS RESOLUTION SPECIALIST
029000404	CLAIMS RESOLUTION SPECIALIST
029000407	CLAIMS RESOLUTION SPECIALIST
029000409	CLAIMS RESOLUTION SPECIALIST
029000421	CLAIMS RESOLUTION SPECIALIST
029000406	CLAIMS RESOLUTION SPECIALIST
029000403	CLAIMS RESOLUTION SPECIALIST
029000101	CLERK IV
029000381	CLERK IV
029000351	CLERK IV
029000277	CLERK IV
029000045	DIR AUDITS
029000422	EX DIR W/C BOARD
029000003	HEARINGS OFFICER WCB
029000004	HEARINGS OFFICER WCB
029000006	HEARINGS OFFICER WCB
029000171	HEARINGS OFFICER WCB
029000357	HEARINGS OFFICER WCB
029000355	HEARINGS OFFICER WCB
029000291	HEARINGS OFFICER WCB
029000260	HEARINGS OFFICER WCB
029000328	LEGAL ADMINISTRATOR
029000318	MANAGEMENT ANALYST I
029000410	MANAGEMENT ANALYST I
029000368	MANAGEMENT ANALYST I
029000064	MANAGEMENT ANALYST II
029000411	MEDIATOR WCB
029000413	MEDIATOR WCB
029000414	MEDIATOR WCB
029000412	MEDIATOR WCB
029000415	MEDIATOR WCB
029000041	OFFICE ASSISTANT II
029000317	OFFICE ASSISTANT II
029000065	OFFICE ASSISTANT II
029000255	OFFICE ASSISTANT II
029000385	OFFICE ASSISTANT II
029000442	OFFICE ASSISTANT II
029000395	OFFICE ASSISTANT II
029000399	OFFICE ASSISTANT II
029000393	OFFICE ASSISTANT II
029000365	OFFICE ASSISTANT II
029000320	OFFICE ASSOCIATE I

**WORKERS' COMPENSATION BOARD
POSITION LISTING
FEBRUARY 2010**

2/2/10

POSITION NUMBER	POSITION TITLE
029000371	OFFICE ASSOCIATE I
029000161	OFFICE ASSOCIATE II
029000312	OFFICE ASSOCIATE II
029000383	OFFICE ASSOCIATE II
029000380	OFFICE ASSOCIATE II
029000367	OFFICE ASSOCIATE II
029000366	OFFICE ASSOCIATE II
029000358	OFFICE ASSOCIATE II
029000343	OFFICE ASSOCIATE II
029000311	OFFICE ASSOCIATE II
029000256	OFFICE ASSOCIATE II
029000268	OFFICE ASSOCIATE II
029000280	OFFICE ASSOCIATE II MGR SUPV
029000392	OFFICE ASSOCIATE II SUPV
029000362	OFFICE SPECIALIST II
029000420	OFFICE SPECIALIST II SUPV
029000062	PARALEGAL
029000319	PARALEGAL
029000335	PARALEGAL
029000389	PARALEGAL
029000423	PUBLIC SERVICE COORDINATOR III
029000363	PUBLIC SERVICE EXECUTIVE III
029000011	PUBLIC SERVICE EXECUTIVE III
029000401	PUBLIC SERVICE EXECUTIVE III
029000417	PUBLIC SERVICE EXECUTIVE III
029000398	PUBLIC SERVICE EXECUTIVE III
029000419	SECRETARY
029000276	SECRETARY ASSOCIATE
029000047	SECRETARY LEGAL
029000397	SECRETARY LEGAL
029000388	SECRETARY LEGAL
029000373	SECRETARY LEGAL
029000340	SECRETARY LEGAL
029000336	SECRETARY LEGAL
029000329	SECRETARY LEGAL
029000313	SECRETARY LEGAL
029000279	SECRETARY LEGAL
029000278	SECRETARY LEGAL
029000265	SECRETARY LEGAL
029000048	SECRETARY LEGAL
029000353	SECRETARY SPECIALIST
029000061	SENIOR PARALEGAL
029000274	SENIOR PARALEGAL
029000418	SENIOR PARALEGAL
029000347	SENIOR PARALEGAL
029000044	SENIOR STAFF ATTORNEY
029000050	WORKERS COMP ADVOCATE
029000053	WORKERS COMP ADVOCATE
029000052	WORKERS COMP ADVOCATE

**WORKERS' COMPENSATION BOARD
POSITION LISTING
FEBRUARY 2010**

2/2/10

POSITION NUMBER	POSITION TITLE
029000307	WORKERS COMP ADVOCATE
029000051	WORKERS COMP ADVOCATE
029000396	WORKERS COMP ADVOCATE
029000408	WORKERS COMP ADVOCATE
029000332	WORKERS COMP ADVOCATE
029000049	WORKERS COMP ATTORNEY ADVOCATE
029000327	WORKERS COMP ATTORNEY ADVOCATE
029000405	WORKERS COMP ATTORNEY ADVOCATE
029000316	WORKERS COMP ATTORNEY ADVOCATE
029000330	WORKERS COMP SPECIALIST
029000425	WORKERS COMP SPECIALIST

**D. COMPLIANCE WITH FEDERAL AND STATE SAFETY AND HEALTH LAWS
INCLUDING THE AMERICANS WITH DISABILITIES ACT, THE FEDERAL
OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION
REQUIREMENTS, AND WORKERS' COMPENSATION**

I. EEO/AA

Provide annual training and/or distribution of state policies, most recently, May and June of 2009.

II. ADA

Publish Civil Service Bulletin 8.19 with annual EEO/AA Policy.

Provide supervisory training on period and as-needed basis.

Comply with state and federal requirements for ADA request and determination.

Work closely with DAFS (which provides human resources support to the Board).

III. SAFETY AND HEALTH

The Board recently completed a comprehensive ergonomic evaluation and replaced/updated work stations as needed.

Provide training on topics such as: Violence in the Workplace; Driving Dynamics; Nutrition and Health.

Conduct annual inspections of all offices.

IV. FAIR LABOR STANDARDS ACT

Provide training for all supervisors of non-exempt employees.

Require employees to accurately reflect work hours.

V. INTERPRETER FOR DEAF AND FOREIGN LANGUAGE

Have TTY phone line available for each regional office.

Utilize registered interpreters and the Language Line Interpreter Services.

VI. WORKPLACE VIOLENCE PREVENTION

The Board has, and continues to, work to minimize the risk of workplace violence.

The Board entered into a contact with Richard Golden to assess the physical safety of each of the Board's six offices. Mr. Goldman made a series of recommendations to improve the safety of the Board's offices. The Board has implemented all of Mr. Goldman's suggestions. The recommendations included the installation of secure doors which can only be accessed by a special card or combination, as well as the erection of barriers to protect workers and the maintenance of escape routes.

Mr. Goldman also helped the Board develop a policy regarding violent or threatening behavior (A copy of the policy is attached.) Pursuant to this policy, the Board obtains the services of an officer whenever a threat is reported. This policy has worked very well to date.

VII. REDUCTION OF WORKPLACE INJURIES

The Board recently concluded a thorough ergonomic evaluation of its various offices. The main focus of the review was to ensure that employees have ergonomically correct work stations. A main goal, of course, is to prevent injuries by providing a safe working environment.

E. BUDGET AND ASSESSMENT (TEN-YEAR FINANCIAL SUMMARY)

The workers' Compensation Board has two accounts: The Administrative Fund and the Employment Rehabilitation Fund. The Administrative Fund is the account from which the Board pays its expenses. It will be discussed more extensively than the Employment Rehabilitation Fund which, as a result of a legislative change, does not figure as prominently in the Board's operations.

I. ADMINISTRATIVE FUND.

As a result of sweeping changes enacted in 1992, the Workers' Compensation Board replaced the Workers' Compensation Commission. As the Legislature and Governor debated the proposed changes to the workers' compensation laws, they also considered how to fund the new agency (i.e. the Board) which was being created.

The Board received an appropriation from the General Fund for fiscal year ("FY") 93. However, the Legislature and Governor decided, in the context of the economic slowdown in the late 1980's and early 1990's, that the Board should have an independent source of funding. Thus, the Board is considered an independent agency and receives no General Fund money. Instead, the Legislature and the Governor created an assessment on Maine's employers that is used to fund the Board's operations.

The Workers' Compensation Board receives virtually all of its revenue from this assessment. The maximum amount that the Board can assess each year is set by statute. 39-A M.R.S. § 154(6).

The process for issuing and collecting the annual assessment is set forth in the Workers' Compensation Act. 39-A M.R.S. § 154. The statute requires the Board to divide the assessment between self-insured employers and insurer employers. The division is based on the pro rata share of disabling cases that each category of employer is responsible for. 39-A M.R.S. § 154(5).

Once the distribution of disabling cases is determined, the Board must determine how much to assess. In calculating the amount to be assessed, the Board first projects its expenditures. The Board then projects the amount, if any, of its surplus. The surplus is defined as the money in the Administrative Fund that exceeds the allowed reserve.⁴ The surplus must be returned to Maine's employers in the form of a reduced assessment.

The Board has reduced its annual assessment ten times in the last ten years. These reductions total \$11,489,500.

⁴ The Board is required to have a reserve equal to one-quarter of its annual budget. 39-A M.R.S. § 154(6). Currently, the Board's reserve account can be funded to a maximum of \$1,700,000. The reserve account is discussed more fully below.

The procedure for assessing self-insured employers is straight-forward. Each self-insured employer is assessed a specific dollar amount based on the aggregate benefits paid by each self-insurer during the previous calendar year. If, for example, a self-insured employer paid 10% of the total aggregate benefits paid by self-insured employers in the previous calendar year, that self-insured employer would pay 10% of the total self-insured assessment. Each self-insured employer must pay its assessment for the upcoming fiscal year on or before each June 1.

The procedure for calculating and collecting the assessment from insured employers is more complicated. Insured employers do not pay a specific dollar amount. Instead, a rate, calculated by the Board with assistance from the Bureau of Insurance and industry experts, is applied to each workers' compensation policy. Insurers collect the money from their insured employers and then remit payment to the Board on a quarterly basis. Due to audits, reconciliations, and the method of collection, the Board's books for a fiscal year do not close at the end of the fiscal year.

As indicated, the Board is funded pursuant to a statutory assessment paid by Maine's employers, both self-insured and insureds. The Legislature, in creating this funding mechanism in 1992, intended the users of the workers' compensation system to pay for it. The agency had previously been funded from General Fund appropriations.

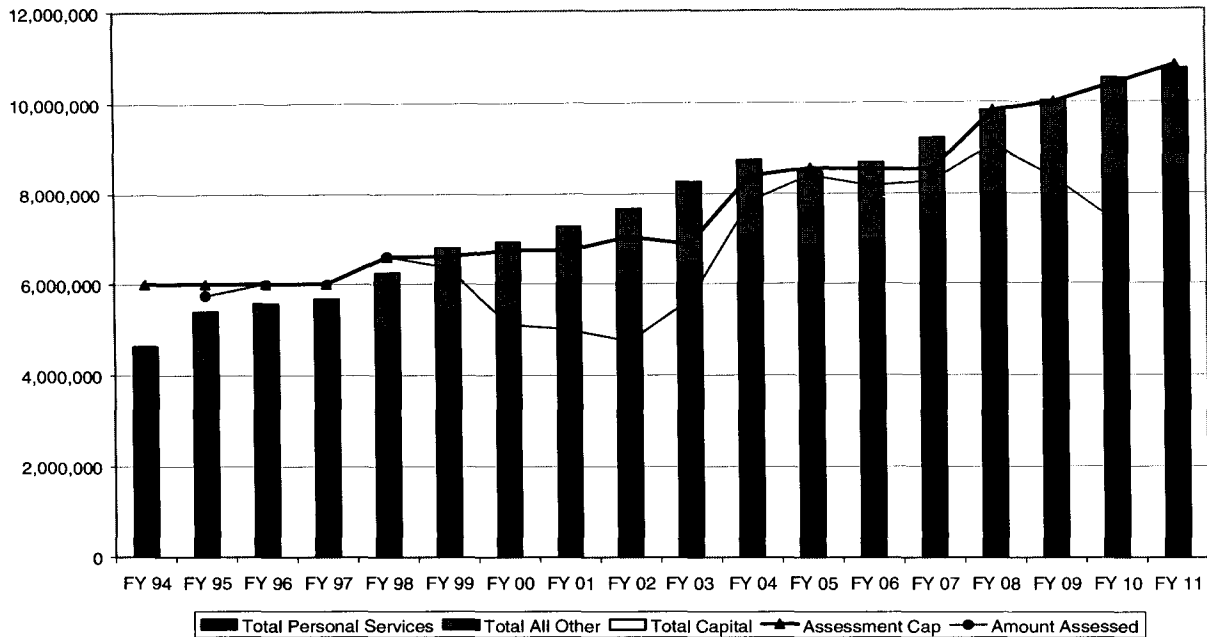
The Legislature established the assessment as a revenue source to fund the Board, but capped the assessment limiting the amount of revenue which can be assessed. A long term solution to this problem is being considered in order to deal with costs, beyond the Board's control, such as contract increases, health insurance, retirement, postage, and lease costs.

The assessment cap has been problematic in submitting a balanced budget. The Board cannot budget more than it can raise for revenue from the annual assessment and other minor revenues collected from the sale of copies of documents, fines and penalties. A majority of the fines and penalties received are deposited in the General Fund which contributes no support to the Board. The Legislature voted to raise the assessment cap beginning in FY08. This legislation increased the maximum assessment to \$9,820,178 in fiscal year 2008, \$10,000,000 beginning in fiscal year 2009, \$10,400,000 beginning in fiscal year 2010, \$10,800,000 beginning in fiscal year 2011, and \$11,200,000 beginning in fiscal year 2012. These increases in the Board's assessment cap should assist in submitting a budget that is balanced between expenditures and revenues for the next biennium. The total Board-approved budget for this biennium totaled \$10,446,994 in FY10 and \$10,681,089 in FY11.

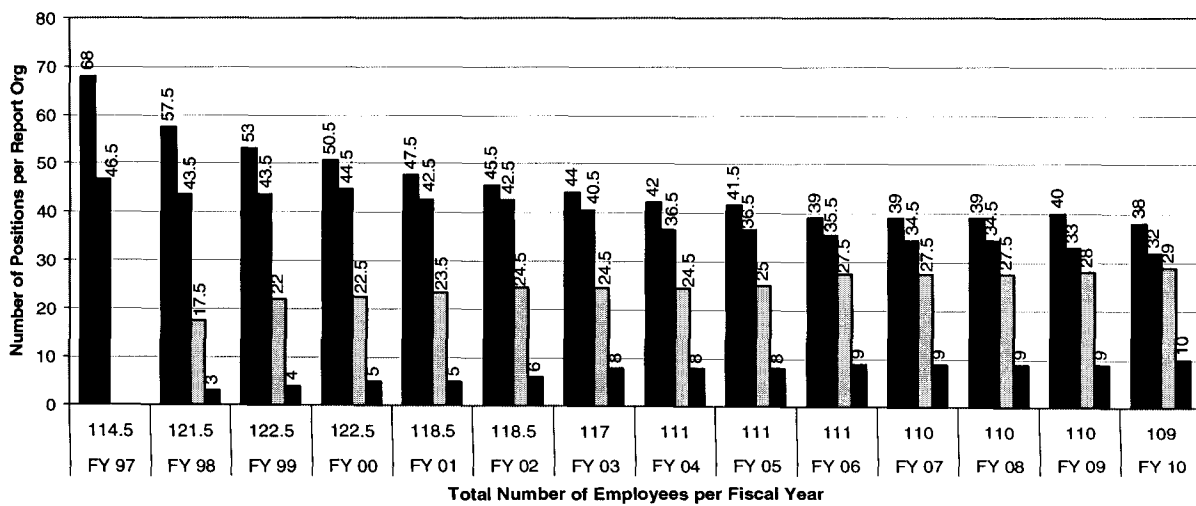
P.L. 2003, C. 93 provides that the Board, by a majority vote of its membership, may use its reserve to assist in funding its Personal Services and All Other expenditures, along with other reasonable costs incurred to administer the Workers' Compensation Act. The Bureau of the Budget and Governor approve the request via the financial order process. This provides greater discretion to the Board in the use of its reserve account. The bar chart entitled "WCB – 18 Year Schedule of Actual and Projected Expenditures" shows actual expenditures through FY09 and projected expenditures for FY10. It also shows the assessment cap and the amounts actually assessed through FY10. The bar chart

entitled "WCB – Personnel Changes Since FY97" demonstrates the Board's efficient use of personnel since 1997.

**WCB - 18 Year Schedule of Actual and Projected Expenditures
Workers' Compensation Administrative Fund - 0183
October 2009**



**WCB - Personnel Changes Since FY 97
October 2009**



The MAE and Worker Advocate programs represent 36% of the agency's total number of employees.

■ Dispute Resolution ■ Central Services □ Advocate Program ■ MAE Program

II. BLAKE HURLEY MCCALLUM & CONLEY REPORT

As part of the FY 08-09 budget process, the Legislature requested that the Workers' Compensation Board oversee an audit of the agency's finances. At the conclusion of the RFP and interview process, the Board hired the accounting firm of Blake Hurley McCallum & Conley to conduct this audit. The firm was asked to review all aspects of the Board's assessment process and financial practices for the fiscal years beginning in July 1, 1997 and ending July 1, 2007. The firm found the Board staff to be "organized, diligent and dedicated in the manner they carried out the mission of the Workers' Compensation Board" and presented a clean bill of health for the Board's fiscal operations for the 10 year period. (A copy of the Report is attached.)

The Board has taken the following steps to comply with the Blake Hurley recommendations to improve the efficiency of the Board's finances: 1) the Board has moved all assessment data from Excel spreadsheets to the Board's computer software program Progress; 2) the Board has implemented steps to ensure segregation of duties relative to assessment collections; and 3) the Board has established a separate account for the agency's reserves. Blake Hurley further recommended that if the present assessment process is retained, that the Board should institute an audit function on insurers and self-insureds to improve compliance with the assessment statute. This recommendation has not yet been implemented. Another consideration was to legislatively change the "assessment statute to require insurance companies to pay assessments on the same basis as the self-insureds" (cash basis in lieu of a rate basis). The change would simplify the process and reduce administrative costs, but would be very cumbersome for the insurance companies to implement; and, therefore, the Board has delayed any action on this recommendation.

**INDEPENDENT ACCOUNTANTS' REPORT ON APPLYING
AGREED-UPON PROCEDURES
FOR
STATE OF MAINE, WORKERS' COMPENSATION BOARD
FISCAL YEARS BEGINNING JULY 1, 1997
AND
ENDING JUNE 30, 2007**

Blake Hurley McCallum & Conley, LLC · Certified Public Accountants

344 Main St. Westbrook, Maine 04092 · (207) 854-2115/Fax 854-2118

December 19, 2007

Mr. Paul R. Dionne
Executive Director
Workers' Compensation Board
Deering Building, AMHI Complex
27 State House Station
Augusta, ME 04333-0027

Re: Agreed-upon procedures

Dear Mr. Dionne:

On behalf of our firm, I want to thank you and your staff for the courtesy, cooperation and forthrightness extended to us during the completion of our field work with respect to our agreed-upon procedures engagement. In particular, with respect to the areas we examined, we found staff to be organized, diligent and dedicated in the manner they carried out the mission of the Workers' Compensation Board. We commend you, and the staff, for those efforts.

Throughout our report, we noted areas where, in our opinion, efficiencies and safeguards could be improved, both in the administrative sector, and in the legislative sector.

With respect to administrative functions, we refer you to our report on the internal controls related to the billing and collection of assessments, which is included as Appendix A of the report. In that report, we recommend that stricter controls over cash receipts be implemented, that WCB add an audit function with respect to the examination of assessment remittance reports and collections, and that WCB transition to a professional accounting software package so that billings and receipts can be tracked and reconciled in a more efficient and accurate manner.

With respect to the statute, we noted that the reserve accounting and refund requirements do not account for the inherent time span over which estimated assessments are collected.

We noted that the application of the refund statute can lead to the case where costs incurred to refund an over-collection exceed the nominal amount of the refund.

We noted that the statute favors self-insurers over insurance carriers' customers in that self-insurers share in the division of over-collections, even though self-insurers do not contribute to the over-collections.

December 19, 2007

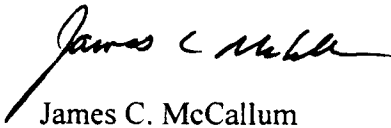
Mr. Paul R. Dionne
Executive Director
Workers' Compensation Board
Page Two

We noted that employers who transition to self-insurer status, by virtue of the statutory mechanics, permanently escape one year of assessment.

Finally, we noted that, in the aggregate, the costs and administrative burdens of all stakeholders would be lessened if insurance carriers were assessed in the same manner as self-insurers.

Thank you again, Mr. Dionne, for your time, consideration and patience. We look forward to discussing these issues with you and with the Labor Committee in the near future.

Sincerely,



James C. McCallum

STATE OF MAINE-WORKERS' COMPENSATION BOARD

Independent Accountants' Report On Applying Agreed-Upon Procedures

Fiscal Years Beginning July 1, 1997 and Ending June 30, 2007

Procedures, Results, Observations & Recommendations

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Blake Hurley McCallum & Conley, LLC · Certified Public Accountants

344 Main St. Westbrook, Maine 04092 · (207) 854-2115/Fax 854-2118

To the Board of Directors
State of Maine-Workers' Compensation Board

We have performed the procedures described herein, which were agreed to by the State of Maine-Workers' Compensation Board, solely to assist you with respect to the following items:

Procedure 1: Written evaluation of the internal controls under which assessments are levied, distributed and refunded.

Procedure 2: Accuracy of recording of assessment collections by applicable year.

Procedure 3: Agreement of WCB schedule of collected assessments to DAFS trial balance.

Procedure 4: Accounting for assessments collected in excess of the statutory cap.

Procedure 5: The consistency of actual expenditures in relation to legally adopted budgets.

Procedure 6: The review of the schedule of the reserve activity.

Procedure 7: Report on development of assessment rates.

Procedure 8: Report on adequacy of resources-Monitoring, Audit and Enforcement Program and Workers' Advocate Program.

The procedures and results, along with observations and recommendations, are described in detail in the pages accompanying this report.

The State of Maine-Workers' Compensation Board's management is responsible for the Board's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants.

We were not engaged to, and did not, conduct an audit, the objective of which would have been the expression of an opinion on specific elements of the accounting records of the State of Maine-Workers' Compensation Board. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the State of Maine-Workers' Compensation Board and is not intended to be and should not be used by anyone other than this specified party.

Blake Hurley McCallum & Conley, LLC
Blake Hurley McCallum & Conley, LLC
Westbrook, Maine

December 19, 2007

STATE OF MAINE-WORKERS' COMPENSATION BOARD

Independent Accountants' Report On Applying Agreed-Upon Procedures

Fiscal Years Beginning July 1, 1997 and Ending June 30, 2007

Procedures, Results, Observations & Recommendations

After reviewing the applicable statutes and documenting our understanding of the procedures used in the computation, distribution, billing, collection and recording of assessments, the development of assessment rates, the calculation of assessments collected in excess of statutory amounts, the calculation of the reserve account balance, and the adoption of and implementation of budgeted expenditures, we performed the following requested procedures:

Procedure 1: Evaluation of Internal Controls-Levy, Distribution and Refund of Assessments

Our report on the evaluation of internal controls is included as Appendix A of this report.

Procedure 2: Accuracy of Recording of Assessment Collections by Applicable Year

We were requested to review a schedule of assessment collections by fiscal year to determine whether they had been tracked appropriately by tracing assessments per the report to the source documents to determine the reasonableness of the report. We were requested to agree total assessment by fiscal year to the Board's minutes.

WCB requested that we develop a sample for testing. Our sample resulted in the tracing of all significant collections (>\$310,000), as well as the random tracing of smaller collections.

The population of collected assessments for the ten fiscal years approximates \$78 MM, and is comprised of \$51 MM of insurance company collections and \$27 MM of self-insurer collections. Using dollar unit sampling, we obtained a sample resulting in a tracing of approximately \$43 MM of total collections (\$28 MM of total insurance company collections and \$15 MM of total self-insured collections). In percentage terms, our tracing sample consisted of approximately 55% of total collections recorded in the Workers' Compensation Board (WCB) collections database.

Procedure 2-Results:

Tracing of self-insurer collections to source documents.

WCB does not copy checks before remitting deposits to the Department of Administrative and Financial Services (DAFS). WCB is not required to save, and does not save, payer remittance advices once the State Audit is completed.

Beginning with the 2004 fiscal year, DAFS began saving copies of checks and began recording receipts in its system by payee, date and amount, and by category of payment. Prior to that fiscal year, no source documents existed at DAFS which could be tied to the WCB database. Accordingly, with the exception of a few cash receipts applicable to the WCB's 2003 FY but received by DAFS in 2004, we could not trace pre-2004 self-insurer cash receipts per the WCB database to any other document or accounting system. However, as noted later in this report, we were asked to perform, and did perform, a reconciliation of ten years of net receipts per the WCB database with net receipts reported per DAFS, arriving at a relatively minor and explainable variance.

STATE OF MAINE-WORKERS' COMPENSATION BOARD

Independent Accountants' Report On Applying Agreed-Upon Procedures

Fiscal Years Beginning July 1, 1997 and Ending June 30, 2007

Procedures, Results, Observations & Recommendations

For fiscal years beginning July 1, 2003 and ending June 30, 2007, we agreed our detailed sample of self-insured collections per the WCB database to the cash receipts report generated by DAFS, without exception.

We did note the following exception. The 2007 assessment called for self-insurers to pay an aggregate of \$3,425,483 in assessments. While tracing collections of self-insurer assessments to the master spreadsheet, we noted in the detailed 2007 fiscal year spreadsheet that the collections of self-insurer assessments fell short from the anticipated collection by an amount of \$284,161. This occurred because, after the original assessment was finalized and mailed, WCB discovered that two self-insurers were no longer self-insured as of May 1, 2006. The shortfall was apportioned among the remaining self-insurers in anticipation of a supplemental assessment. To date, the supplemental assessment has not been made. We also noted the occurrence of this event in two other fiscal years. However, those short falls were less than \$10,000 in each instance.

WCB obtains a list of all previous year self-insurers from the Bureau of Insurance in April, along with claims paid for that year. Staff indicated that letters are mailed in April to all self-insured employers, asking them to confirm the dollar amount of claims reported to WCB from the Bureau of Insurance, and to notify WCB if they are no longer self-insured. WCB assumes that the employer is still self-insured if no reply is received.

In this case, the two employers dropped self-insurance at some point between the date the Bureau of Insurance notified WCB of their status, and May 1, which is the cut-off date for assessment. The two employers did not notify WCB of their change in status until they received the assessment. Staff indicated that, usually, these letters are sent to employers via certified mail. In this year, the letters were sent by ordinary mail, and receipt by the employers in question could not be verified. We were told that, because receipt could not be verified, WCB did not pursue payment from these employers. We question whether the law will allow such a pursuit, as the statute indicates that the employers would not be liable for the assessment.

Tracing of insurance company collections to source documents.

We traced receipts and refunds recorded in the database for each of the insurance companies included in our sample to the source documents remitted to WCB by the applicable insurance company. With the exception of minor posting errors in the nature of transposition errors or input errors, and rare postings to the wrong insurance company (usually located above or below the appropriate cell of the database), we were able to successfully trace source documents to the WCB database.

Tracing of total assessment by fiscal year to the Board's approved minutes.

We agreed the total assessment by fiscal year to the Board's approved minutes without exception.

STATE OF MAINE-WORKERS' COMPENSATION BOARD

Independent Accountants' Report On Applying Agreed-Upon Procedures

Fiscal Years Beginning July 1, 1997 and Ending June 30, 2007

Procedures, Results, Observations & Recommendations

Observation

Need for Audit Function

With respect to insurance companies, assessments are, similar to income taxes, self-assessed. However, unlike the income tax collection process, which functions on a "trust but verify" basis, no audit function exists at the WCB. Accordingly, insurance companies report and pay assessments on the honor system.

We noted that insurance company remittance reports are recalculated by WCB for mathematical accuracy, and math errors are brought to the attention of the insurance company for resolution. Ultimately, the collected assessment agreed to the corrected remittance report. However, WCB does not request documentation from the insurance company to substantiate that the correct amount of premiums, upon which the assessment is based, are being reported on the remittance report.

In one instance, we noted that an insurance company reported fourth quarter premiums written in the amount of negative \$16,816,586, (approximately 75% of the premiums reported by the company over the first three quarters of the fiscal year). A refund of \$312,000 was allowed, as the insurance company submitted the report along with reports of related insurance companies reporting assessments, and one check, net of the \$312,000, was received and deposited by WCB. Ultimately, the company's September reconciliation report reflected a true-up liability of \$282,000, and the fourth quarter refund, if erroneous, may have been negated with the reconciliation payment.

Another example of non-compliance appears to exist in the reporting and payment of audit premium assessments. Staff informed us that some insurance companies never report and pay audit premium assessments, because they are either unaware of the requirement, or they ignore the requirement.

Recommendation

When insurance companies underpay their assessments, and are not held accountable, stakeholders who comply with the law ultimately pay for the non-compliers' underpayments. We recommend that, if the present assessment regimen is retained, WCB should institute an audit function to improve compliance with the assessment statute.

Of course, if insurance companies were assessed on the same basis as self-insurers, thus paying one assessment, once per year, 95% of the insurance companies' reporting and payment requirements would be eliminated, thus eliminating the need for WCB to institute an audit function with respect to assessment collections. We recommend that the Legislature give serious consideration to this proposal.

Observation

Statutory Loophole Allows Escape From Assessment

A loophole exists in the statute allowing an employer transitioning to self-insured status to escape assessment for the initial year of self-insurance. The statute requires that the self-insurers' assessment be

STATE OF MAINE-WORKERS' COMPENSATION BOARD

Independent Accountants' Report On Applying Agreed-Upon Procedures

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Procedures, Results, Observations & Recommendations

apportioned among the self-insurers' pool based upon the proportionate amount of total benefits paid by the self-insurers in the previous year. A new self-insurer will not have a previous years' history of claims paid. Therefore, that employer will not be liable for an assessment with respect to its initial year of self-insurer status. In an extreme case, an employer could change status every other year and avoid paying the assessment every other year.

Recommendation

We recommend that the statute be amended to require self-insurers to remain in the self-insurer pool for assessment purposes in the year after they no longer are a self-insurer, in order to true up their assessment. Alternatively, self-insurers could be assessed in the initial year of self-insurer status, using the prior year's amount of claims paid on its behalf by its former carrier as its basis for assessment.

Observation

Misallocation of Resources-Estimated Assessments-Insurance Companies' Customers

The time consumed in administrating the billing and collection of assessments from insurance companies dwarfs the time consumed in administrating the collection of assessments from self-insurers. Close to 40% of an annual assessment is paid by the self-insurers. Yet, billing and collecting from self-insurers takes up only about 5% of WCB's total time to administer the billing and collection process.

Pursuant to the statute, self-insurers always pay exactly what they owe. They are assessed for their portion of the entire assessment, based upon their proportion of total disability cases reported in the previous year, and they pay their assessment once per year.

Insurance companies, on the other hand, pay WCB as they bill their customers for assessments. They pay three quarterly payments, a fourth quarter estimated payment, and finish the process with a final reconciliation report, which reflects a final payment or refund for the applicable year. In addition, in subsequent years, as insurance companies complete their customers' premium audits, they prepare additional reports and remit additional payments or refund requests, based upon the results of the audits. Audit remittances can trickle in for up to five years after the close of a fiscal year.

On a cumulative basis, thousand of hours are expended by WCB and the insurance companies to meet the compliance requirements of the assessment and payment statute. This cost to the system can be eliminated if insurance companies paid one bill, once per year, on the same basis as the self-insurers. Of course, the assessment would become a liability of the insurance companies. However, it would seem to be a more efficient use of resources for all stakeholders if the insurance companies adjusted their premium charges in order to pass one exact assessment on to their customers.

STATE OF MAINE-WORKERS' COMPENSATION BOARD

Independent Accountants' Report On Applying Agreed-Upon Procedures

Fiscal Years Beginning July 1, 1997 and Ending June 30, 2007

Procedures, Results, Observations & Recommendations

Recommendation

Again, we recommend that the Legislature consider amending the assessment statute to require insurance companies to pay assessments on the same basis as self-insurers. This change would reduce the WCB's and the insurance companies' administrative costs.

Procedure 3: Reconciliation of WCB Receipts to DAFS Receipts

Originally, we were requested to trace annual assessment collection totals from WCB schedules to DAFS prepared trial balance accounts. However, while documenting our understanding of the procedures relating to the recording of insurance company collections at WCB, we discovered that WCB records collections only by the fiscal year to which the collections apply. For example, if WCB receives an audit premium assessment in June 2007 that applies to the 2003 fiscal year, WCB records the receipt in the 2003 database. DAFS, on the other hand, will record the collection in the 2007 fiscal year. In addition, assessments billed by the WCB in May and collected in June of any fiscal year are applied to the following fiscal year. DAFS will record that collection in the year of receipt, which is WCB's previous fiscal year. To complicate matters further, many times a customer will pay the assessment in July or a later month, which is after the due date of the payment. In that case, DAFS will have recorded the receipt in the same year as it is recorded on the WCB database.

Accordingly, it is impossible to trace the WCB totals to the DAFS trial balance without reconstructing the entire WCB database to reflect collections by applicable fiscal year AND by fiscal year of receipt.

Our documentation of procedures revealed that WCB does record the date of receipt of each self-insured collection. Because the vast majority of self-insured collections are received in a three-month period spanning only two fiscal years, and consists of a one time payment for the WCB's applicable fiscal year, we determined it would be feasible to attempt to reconcile self-insured collections for the 2004 through 2007 fiscal years to the applicable DAFS trial balance. This is possible because, beginning with the 2004 fiscal year, DAFS recorded the detail of self-insured receipts by name and date received. Accordingly, WCB's management requested that we attempt to reconcile the FY 2004 through 2007 WCB self-insured collections to the DAFS books of record.

WCB's management also requested that we attempt to perform a reconciliation of the aggregate net receipts recorded by WCB by applicable fiscal year to the aggregate net cash receipts reported by DAFS for the ten fiscal years in question, so that WCB could determine whether a reasonable and acceptable variance resulted from the reconciliation.

Procedure 3-Results:

We were able to reconcile the total of self-insured collections reported by WCB for the 2004-2007 fiscal years, noting the following variances:

STATE OF MAINE-WORKERS' COMPENSATION BOARD

Independent Accountants' Report On Applying Agreed-Upon Procedures

Fiscal Years Beginning July 1, 1997 and Ending June 30, 2007

Procedures, Results, Observations & Recommendations

For the 2007 FY, the DAFS cash receipts report reflected three self-insured collections, totaling \$62,328, which were erroneously posted to DAFS insurance company collections account. After accounting for this error, we arrived at a variance of \$2,087 from the \$3,141,362 reported collected by WCB.

We reconciled the 2006 FY total self-insured collections to the DAFS reports, without exception.

We reconciled the 2005 FY total self-insured collections to the DAFS reports to within \$733.

We reconciled the 2004 FY total self-insured collections to the DAFS reports to within \$51.

For the period beginning July 1, 1997 and ending November 9, 2007, we attempted to reconcile the collections reported by WCB, as applicable to that period, with the total collections received by DAFS during that period.

During that period, DAFS recorded \$82.7 MM of cash receipts. After accounting for obvious reconciling items (e.g. June payments recorded in FY 1997 by DAFS but applicable to WCB's succeeding fiscal year), we reconciled the WCB collections to DAFS collections to within \$285,000. The variance equals .33% of the approximately \$82 MM received by DAFS during the period tested, and most likely is attributable to input errors, as well as timing differences which have not been identified, but should have been excluded from or included in the reconciling items.

Observation

Need for Accounting Software

As we note in our internal control report (see Appendix A), the use of Microsoft EXCEL to track the database of detailed billings and collections does not facilitate accurate recording and reporting of billings and collections. By its nature, the task of manual data entry is error prone. Data entry errors can only be discovered and corrected if a reconciliation function is present. As designed, the EXCEL database does not allow for a reconciliation function.

During our first pass at reconciling the WCB collections to DAFS collections, we arrived at a variance of approximately \$1.3 MM. That variance narrowed to \$285,000 after we discovered, and the WCB corrected, Excel cell references in the master summary sheet, linked to incorrect cells from the detailed FY databases.

It is critical that the master summary sheet reflect accurate balances. The report tracks assessment collections by applicable year, and, among other uses, the data is used to determine whether or not the 10% cap has been exceeded for any particular year.

Recommendation

We recommend that WCB transition to a professional accounting software package, beginning with the commencement of the assessment process for the 2009 FY. WCB should coordinate with the Controller's

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office to determine the feasibility of accounting for billings and collections using the State's accounting system. Alternatively, WCB could use QuickBooks in place of its EXCEL database.

Procedure 4: Accounting for Assessments Collected in Excess of Statutory Amounts

We were requested to determine whether collections exceeded statutory amounts, and, if so:

a) determine whether collections exceeding the statutory cap by more than 10% were properly refunded,

or

b) determine whether collections exceeding the statutory cap by less than 10% and above the allocated WCB budget were appropriately reserved in the WCB operating account.;

and

c) State whether refunds and distributions met statutory requirements.

Procedure 4-Results:

Procedure 4 (b) was performed in conjunction with the performance of Procedure 5. Please refer to that section of the report for those results.

WCB uses EXCEL to generate a report summarizing historic assessments and collections by fiscal year. We refer to this report as the "Master Summary Spreadsheet". This spreadsheet is linked to underlying detailed spreadsheets, which track collections by fiscal year. The spreadsheet also contains a formula to compute the difference between the amount of fiscal year collections and the Statutory amounts allowed to be collected for that particular fiscal year.

We tested the accuracy of all relevant components of the Master Summary Spreadsheet when performing Procedures 1 and 2. After correcting for errors discovered during the completion of those procedures, WCB produced an updated Master Summary Spreadsheet. Our review of this schedule resulted in the following determinations:

With respect to fiscal years 1998, 2005, and 2006, collections, net of refunds, to date, have exceeded the statutory cap in excess of 10% by the amounts of \$790,940, \$198,849 and \$135,536, respectively. In each of the remaining fiscal years at issue, at this point in time, net collections are not in excess of the statutory cap plus 10%.

To date, no collections in excess of 10% of the statutory cap have been refunded. Because refunds have not been issued, Procedure 4 (c) is moot. The 1998 estimated excess collection was "refunded" by reducing planned assessments in 1999 and 2000. WCB intends to issue refund checks with respect to the 2005 FY excess collection, as well as the tentative 2006 excess collection.

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Observation

Statutory Refund Language Can Lead to Misallocation of Resources

The statute states that over-collections "must be refunded to those who paid the assessment" (39-A MRSA Sec. 154 (6).) Taken literally, this section requires WCB to issue refunds to the insurance companies and the self-insurers in proportion to the assessments paid by them with respect to the year of excess collection, no matter how small the amount of the refund.

An apportionment of the FY 2005 \$198,000 over-collection among every eligible employer in the State would result in refunds to some which would amount to pennies. In many cases, where a credit to an account is not possible, postage would be greater than the amount of the refund.

In addition, aggregate administrative costs of all parties involved in the delivery and acceptance of the refund could conceivably outweigh the benefit of the refund. Insurance companies will need to apportion their piece of the refund among all of their customers and issue refunds to those who are no longer customers, and issue credit memos to those who are still customers.

Finally, some of these employers may no longer exist. (In fact, WCB states that some of the insurance companies who remitted assessments in 2005 are no longer in business. WCB is attempting to determine who the successor company is, or if a successor company exists.) In these cases, insurance companies and the WCB will need to file abandoned property reports and remit the refunds to the State Treasurer.

Recommendation

We recommend that the Statute be amended to eliminate the 10% cap language and the refund requirement, and, instead, require WCB to reduce future assessments when it determines that an excess reserve balance has accumulated.

Observation

When Should the Refund Settle?

The refundable amount of an over-collection is a moving target. Because insurance companies conduct premium audits in years subsequent to the year of assessment, the actual amount of assessment WCB collects, net of refunds, relative to an applicable fiscal, will not be known until five years after the close of the applicable fiscal year. Until that time, the refundable amount of over-collection is a moving target.

For example, WCB is processing a refund in the amount of \$201,000 for the 2005 fiscal year. This refund amount was arrived at in October, and was based upon the historic results known at that time. Today, the schedule reflects an excess collection of \$198,849, and this amount is sure to change over the next one to two years. An accurate refund can be issued only if the results of the fiscal year have settled.

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Recommendation

The statute does not impose a definitive time at which WCB must issue a refund. If the refund statute is not eliminated, we recommend that the statute should be amended to require WCB to refund only the amount in excess of the 10% cap which has been collected as of October 31 of the following fiscal year. The excess collected after that point would be added to the reserve account.

The practical reason for adopting this method is that insurance companies will more likely be able to track down their customers while the over-collection is fresh. If WCB must wait five years before the exact amount of over-collection settles, by then, many customers will have changed insurance companies, sold, merged or terminated their existence. Insurance companies will be vexed in their attempt to forward refunds to these customers.

Observation

Who is Entitled to a Refund of Over-Collected Assessments?

The statutory language is flawed in that it requires that an over-collection in excess of the 10% cap to be refunded to all who paid assessments in the applicable year of over-collection. Yet, self-insurers do not overpay their assessment, and should not be entitled to any portion of a refund.

Self-insurers pay exactly what they owe. Insurance companies' customers pay their share of the assessment based upon an estimate of premium dollars to be written for that year. Logically, any collection in excess of the annual assessment must have been paid by the insurance companies' customers, and, based on a principle of equity, only they would be entitled to a refund.

Recommendation

At a minimum, we recommend that the statute be amended to require that collections in excess of the 10% cap be remitted only to the insurance company customer base. The easiest and obvious solution, however, is to amend the law and place insurance companies on a par with self-insurers for assessment purposes.

Observation

Reducing a Subsequent Year's Assessment Does Not Comply With Statute

The statute (39-A MRSA Sec. 154 (6).) requires that assessments over and above the 10% cap "must be refunded to those who paid the assessment". With respect to the 1998 over-collection, WCB concluded that reducing the 1999 assessment was a proper means of refunding a previous year's collection in excess of the 10% cap.

We believe that WCB's 1999 action was at odds with the statute. The statute requires that refunds be issued "to those who paid the assessment". A refund in the form of a future year's assessment reduction

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will never result in an exact apportionment of an over-collection "to those who paid the assessment". WCB intends to refund over-collections with respect to the 2005 and 2006 fiscal years.

Procedure 5: The Consistency of Actual Expenditures in Relation to Legally Adopted Budgets

We were requested to examine WCB expenditure activity to determine if WCB has operated within its legally adopted budgets each year, assess whether internal expenditures have been consistent with legally adopted budget, and examine whether WCB expenditures authorized through the use of financial orders comply with M.R.S.A. Title 39-A, §154, paragraph 6.

Procedure 5-Results:

By relying on reports generated by the Appropriation Inquiry function of the State Budget and Financial Management System, we determined that the WCB has operated within its legally adopted budgets each year, as adjusted for authorized financial orders. Expenditures in each fiscal year were less than the allotted amounts. The excess allotments ranged from \$67,224 to \$555,975.

The Bureau of the Budget also provided us with the original adopted budgets and adjustments for financial orders for the fiscal years ended June 30, 2004 through June 30, 2007. We traced and agreed these amounts to the Appropriation Inquiry reports, which were provided to us by the State Controller's Office, without exception.

Adopted budgets and approved and recorded financial orders for the fiscal years beginning July 1, 1998 and ending June 30, 2003 were recorded on an outdated Financial Management system. The Bureau was not able to provide this information to us before the due date of our report. Accordingly, we were not able to trace Appropriation Inquiry totals to actual budget documents for those years. However, we were assured by the Controller's office that its system of internal controls act to prohibit WCB from spending any amount above and beyond its allocation, including approved financial orders.

Procedure 6: The Calculation of the Reserve Account Balance

We were requested to review a schedule of reserve activity in order to determine whether the reserve ever exceeded the 25% cap, and to examine compliance with the reserve language in M.R.S.A. Title 39-A, §154, paragraph 6.

Prior to fiscal year ending 2002, WCB did not perform a formal calculation of the reserve activity and ending reserve balance. As of the end of FY 2002, and through FY 2007, WCB began performing formal calculations, and we were provided with copies of these calculations. WCB informed us that, in consultation with Berry Dunn, it arrived at an estimated reserve balance of \$1,775,000 as of June 30, 2002. We reviewed the report issued by BDMP and agree with their conclusion that the accumulated reserve dollars are not easily identifiable prior to FY 2002.

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WCB requested that we modify our procedure and instead review the calculation of the reserve balance for the fiscal years 2003 through 2007, using the assumption that the estimated June 30, 2002 balance was accurate within reason.

Procedure 6-Results:

We reviewed the calculations of the estimated reserve balance as of the end of the 2003 through 2007 fiscal years. The schedules reflect balances not in excess of the statutory limit. The items affecting the change in reserve from year to year appear reasonably stated.

Observation

Reserve Statute Implies Immediate Collection of Assessments

The reserve statute is poorly designed. The statute requires that the following year's assessment be reduced when the reserve exceeds 25% of the previous year's budget. The statute implies that a fiscal year's assessment is fully collected by the close of the fiscal year. In fact, the assessment is collected over several years.

The WCB attempts to comply with the spirit of the statute by using good faith estimates to calculate an estimated reserve balance. Only in hindsight, many years down the road, will the WCB know if a calculated estimated reserve balance as of the end of any fiscal year compares favorably with actual reserve balance for that year.

Recommendation

WCB and the State Controller informed us that confusion abounds with respect to understanding of the accounting for reserves. They recommended, and we agree, that, in order to achieve more transparency, the statute should require WCB to calculate its reserve at October 31 of every year (a date by which WCB has collected it's the vast majority of its receipts for the preceding fiscal year). Once the reserve has been calculated, that amount could be transferred from the operating account to a separate account. The reserve account balance would be trued up on each October 31st.

We recommend that the statute be amended to reflect the reality of the timing of collections. The statute should recognize that the reserve calculation is, by necessity, an estimate. Accordingly, an excess reserve could simply be declared to exist in an amount to be determined by the legislature, in consultation with the Board, or by the Board itself, thus eliminating the need for the 25% excess reserve language.

We also note that, by operation of statute, self-insurers also benefit from a subsequent year's assessment reduction when the reserve exceeds the 25% cap. As noted in our observations at Procedure 4, self-insurers pay exactly what they owe each year. Over-collections which are less than the 10% cap accumulate in the reserve. Over-collections exist only because the insurance companies' customers have overpaid previous years' assessments. However, the statutory language provides that self-insurers will benefit from

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assessment reductions due to an excess reserve adjustment, to the detriment of the insurance company customers.

This inequity can be remedied by assessing insurance companies' customers and self-insurers in the same manner.

Procedure 7: Report on Development of Assessment Rates

We were requested to report on how the assessment rates used to fund the Workers' Compensation Fund and Supplemental Benefits Fund (SBF) are developed. To accomplish this task, we reviewed the statutory language, the annual assessment reports, and the "Final Report of the Commission To Review The Budget Process of the Workers' Compensation Board". We also interviewed staff to obtain their understanding of the process. With respect to the Supplemental Benefits fund, we obtained a copy of the assessment letter issued by that organization. We also spoke with Kevin Cyr, The Supplemental Benefits Fund's financial analyst, to obtain his understanding of how the SBF assessment is developed.

Procedure 7-Results:

In the April or May of the preceding fiscal year beginning July 1, WCB determines the amount needed to fund its budgeted expenditures for the next fiscal year, and, after accounting for anticipated investment earnings and fines and revenue from sales of publications, it arrives at its target assessment, which must be less than the statutory cap for that fiscal year.

After adjusting for additions to or subtractions from the estimated reserve balance, the board arrives at a final assessment amount.

Next, the Board apportions the assessment among the self-insured pool and the insurance carrier pool. The apportionment rate is equal to each pool's share of the prior years' disabling cases as reported by the Department of Labor.

The self-insurers' share of the assessment is apportioned among them based on each member's share of the amount of total claims paid in the previous year.

The insurance carriers' customers' share of the apportionment must be further refined. The law requires that insurance carriers pass the assessment through to their customers as a percentage of the premium billed to their customers. To arrive at this rate, WCB obtains from the Bureau of Insurance a report stating the amount of previous years' premiums written in Maine. Using this report as well as other information which helps to establish a trend in the market, WCB arrives at an estimate of premiums to be billed in the next fiscal year. Using the final estimate of premiums to be billed as the denominator, and the insurance carriers' share of the assessment as the numerator, the WCB arrives at the percentage or rate which each carrier must apply to its customers' net premiums. WCB requests feedback from a number of the carriers before the assessment rate is adopted.

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SBF's representative informed us, and its assessment form indicates, that it develops its assessment rates in the same manner as WCB, as required by the statute, based upon its' Board's estimate of the amount needed to reimburse qualified insurers in the subsequent fiscal year.

Procedure 8: Report on Adequacy of Resources-Monitoring, Audit and Enforcement Program and the Workers' Advocate Program

We were requested to report on the adequacy of the resources devoted to these programs. To accomplish this goal, we attended a four hour presentation and a two hour follow up meeting with staff to obtain information on the history of the programs, the objectives of the programs, the positions assigned to each program, and to ascertain the additional resources needed to meet the goals and objectives of the programs, as mandated by the statute. Below, we briefly summarize the history and responsibilities of the programs, and point out unmet statutory obligations.

Procedure 8-Results

Monitoring, Audit & Enforcement Program: In 1997, Public Law 1997, Chapter 486 was enacted to establish the Office of Monitoring, Audit, and Enforcement (MAE). The basic goals of MAE are to: (1) provide timely and reliable data to policymakers; (2) monitor and audit payments and filings; and (3) identify insurers, self-administered employers, and third-party administrators (collectively "insurers") that are not complying with minimum standards.

Monitoring Program: The Monitoring Division monitors the claims administration of insurers, self-insurers and third-party administrators to measure and report on their compliance with the Maine Workers' Compensation Act. It also provides basic compliance training to insurers, self-insurers, third-party administrators and employers to promote compliance with the obligations of the Maine Workers' Compensation Act.

The Maine Workers' Compensation Board measures compliance on four key performance indicators:

- 1) Filing of First Reports of Injury
- 2) Payment of Initial Indemnity Benefit
- 3) Filing of Initial Memoranda of Payment
- 4) Filing of Initial Indemnity Notices of Controversy (NOCs)

By 2003, the Monitoring Division's responsibilities had increased from simply updating insurer data and issuing reports, to providing in-depth analysis of Workers' Compensation trends (as directed by the Legislature), insurer work system analysis, workers compensation research, development and management of insurer "Corrective Action Plans" and development of communications methods to the insurer community.

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Monitoring Program: Unmet Statutory Obligations:

As of today, the program employs 3 monitoring specialists. Five (5) additional positions are required to meet increased demand for training and to meet outstanding statutory obligations.

The key unmet statutory obligations are:

1. Sec. 152 (10) requires WCB to continually monitor individual cases to ensure that benefits are provided in accordance with the Act.
2. Sec. 153 (1) requires WCB to perform the actions required by this section to ensure just and efficient administration of claims.
3. Sec. 213 requires WCB to create a work system to identify and monitor all claims requiring a permanent impairment ("PI") rating and assessment.
4. Sec. 359 (3) requires WCB to implement a monitoring program to evaluate and compare the cost, utilization and performance of the workers' compensation system for each calendar year beginning with 1988. The information compiled must include the number of injuries occurring and claims filed as compared to employment levels, the type and cost of the benefits provided, attorney involvement and litigation levels, and the long-term, post-injury economic status of injured workers, as well as any other data that is actuarially valid and can be utilized to accomplish the purposes of this Act, including rulemaking and recommending legislation.

Unmet Monitoring Program Needs.

As noted earlier, to fulfill its duties in a manner consistent with the statute, WCB needs 5 additional monitoring specialists (Management Analyst II).

In addition, in order to comply with the statutory obligations of the Act, the position of a Deputy General Counsel (as authorized by Title 2 Sec. 6(E)), is required to provide sorely needed legal support for both the Monitoring and the Auditing Programs.

Finally, WCB needs the services of a Communications/Education Officer to serve both the Monitoring and the Auditing Programs. This position would address the information "void" between WCB and the insurer community. This Officer will inform the insurance community of Electronic Data Interchange changes and instructions, performance benchmarks, legal decisions and Board positions. The Officer would also generate newsletters, maintain the Forms and Petitions Manual and conduct "Open" and "Rehabilitation" Training workshops.

Audit Program: The Audit Division conducts compliance audits of insurers, self-insurers and third-party administrators to ensure that obligations under the Workers' Compensation Act are met. In addition, the

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Audit Division provides advanced compliance training to insurers, self-insurers and third-party administrators to promote compliance with the obligations under the Workers' Compensation Act.

The functions of the audit program include, but are not limited to, ensuring that reporting requirements of the WCB are met, auditing the timeliness of benefit payments, auditing the accuracy of indemnity payments, and evaluating claims-handling practices.

Audit Program: Unmet Statutory Obligations:

As of today, the auditing program employs 4 auditors. Four additional auditors and one new audit manager position are required to meet the three year audit cycle, to meet increased demand for training, and to meet other outstanding statutory obligations.

The key unmet statutory obligations are:

1. Sec. 208 (2) requires WCB to ensure that health care providers file a medical report within five days of the date of visit. Failure to do so results in excessive denials of claims by insurers, thus creating an administrative burden on WCB and the insurers.
2. Ensuring that a health facility or health care provider is paid pursuant to statutory and regulatory requirements file petitions for payment, resulting in unnecessary disputes.
3. Sec. 213 requires that WCB to ensure that all cases involving permanent injury include an impairment rating, verify information provided to WCB by the insurers, and to audit compliance with threshold adjustments, benefit determinations and durational limits.
4. Sec. 359 (1) requires that WCB audit claims on an ongoing basis to determine whether insurance entities are meeting their obligations under the Act. Specifically, WCB is required to identify the disputes that arose, the reasons for the disputes, the method and manner of their resolutions, the costs incurred, the reasons for attorney involvement, the services rendered by the attorney, and repeated unreasonably contested claims.

Unmet Auditing Program Needs.

As noted earlier, to fulfill its duties in a manner consistent with the statute, WCB needs 4 additional auditors, and 1 new audit manager.

In addition, in order to comply with the statutory obligations of the Act, the position of a Deputy General Counsel (as authorized by Title 2 Sec. 6(E)), is required to provide sorely needed legal support for both the Monitoring and the Auditing Programs.

Finally, WCB needs the services of a Communications/Education Officer to serve both the Monitoring and the Auditing Programs.

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Workers' Advocate Program: History: 1992 legislation eliminated the "prevail" standard for injured workers' attorney fees. After 1992, attorney fees became the responsibility of the injured worker. Injured workers could not afford to obtain legal counsel unless the case involved a significant amount of money. The exodus of private lawyers for employees resulted in approximately 40% of injured workers being unrepresented.

In 1996 the Workers' Compensation Board administratively established a pilot worker Advocate Program. The program provided employees with the use of one non-attorney advocate to assist employees through the mandatory mediation process. In 1997, again with respect to mediation, the WCB expanded the program from one to five non-attorney advocates, with one advocate to be located at each regional office. In 1997, legislation was enacted to expand the advocate program to include litigation as well as mediation services.

Worker Advocates are similar to Public Defenders for injured workers. They provide legal services, advise and inform about statutory benefits and the claims process, represent injured employees in disputed workers compensation claims, and represent injured workers at Mediations and Formal Hearings.

By all accounts, the program has been successful in meeting its goals. Advocates now participate in approximately 50% of all mediation hearings (2,000 cases per year) and approximately 35% of formal hearings (approximately 700 cases per year).

Unmet Workers' Advocate Program Needs:

As of today, the program employs 12 Advocates (8 attorneys and 4 non-attorneys). However, WCB feels that the intent of the statute is to place the injured employee at legal parity with the employer and insurance carrier. To achieve this goal, WCB needs the addition of one deputy staff attorney and four paralegals.

The addition of one deputy staff attorney would allow each field office to have access to an on-site working supervisor. The additional paralegals would put the WCB attorneys on par with the typical private law firms, which, in general, assign a paralegal to each of its attorneys.

Recommendation

WCB's staff represented to us throughout our engagement that these programs need additional staff in order to function as intended by the legislation. We found their presentations to be convincing and compelling. We agree with staff that more resources are needed to fulfill unmet statutory requirements.

The WCB's Executive Director recognizes that State Government is entering an era of belt tightening. For this reason, we recommend that WCB attempt to fill these positions on an incremental basis. We recommend that staff prioritize these resources to serve as a blueprint for implementation once economic circumstances improve. The Executive Director concurs with this recommendation and agrees that the implementation can be carried out over time as the economic climate improves.

Appendix A-Evaluation of Internal Controls With Respect to Assessments

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To the Board of Directors
State of Maine-Workers' Compensation Board

In planning and performing our agreed-upon procedures engagement, we considered internal control over collections and recording of assessments (internal control) as a basis for performing some of the agreed-upon procedures, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. However, as discussed below, we identified certain deficiencies in internal control that we consider to be significant deficiencies, as well as material weaknesses.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or a combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected by the entity's internal control. We consider the following deficiencies to be significant deficiencies in internal control:

1. Segregation of Duties

We noted that one person is responsible for billing, collecting and recording assessment receipts. Although the size of WCB's accounting staff may limit the ability to separate duties, we believe certain steps could be taken to separate incompatible duties. The basic premise is that no one employee should have access to both physical assets and the related accounting records, or to all phases of a transaction.

An employee who has custody of checks as well as responsibility for recording cash receipts and tracking assessment receivables can easily convert cash to personal use and escape detection.

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1. Segregation of Duties (Concluded)

Recommendation

We suggest that the clerk who opens the mail also perform the following tasks:

1. restrictively endorse all checks upon receipt,
2. prepare the deposit ticket to accompany the remittance to the Controller's office
3. give the remittance reports and a copy of the deposit ticket to the accounting department.
4. Accounting should tie its daily postings per its software's report to the deposit ticket as well as to the Controller's daily cash received report and resolve any discrepancies.

WCB's management indicates that it will implement this recommendation.

2. Change in Accounting Software

Currently, no practicable methodology exists whereby one can reconcile each year of WCB record of cash receipts to each year of DAFS recorded cash receipts. Because WCB can not reconcile its data base entries to DAFS' cash receipt report on a daily basis, data input errors are not discovered. It is critical that the data input be accurate, as the 10% cap and 25% cap measurements are performed using reports generated from the data base.

Recommendation

The Controller's office has suggested that WCB contact their office and schedule a review of WCB's accounting software needs. They believe they can design an accounting function within the State's current accounting software system which would allow WCB to post and track all billings and collections on both an "applicable year" and a "cash basis" format.

WCB's management indicates that it will follow through with this recommendation.

3. Implement Audit Function

We noted that insurance company remittance reports are recalculated by WCB for mathematical accuracy, and math errors are brought to the attention of the insurance company for resolution. However, WCB does not request documentation from the insurance company to substantiate that the correct amount of premiums are being reported.

Appendix A-Evaluation of Internal Controls With Respect to Assessments
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We noted one instance where a remittance report, and the refund request accompanying it, did not on its face appear reasonable, yet the report was not challenged.

Staff also informed us that some insurance companies never report and pay audit premium assessments, because they are either unaware of the requirement, or they ignore the requirement.

WCB has a fiduciary responsibility to maintain the integrity of the assessment process. When insurance companies underpay assessments, and are not held accountable, stakeholders who comply with the law ultimately pay for non-compliers' underpayments.

Recommendation

We recommend that, if the present assessment regimen is retained, WCB should institute an audit function to improve compliance with the assessment statute. Audit techniques could include requiring an insurance company to submit an internal accounting document supporting the remittance report, or on-site audits of insurance companies. WCB should also contact all insurance companies which do not submit audit reports and inquire as to the reasons for non-submission.

WCB's management indicates that it will implement this recommendation.

Material Weaknesses

A material weakness is a significant deficiency, or a combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by the entity's internal control.

We believe that the following deficiencies constitute material weaknesses.

Items 1, 2 and 3, above.

This communication is intended solely for the information and use of management of the State of Maine-Workers' Compensation Board and others within the organization and is not intended to be and should not be used by anyone other than these specified parties.

Blake Hurley McCallum & Conley, LLC
Blake Hurley McCallum & Conley, LLC
Westbrook, Maine

December 19, 2007

**F. REGULATORY AGENDA
AND SUMMARY OF RULES ADOPTED**

I. 2009-2010 REGULATORY AGENDA, September 22, 2009

AGENCY UMBRELLA-UNIT NUMBER: 90-351

AGENCY NAME: Workers' Compensation Board

CONTACT PERSON: John C. Rohde, General Counsel, 27 State House Station,
Augusta, Maine 04333-0027 Tel: (207)287-7086

EMERGENCY RULES ADOPTED SINCE THE LAST REGULATORY AGENDA: None

EXPECTED 2009-10 RULE-MAKING ACTIVITY:

CHAPTER 1: Payment of Benefits

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §152(2-A)

PURPOSE: Update procedures regarding Board forms impacted by electronic filing of information.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 1: Payment of Benefits

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §152(2-A)

PURPOSE: Clarify coverage notification requirements.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 2: Section 213 Compensation for Partial Incapacity

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §213(2)

PURPOSE: To address the permanent impairment threshold.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 2: Section 213 Compensation for Partial Incapacity

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §213(2)

PURPOSE: To clarify the procedures for collecting permanent impairment data.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 2: Section 213 Compensation for Partial Incapacity

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §213(1)

PURPOSE: To clarify the procedures regarding extensions of benefits due to extreme financial hardship.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 3: Form Filing

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §152(2-A), §303

PURPOSE: To require electronic filing of payment and related information.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 4: Independent Medical Examiner

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §312

PURPOSE: To clarify procedural issues.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 4: Independent Medical Examiner

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §312

PURPOSE: To update fees and expenses and procedures.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 5: Medical Fee Schedule

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §209

PURPOSE: To update the medical fee schedule.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 5: Medical Fee Schedule

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §209

PURPOSE: To update facility fee section.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 6: Rehabilitation

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §217

PURPOSE: To update/clarify procedures related to rehabilitation.

ANTICIPATED SCHEDULE: Winter 2010

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 7: Utilization Review, Treatment Protocols, Permanent Impairment

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §210

PURPOSE: Update utilization review procedures and guidelines.

ANTICIPATED SCHEDULE: Winter 2010

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 7: Utilization Review, Treatment Protocols, Permanent Impairment

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §153(8)

PURPOSE: Establish a schedule for determining permanent impairment.

ANTICIPATED SCHEDULE: Winter 2010

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 8: Procedures for Payment

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §152(2-A)

PURPOSE: Update to conform with electronic filing requirements.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 9: Procedure for Coordination of Benefits

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §152(2-A)

PURPOSE: Update to conform with electronic filing requirements.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 12: Formal Hearings

STATUTORY AUTHORITY: 39-A M.R.S. §152(2); §315

PURPOSE: Update expenses.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 12: Formal Hearings

STATUTORY AUTHORITY: 39-A M.R.S. §152(2)

PURPOSE: Clarify procedures related to filing of Joint Scheduling Memo and Exchange of Information.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 14: Review By Full Board

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §320

PURPOSE: Update procedure for Board review of hearing officer decisions.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 15: Penalties

STATUTORY AUTHORITY: 39-A M.R.S. §152(2)

PURPOSE: Update process/procedure regarding section 324(2) penalties.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 18: Examinations by Impartial Physicians Pursuant to 39-A M.R.S.A. §611

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §611

PURPOSE: Update expenses and fees.

ANTICIPATED SCHEDULE: Fall 2009

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER ? : Worker Advocates

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §153-A(7)

PURPOSE: Worker Advocate case management authority.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 7: Expenses

STATUTORY AUTHORITY: 39-A M.R.S. §152(2)

PURPOSE: Consolidate mileage and expense reimbursement.

ANTICIPATED SCHEDULE: Winter 2009-10

AFFECTED PARTIES: Injured employees, employers, self-insured employers, insurance companies, third-party administrators, health care providers, attorneys

CHAPTER 7: Predeterminations

STATUTORY AUTHORITY: 39-A M.R.S. §152(2), §153-A(7)

PURPOSE: Establish procedures regarding independent contractors.

ANTICIPATED SCHEDULE: Fall 2009

II. SUMMARY OF RULES ADOPTED.

The Government Evaluation Act requires submission of an agency's regulatory agenda and a summary of the rules it has adopted. 5 M.R.S. § 956(2)(F). A copy of the Board's most recent regulatory agency (filed on September 22, 2009) is attached. For the sake of completeness, a copy of the Board's rules is enclosed; for the sake of ease, a summary of the rules follows.

Chapter 1 regulates the payment of benefits, and includes some form filing requirements. It also defines fringe benefits and requires that the Board be notified within 14 days after issuance, renewal, or endorsement of a workers' compensation policy.

Chapter 2 contains the threshold adjustment and 52-week extensions; it regulates the collection of permanent impairment data and establishes a procedure for seeking extended benefits due to financial hardship. The current threshold is 13.4%, and the benefit limitation has been extended to the maximum 520 weeks.

Chapter 3 regulates form filing and includes a requirement that First Reports, Notices of Controversy, and Notices of Proof of Coverage be filed electronically.

Chapter 4 establishes the Independent Medical Examiner process.

Chapter 5 contains the Medical Fee Schedule which establishes maximum levels of reimbursements for medical services.

Chapter 6 defines the process for resolving disputes over entitlement to vocational rehabilitation.

Chapter 7 regulates the utilization review process, includes certain treatment guidelines, and defines the method of determining permanent impairment.

Chapter 8 sets forth procedures for mailing payments (including some form filing requirements), establishes a table for calculating interest, and created a Consent Between Employer and Employee form and procedure.

Chapter 9 requires insurers to report deductions in workers' compensation payments that result from a coordination of benefits.

Chapter 10 establishes the parameters for payment of attorney's fees.

Chapter 11 deals with the mediation process and provides for the confidentiality of mediation.

Chapter 12 governs the procedures involved in formal hearings. This chapter is a linchpin in the Board's effort to streamline dispute resolution.

Chapter 14 establishes the procedure for Board Review of Hearing Officer Decisions Pursuant to 39-A M.R.S. § 320.

Chapter 15 delegates authority to the Abuse Investigation Unit to assess certain penalties. It also sets forth the procedure to be used in penalty cases.

Chapter 16 provides for the confidentiality of Board files.

Chapters 13 and 17 are reserved for future use.

Chapter 18 governs examinations by impartial physicians pursuant to 39-A M.R.S. § 611,

III. CURRENT RULES (SEE ATTACHMENT).

**MAINE
WORKERS' COMPENSATION BOARD
RULES AND REGULATIONS**



Last Amended – OCTOBER 11, 2009

The Workers' Compensation Board rules may also be obtained online at:

<http://www.maine.gov/wcb/>

Lower right – online services

WCB Rules/Regs

NOTICE: While care has been taken care with the accuracy of the chapters accessible here, they are not "official" state rules in the sense that they can be used before a court. Anyone who needs a **certified copy** of a rule chapter should contact the Administrative Procedures Act Officer at the Secretary of State's Office.

90-351 Workers' Compensation Board

<http://www.maine.gov/sos/cec/rules/90/chaps90-.htm>

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RULES AND REGULATIONS

90-351 WORKERS' COMPENSATION BOARD

The Workers' Compensation Board promulgates these rules pursuant to 39-A M.R.S.A. § 152(2).

CHAPTER 1 PAYMENT OF BENEFITS

§ 1. Claims for Incapacity and Death Benefits

1. Within 14 days of notice or knowledge of a claim for incapacity or death benefits for a work-related injury, the employer or insurer will:
 - A. Accept the claim and file a Memorandum of Payment checking "Accepted" in Box 18; or
 - B. Pay without prejudice and file a Memorandum of Payment checking "Voluntary Payment Pending Investigation" in Box 18; or
 - C. Deny the claim and file a Notice of Controversy.
2. If the employer fails to comply with the provisions of Rule 1.1, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39-A M.R.S.A. Sec. 205(2) and in compliance with 39-A M.R.S.A. Sec. 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any accrued benefits.
3. Payment under Section 1.2 requires the filing of a Memorandum of Payment.
4. Benefits paid under this section are indemnity payments and are credited toward future benefits in the event that benefits are ordered or paid.
5. Failure to comply with the provisions of Rule 1.1 may also result in the imposition of penalties pursuant to 39-A M.R.S.A. Secs. 205(3), 359, and 360.

§ 2. Payment without prejudice

1. Payment without prejudice does not constitute a payment scheme.
2. If no payment scheme exists, the employer may reduce or suspend the payment of benefits pursuant to 39-A M.R.S.A. Sec. 205(9)(B)(1). The provisions of 39-A

M.R.S.A. Sec. 214 do not apply to compensation payments that are made without prejudice.

3. Failure to file a Memorandum of Payment or a Notice of Controversy within 14 days from the date of incapacity does not create a compensation payment scheme under 39-A M.R.S.A. Sec. 102(7).

§ 3. Provisional Orders

1. Mediation need not be held prior to issuance of an order under 39-A M.R.S.A. Sec. 205(9)(D). All orders under 39-A M.R.S.A. Sec. 205(9)(D) shall be issued only by hearing officers.

§ 4. Permanent Impairment - Applicable Law

1. Determination of the employee's right to receipt of payment for permanent impairment benefits shall be governed by the law in effect at the time of the employee's injury.

§ 5. Fringe Benefits

1. Fringe or other benefits shall be defined as anything of value to an employee and dependents paid by the employer which is not included in the average weekly wage. When the employer has paid the employee a sum to cover any special expense incurred by the employee by the nature of the employee's employment, that sum shall not be considered a fringe benefit. For those companies which self-fund health and dental coverage, the value of such health and dental coverage shall be equal to the cost to the employee for maintaining such coverage pursuant to the federal C.O.B.R.A. provisions less the employee's pre-injury contributions.
 - A. A "fringe or other benefit" pursuant to Section 102(4)(H) shall include, but is not limited to, the following:
 - (1) For those who do not self-fund, the employer's cost to provide health, dental and disability insurance benefits less the employee's contribution;
 - (2) For those who self-fund disability, the employer's cost to provide disability benefits less the employee's contribution;
 - (3) The employer's cost to provide pension benefits, including 401(k) matching funds;
 - (4) The fair market value of employer provided meals and/or housing;

- (5) The employer's cost of providing utilities and other costs associated with the provision of housing; and
- (6) The value of using a company vehicle for personal purposes; and
- (7) The employer's cost to provide life insurance benefits less the employee's contribution.

B. The following generally shall not be considered a "fringe or other benefit" pursuant to Section 102(4)(H):

- (1) The cost of uniforms provided by the employer for use in the employment;
- (2) Employer contribution to Social Security, unemployment insurance or workers' compensation insurance;
- (3) A company vehicle for which the employee must reimburse the employer for personal use;
- (4) Charitable contributions and/or matching gifts;
- (5) Company sponsored picnics and other social activities; and
- (6) Reimbursements for travel, parking, etc.

2. Average Weekly Wage Calculation.

- A. In all cases of more than seven (7) days lost time, the employer/ insurer shall calculate the employee's average weekly wage as of the date of the injury and file form WCB- 2.
- B. The employer shall recalculate the employee's average weekly wage when fringe benefits cease being paid by the employer. The employer must notify the insurer and the employee within seven (7) days when fringe benefits cease by filing an amended wage form, form WCB-2. The insurer or self-insured employer shall file the amended WCB-2 with the Board if it results in increased compensation to the employee.
- C. The employee's fringe benefits shall be determined as of the date of injury.

3. Calculating benefits.

- A. The fringe benefit package of any subsequent employers must be included in the computation of the employee's post-injury earnings to the same extent that it is included in the employee's pre-injury average weekly wage. The fringes included in the employee's post-injury earnings shall be computed by using the employer's cost of the fringe benefits on the date benefits commence.

§ 6. Notices of Controversy

1. All Notices of Controversy shall initially be referred to the Office of Troubleshooters where an attempt shall be made to informally resolve the dispute. If the Office of Troubleshooters is unable to resolve the dispute, the Notice of Controversy shall be scheduled for mediation.

- § 7. The Wage Statement (WCB-2), Schedule of Dependent(s) and Filing Status Statement (WCB-2A), Memorandum of Payment (WCB-3), Discontinuance or Modification of Compensation (WCB-4), Certificate of Discontinuance or Reduction of Compensation (WCB-8), Lump Sum Settlement (WCB-10), Statement of Compensation Paid (WCB-11), and the Employee's Return to Work Report (WCB-231) shall be filed with the Board's Central Office in Augusta, State House Station #27, Augusta, Maine 04333-0027. These forms shall be distributed as follows: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, and (4) Employer.

The Notice of Controversy (WCB 9) and the Employer's First Report of Occupational Injury or Disease (WCB-1) shall be filed and distributed as set forth in W.C.B. Rule Ch. 3, § 4.

- § 8. The Employment Status Report (WCB-230) shall be distributed as follows: (1) Employee, (2) Insurer, and (3) Employer.
- § 9. The Request for Expedited Proceeding (WCB-250) shall be attached to the front of the appropriate Petition and supporting documents.

STATUTORY AUTHORITY: 39-A M.R.S.A. Sec. 152(2); Sec. 403(1)

EFFECTIVE DATE:

January 8, 1993 (EMERGENCY)

EFFECTIVE DATE OF PERMANENT RULE:

April 7, 1993

AMENDED:

March 1, 1995
March 12, 1995
June 20, 1995

EFFECTIVE DATE (ELECTRONIC CONVERSION):

April 28, 1996

AMENDED:

July 7, 1996

NON-SUBSTANTIVE CORRECTIONS:

September 12 and October 9, 1996 - minor spelling and formatting.

AMENDED:

November 29, 1997 - Section 5.
May 23, 1999 - Section 10 added.

NON-SUBSTANTIVE CORRECTIONS:

October 26, 1999 - minor punctuation.

AMENDED:

September 24, 2002 - filing 2002-349 affecting Section 7.

NON-SUBSTANTIVE CORRECTIONS

January 8, 2003 - character spacing only.

AMENDED:

June 24, 2007 - Sec. 7 amendments
August 22, 2009 - Sec 10 deleted; filing 2009-442

CHAPTER 2 SECTION 213 COMPENSATION FOR PARTIAL INCAPACITY

§ 1. Threshold Adjustment

1. The permanent impairment threshold referenced in 39-A M.R.S.A. §§ 213(1) and (2) shall be reduced from "in excess of 15%" to 11.8% or greater effective January 1, 1998. This adjustment is based on an independent actuarial review performed by Advanced Risk Management Techniques, Inc.
2. For all cases with dates of injury on or after January 1, 2002 through and including December 31, 2003, the permanent impairment threshold referenced in 39-A M.R.S.A. §213 is 13.2%.
3. For all cases with dates of injury on or after January 1, 2004 through and including December 31, 2005, the permanent impairment threshold referenced in 39-A M.R.S.A. §213 is 13.4%.
4. For all cases with dates of injury on or after January 1, 2006 and prior to the effective date of the next adjustment, the permanent impairment threshold referenced in 39-A M.R.S.A. §213 is 11.8%.

§ 2. Extension of 260-week limitation

1. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall not be extended for 52 weeks on January 1, 1998 because the frequency of such cases involving the payment of benefits under §212 or §213 is greater than the national average based on frequency from the *1997 Statistical Bulletin* issued by the National Council on Compensation Insurance.
2. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall be extended for 52 weeks on January 1, 1999 because the frequency of such cases involving the payment of benefits under §212 or §213 is no greater than the national average based on frequency from the *1998 Statistical Bulletin* issued by the National Council on Compensation Insurance.
3. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall be extended for 52 weeks on January 1, 2000 because the frequency of such cases involving the payment of benefits under §212 or §213 is no greater than the national average based on frequency from the *1999 Statistical Bulletin* issued by the National Council on Compensation Insurance.
4. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall not be extended for 52 weeks on January 1, 2004 because the frequency of such cases involving the payment of benefits under §212 or §213 is greater than the national

average based on frequency from the *2003 Statistical Bulletin* issued by the National Council on Compensation Insurance.

5. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall not be extended for 52 weeks on January 1, 2005 because the frequency of such cases involving the payment of benefits under §212 or §213 is greater than the national average based on frequency from the *2004 Statistical Bulletin* issued by the National Council on Compensation Insurance.
6. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall not be extended for 52 weeks on January 1, 2006 because the frequency of such cases involving the payment of benefits under §212 or §213 is greater than the national average based on frequency from the *2005 Statistical Bulletin* issued by the National Council on Compensation insurance.
7. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall be extended for 52 weeks on January 1, 2007 because the frequency of such cases involving the payment of benefits under §212 or §213 is no greater than the national average based on frequency from the *2006 Statistical Bulletin* issued by the National Council on Compensation Insurance.
8. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall be extended for 52 weeks on January 1, 2008 because the frequency of such cases involving the payment of benefits under §212 or §213 is no greater than the national average based on frequency from the *2007 Statistical Bulletin* issued by the National Council on Compensation Insurance.
9. The 260-week limitation referenced in 39-A M.R.S.A. §213(4) shall be extended for 52 weeks on January 1, 2009 because the frequency of such cases involving the payment of benefits under §212 or §213 is no greater than the national average based on frequency from the *2008 Statistical Bulletin* issued by the National Council on Compensation Insurance.

§ 3. Collection of permanent impairment data

1. In all cases involving permanent injury, the employer/insurer and/or the employee shall submit a permanent impairment rating on the WCB-3, Memorandum of Payment, WCB-4, Discontinuance or Modification of Compensation, or the WCB-11, Statement of Compensation Paid or any other appropriate form adopted by the Board. Permanent impairment ratings submitted under this subsection are not binding in any subsequent dispute. If the permanent impairment rating is disputed, it need not be submitted until the case settles pursuant to 39-A M.R.S.A. §352 or the issue is otherwise resolved between the parties or by the Board.

2. Before approving a lump sum settlement, all Hearing Officers shall obtain either a permanent impairment rating or a report from a qualified health care provider establishing that there is no permanent injury. Either the permanent impairment rating or a finding that there is no permanent injury shall be written on the WCB-10.
3. A case involves "permanent injury" if any qualified health care provider has indicated that the employee's limitations are likely permanent. Once this determination has been made the employee may seek a permanent impairment assessment.
4. Permanent impairment ratings required under this rule shall be calculated by a specialist in a field applicable to the employee's injury who is qualified by training and/or experience to perform permanent impairment assessments.
5. The specialist's fee for calculating the permanent impairment rating must be paid by the employer/insurer. The impairment rating may be done in conjunction with a regularly scheduled appointment so long as subsection 4 of this rule is complied with.

§ 4. [Reserved]

§ 5. Requests for extension of benefits pursuant to 39-A M.R.S.A. §213(1)

1. Prior to cessation of benefits pursuant to 39-A M.R.S.A. §213(1), the employer/insurer must notify the employee that the employee's lost time benefits are due to expire. The notice must be sent at least 21 days in advance of the expiration date, and must include the date the lost time benefits are due to expire and the following paragraph:

If you are experiencing extreme financial hardship due to inability to return to gainful employment, you may be eligible for an extension of your weekly benefits. To request such an extension, you must file a Petition for Extension of Benefits within 30 calendar days of the date that benefits expire, or, in cases where the expiration date is contested, within 30 calendar days of a final decree as to the expiration date.

Failure to send the required notice will automatically extend the employee's entitlement to lost time benefits for the period that the notice was not sent.

Notice shall be considered "sent" if it is mailed to the last address to which a compensation check was sent.

2. An employee must file a Petition for Extension of Benefits within 30 calendar days of the date that benefits expire, or, in cases where the expiration date is

contested, within 30 calendar days of a final decree as to the expiration date. The petition must be served by certified mail, return receipt requested, to the other parties named in the petition.

3. No response to a petition filed under subsection 2 is required. It will be presumed that all allegations are denied.
4. The employee must file responses to the questions contained in Appendix I attached to this rule within 15 days of the date the employee's petition is filed. The responses must be sent to the employer/insurer.
5. The employer must turn over any documentary evidence it intends to introduce at hearing at least 15 days prior to the hearing. The information must be sent to the employee.
6. Hearings will be held expeditiously in all cases. Hearings will take place before the Board of Directors. A majority vote of the membership of the Board will be required to extend benefits under this rule. Either the General Counsel or the Assistant General Counsel will be present to assist the Board with legal issues.
7. Parties will be allowed to present relevant evidence along with closing arguments on the date of the hearing. Unless extraordinary circumstances warrant, evidence submitted after the hearing will not be accepted.
8. In cases where benefits have been extended, a Petition for Reconsideration of Extended Benefits may be filed by the employer/ insurer responsible for payment of the additional benefits. The employer/ insurer must establish a material change in circumstances since the previous order. Petitions for Reconsideration of Extended Benefits may not be filed until 120 days have elapsed from the date of the most recent order granting benefits.

STATUTORY AUTHORITY: 39-A M.R.S.A. §213

EFFECTIVE DATE:

February 22, 1998 - Sections 1 and 2

AMENDED:

August 30, 1998 - Sections 3 and 4 added

December 14, 1998 - Section 5 and Appendix I added

May 8, 1999 - Subsections 2(2) and 4(2) added

July 24, 2000 - amendments to Section 2(3) added

March 28, 2001 - amendments to Section 4 (repeal & replace) & Section 5(4)

September 29, 2002 - Section 4 repealed, filing 2002-359

NON-SUBSTANTIVE CORRECTIONS:

January 8, 2003 - character spacing only.

AMENDED:

March 11, 2006 - Sections 1(2) & (3) and 2(4) & (5) added, filing 2006-104
December 4, 2007 - Section 2(6) and (7) added - 2007 Extension of Benefits, filing
2007-506
April 12, 2008 - Section 3(2) and (3), regarding PI collection, filing 2008-160
June 17, 2008 - Section 1(3) and (4), Section 2(6), added 2006 PI adjustment,
Section 2(6) added - 2006 Non-Ext of Benefits, filing
2008-256
February 2, 2009 Section 2(8) added - 2008 Extension of Benefits, filing 2009-43
August 17, 2009 Section 2(9) added - 2009 Extension of Benefit, filing 2009-434

Appendix I

(Employees must provide the following information to the employer/insurer within 15 days of filing the Petition for Extension of Benefits.)

1. State what your present financial condition is (i.e. present monthly income vs. present monthly expenses).
2. State when and where you have looked for work in at least the last 3 months.
3. Provide a copy of your most recent tax return, if one was filed.
4. Please provide any other information that may be relevant to your present financial condition that you plan to rely on at hearing.

CHAPTER 3 FORM FILING

- § 1. The definition of a day for purposes of filing a First Report of Occupational Injury or Illness (WCB-1) under § 303 is the number of hours or wages in an employee's regular workday. If an employee does not have a regular workday, then average hours or wages should be used. The following non-exhaustive list of examples are for illustrative purposes only:

EXAMPLE 1: Employee usually works three 12-hour shifts. Once employee misses a total of 12 scheduled hours, a day has been missed.

EXAMPLE 2: Employee works erratic hours.

2(A) An employee has missed a day when a normally scheduled workday is missed; regardless of the number of hours missed;

2(B) When an employee misses part of a normally scheduled workday, a day is missed when an average day is missed. (Average day = Hours worked in previous month/Number of days worked during the month.)

EXAMPLE 3: Employee works piecework and loses the equivalent of the pre-injury daily wage. (Daily wage = Money earned in previous month/Number of days worked during the month.)

EXAMPLE 4: Employee works more than one job and employer is aware that employee has lost a day (see definitions above) of work at any job, the employer at the place of injury must file a First Report.

§ 2.

1. Except as specifically provided in 39-A M.R.S.A. § 101 *et seq.* or in these rules, all forms and correspondence, including, but not limited to petitions, shall be filed in the Central Office of the Workers' Compensation Board.
2.
 - A. Except as specifically provided in 39-A M.R.S.A. § 101 *et seq.* or in these rules, forms and correspondence required to be filed in the Central Office of the Workers' Compensation Board are filed when the Board receives the form by mail, in-hand delivery, fax, or other form of electronic transfer.
 - B. Paper copies of forms that are filed by fax or other form of electronic transfer will not be accepted.

§ 3.

1. Except as specifically provided in 39-A M.R.S.A. § 101 *et seq.* or in these rules, formal hearing correspondence on a proceeding in progress before a Hearing Officer, including, but not limited to, motions to continue, motions for findings of fact and conclusions of law, applications for additional discovery, stipulations, and position papers shall be filed in the appropriate regional office to which the case has been assigned.
2. Formal hearing correspondence on a proceeding in progress before a Hearing Officer shall be filed by mail, in-hand delivery, or fax.

§ 4. Electronic filing

1. General.

- A. First Reports of Injury. Unless a waiver has been granted pursuant to subsection (1)(D)(1) or (2) of this section, all First Reports of Injury and all changes or corrections to First Reports of Injury shall be filed by using either the State of Maine Proprietary Electronic Data Interchange (“EDI”) Format or by using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format.
- B. Notices of Controversy. Except as otherwise provided in this paragraph, effective July 1, 2006, unless a waiver has been granted pursuant to subsection (1)(D) (1) or (2) of this section, all Notices of Controversy and all corrections to Notices of Controversy shall be filed using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. Changes to Notices of Controversy that have been filed electronically must be made by filing WCB-9 (1/12/06) (Notice of Controversy). Changes to Notices of Controversy filed prior to July 1, 2006 using WCB-9 (10/98) (Notice of Controversy) must be made by filing an amended WCB-9 (10/98) (Notice of Controversy).
- C. Reserved.
- D. (1) Waivers. The Board, at its discretion by majority vote of its membership, may grant an employer, insurer or third-party administrator a waiver of the filing requirements of this section if the employer, insurer or third-party administrator establishes to the satisfaction of the Board that compliance with these requirements would cause undue hardship. For purposes of this section, undue hardship means significant difficulty or expense. The selection of EDI format is one factor that the Board may consider in deciding upon a request for a waiver. Requests for waivers should be submitted in writing and addressed to the Chair of the Workers’

Compensation Board, 27 State House Station, Augusta, Maine
04333-0027.

- (2) Waiver in an individual case. A First Report of Injury or a Notice of Controversy can be filed by paper or fax in an individual case if the Executive Director or the Executive Director's designee finds that the employer or claim administrator was prevented from complying with this section because of circumstances beyond the control of the employer or claim administrator. A decision by the Executive Director or the Executive Director's designee may be appealed to the Board of Directors. The appeal must be in writing; must set forth the reasons why the appealing party believes the decision should be reversed; and must be filed within 7 (seven) days of the date of the decision appealed from.
- E. Board file. The Board file shall include all accepted electronic transactions regardless of whether a paper copy is physically in the file.
- 2. Definitions for filing using IAIABC Claims Release 3.
 - A. Application acknowledgement code. A code used to identify whether or not a transaction has been accepted by the Board. A sender will receive one of the following codes after submitting a transaction:
 - (1) TA (Transaction accepted). The transaction was accepted and the First Report of Injury or Subsequent Report of Injury is filed.
 - (2) TE (Transaction accepted with errors). The transaction was accepted with errors and the First Report of Injury or Subsequent Report of Injury is filed. The error or errors will be identified in the acknowledgement transmission that is sent by the Board. All identified errors must be corrected within 14 days after the date the acknowledgement transmission was sent by the Board or prior to any subsequent submission for the same claim, whichever is sooner.
 - (3) TR (Transaction rejected). The entire transaction has been rejected and the First Report of Injury or Subsequent Report of Injury is not filed.
 - B. Claim administrator. An insurer, self-insured employer, group self-insurer, third-party administrator or guaranty association.
 - C. Data element. A single piece of information (for example, date of injury). Each data element is assigned a name and a number. Except as modified in this rule, data element names and numbers are as defined in IAIABC

Claims Release 3.0 Standards, Data Dictionary June 1, 2006 Edition
(Appendix VIII).

- D. Data element requirement code. A code used to designate whether or not a data element has to be included in a transaction. Each data element is assigned one of the following data element requirement codes:
- (1) M (Mandatory). The data element must be present and must be in a valid format or the transaction will be rejected.
 - (2) MC (Mandatory/Conditional). The data element is mandatory if the conditions defined in the Maine Workers' Compensation Board Claims Release 3 First Report Conditional Requirement Table (Appendix III) or the Maine Workers' Compensation Board Claims Release 3 Subsequent Report of Injury Conditional Requirement Table (Appendix IV) exist.
 - (3) E (Expected). The data element is expected when a transaction is submitted. The transaction will be accepted without the data element and the First Report of Injury or Subsequent Report of Injury is filed but is incomplete. The entity submitting the transaction will receive a message indicating the transaction was accepted with errors and identifying the missing or incorrect data element or elements. The First Report of Injury or Subsequent Report of Injury must be completed by submitting the missing or corrected data element or elements within 14 days after the error message is sent by the Board or prior to any subsequent submission for the same claim, whichever is sooner.
 - (4) EC (Expected/Conditional). The data element is expected if the conditions defined in the Maine Workers' Compensation Board Claims Release 3 First Report Conditional Requirement Table (Appendix III) or the Maine Workers' Compensation Board Claims Release 3 Subsequent Report of Injury Conditional Requirement Table (Appendix IV) exist. The transaction will be accepted without the data element and the First Report of Injury or Subsequent Report of Injury is filed but is incomplete. The entity submitting the transaction will receive a message indicating the transaction was accepted with errors and identifying the missing or incorrect data element or elements. The First Report of Injury or Subsequent Report of Injury must be completed by submitting the missing or corrected data element or elements within 14 days after the error message is sent by the Board or prior to any subsequent submission for the same claim, whichever is sooner.
 - (5) IA (If Available). The data element should be sent if available. If

the data element is sent, the Workers' Compensation Board may edit the data to ensure valid value and format. A filing will not be rejected if the only error is a missing data element designated IA.

- (6) NA (Not Applicable). The data element does not apply to the maintenance type code and does not have to be sent. The Board will not edit these data elements.
 - (7) F (Fatal Technical). Data elements that must be sent. If a data element designated F is not present and in a valid format, the filing will be rejected.
 - (8) X (Exclude). The data element does not apply to the maintenance type code and does not have to be sent. The Board will not edit these data elements.
 - (9) FY (Fatal Yes Change). If a data element designated FY changes after a First Report of Injury or Subsequent Report of Injury has been filed, the claim administrator must report the change to the Board within 14 days after the data element changes.
 - (10) N (No Change). This data element cannot be changed, but it must be reported, if applicable.
 - (11) Y (Yes Change). Data elements designated Y may be changed.
 - (12) FC (Fatal/Conditional). This data element must be populated with previously reported values if the segment has previously been reported on the claim.
 - (13) YC (Yes Change/Conditional). The data element must be changed if the conditions defined in the Maine Workers' Compensation Board Claims Release 3 First Report of Injury Conditional Requirement Table (Appendix III) or the Maine Workers' Compensation Board Claims Release 3 Subsequent Report of Injury Conditional Requirement Table (Appendix IV) exist.
- E. Maintenance type code. Maintenance type codes define the specific purpose of individual records within the transaction being transmitted.
- F. Record. A defined group of data elements that is identified by the transaction set identifier.
- G. Report. A report is equivalent to a transaction.
- H. Transaction. The communication of data that represents a single business

event. A transaction consists of one or more records.

I. Transaction set identifier. A code that identifies the transaction being sent.

- (1) 148 - First Report of Injury
- (2) R21 - First Report Companion Record
- (3) A49 - Subsequent Report
- (4) R22 - Subsequent Report Companion Record
- (5) AKC - Claims Acknowledgement Detail Record
- (6) HD1 - Transmission Header Record
- (7) TR2 - Transmission Trailer Record

J. Transmission. One or more sets of records sent to the Board.

3. Requirements for filing using IAIABC Claims Release 3.

A. Maintenance type codes for First Reports of Injury. One of the following maintenance type codes shall be used when transmitting a First Report of Injury:

- (1) 00 (Original): Used to file an original First Report of Injury or to re-transmit a First Report of Injury that was previously rejected or cancelled.
- (2) 01 (Cancel): Used to cancel an original First Report of Injury that was sent in error.
- (3) 02 (Change): Used to change a data element.
- (4) 04 First Report Of Injury (First Report of Injury/Full Denial): Used to file an original First Report of Injury and simultaneously deny a claim in its entirety.
- (5) CO (Correction): Used to correct a data element or elements when a filing is accepted with errors ("TE").
- (6) AQ (Acquired Claim): Used to report that a new claim administrator has acquired the claim.
- (7) AU (Acquired/Unallocated): Used to file an initial First Report of

Injury by a new claim administrator when an AQ transaction has been rejected because the claim was not previously reported, or when the acquiring claim administrator is reopening a claim that was previously cancelled.

- (8) UR (Upon Request): Submitted in response to a request from the Board. Responses must be filed no later than 14 days after the request is made by the Board.

B. Maintenance type codes for Subsequent Reports of Injury. One of the following maintenance type codes shall be used when transmitting a Subsequent Report of Injury.

- (1) 04 (Notice of Controversy -- Full Denial): Used when a claim is being denied in its entirety after any First Report of Injury or Subsequent Report of Injury has been filed.
- (2) PD (Notice of Controversy -- Partial Denial): Used to file a Notice of Controversy denying a specific benefit or benefits. A Notice of Controversy -- Partial Denial may not be filed unless a First Report of Injury has been filed.
- (3) CO (Correction): Used to correct a data element or elements when a Subsequent Report of Injury has been accepted with errors ("TE").

C. Data element requirements and modifications.

- (1) Data element requirements are as set forth in the Maine Workers' Compensation Board, Claims Release 3 First Report Of Injury Element Requirements Table contained in Appendix I of this rule, and the Maine Workers' Compensation Board, Claims Release 3 Subsequent Report Of Injury Element Requirements Table contained in Appendix II of this rule.
- (2) Modifications.
 - (a) Data number 270, Employee ID Type Qualifier. When submitting a First Report of Injury, data number 270 is mandatory conditional. However, if the claim administrator is unable to obtain an employee identification number from an employer prior to transmitting a First Report of Injury, the claim administrator must obtain an employee ID assigned by jurisdiction number from the Board. The claim administrator shall file the First Report of Injury using the employee ID assigned by jurisdiction number obtained from the Board. A First Report of Injury submitted with an

employee identification number obtained from the Board is filed but is incomplete. The claim administrator must either establish that it is unable to obtain an employee identification number from the employer or complete the First Report of Injury by submitting an employee identification number obtained from the employer within 14 days after the First Report of Injury was filed or prior to any subsequent submission for the same claim, whichever is sooner. Unless the claim administrator obtains and submits an employee identification number obtained from the employer, the employee ID assigned by jurisdiction number obtained from the Board must be used on all future filings regarding the same claim.

- (b) Data number 200, Claim Administrator Alternative Postal Code. Data number 200, Claim Administrator Alternative Postal Code shall be M (Mandatory) effective April 1, 2007.

- 4. Requirements for filing First Reports of Injury using the State of Maine Proprietary Electronic Data Interchange Format ("Proprietary FROIs").
 - A. Layout. Proprietary FROIs shall be filed in accordance with the Proprietary EDI First Report of Injury Layout Table (Appendix V).
 - B. Data Element Requirements. Data element requirements are defined as one of the following:
 - (1) Mandatory. The data element must be present and must be in a valid format or the transaction will be rejected except that, with respect to the employee's Social Security Number, if the filing entity is unable to obtain the employee's social security number prior to transmitting a First Report of Injury, the claim administrator must obtain an alternate identification number from the Workers' Compensation Board. A First Report of Injury submitted with an alternate identification number obtained from the Board is filed but is incomplete. The claim administrator must either establish that it is unable to obtain the employee's social security number or complete the First Report of Injury by submitting the employee's social security number within 14 days after the First Report of Injury was filed or prior to any subsequent submission for the same claim, whichever is sooner. Unless the claim administrator obtains and submits the employee's social security number, the alternate identification number obtained from the Board must be used on all future filings regarding the same claim.

- (2) E (Expected). The data element is expected when the First Report of Injury is submitted. The First Report of Injury will be accepted without the missing or incorrect data element or elements and the First Report of Injury is filed but is incomplete. The entity submitting the First Report of Injury will receive an error message identifying the missing or incorrect data element or elements. The missing or corrected data element or elements must be filed within 14 days after the error message is sent by the Board or prior to any subsequent submission for the same claim, whichever is sooner.
 - (3) IA (If Available). The data element should be sent if available. If the data element is sent, the Board may edit the data to ensure valid value and format. A filing will not be rejected if the only error is a missing data element designated IA.
 - C. Specific data element requirements. Specific data element requirements are defined in the Proprietary EDI First Report Of Injury Element Requirement Table (Appendix VI).
 - D. Errors. Error messages are defined in the Proprietary EDI First Report Of Injury Error Message Table (Appendix VII). Error messages related to Mandatory or Expected data elements must be corrected within 14 days after the error message is sent by the Board or prior to any subsequent submission for the same claim, whichever is sooner.
 - E. Board requests. Responses to requests for information from the Board must be filed no later than 14 days after the request is made by the Board.
- 5. Paper distribution of forms filed electronically.
 - A. First Report of Injury.
 - (1) Form WCB-1 (First Report of Injury) shall be used when a copy of the First Report of Injury is mailed pursuant to this subsection.
 - (2) Form WCB-1 shall be mailed to the employee and the employer within 24 hours after the First Report of Injury is transmitted to the Board.
 - (3) Unless a waiver has been granted pursuant to subsection (1)(D) of this section, a First Report of Injury sent to the Board in a paper as opposed to electronic format shall not be considered filed.
 - B. Notices of Controversy.

- (1) Form WCB-9 (1/12/06) (Notice of Controversy) shall be used when a copy of the Notice of Controversy is mailed pursuant to this subsection.
- (2) Form WCB-9 (1/12/06) (Notice of Controversy) shall be mailed to the employee, the employer and, if required by W.C.B. Rules Ch. 5 § 7 (2) or Ch. 8 § 2, the health care provider, within 24 hours after the Notice of Controversy is transmitted to the Board.
- (3) Except as provided in subsection (1)(B) of this section, unless a waiver has been granted pursuant to subsection (1)(D) of this section, a Notice of Controversy sent to the Board in a paper as opposed to electronic format shall not be considered filed.

§ 5. Electronic filing of proof of coverage

1. General

- A.
 - (1) Unless a waiver has been granted pursuant to subsection (1)(B) of this section, insurance companies shall file with the Board notice of the new, renewal, or endorsement of any workers' compensation policy to an employer using International Association of Industrial Accident Boards and Commissions ("IAIABC") Proof of Coverage Release 2.1.
 - (2) For notices filed within the 52-week period immediately following the effective date of this rule, the required notice must be filed with the Board no later than 14 days from the transaction effective date for issuance, renewal or add endorsement. However, if a transaction is submitted and rejected within the initial 14 day period, the notice will not be considered late if it is resubmitted and accepted by the Board within 30 days after the TR acknowledgement code is sent by the Board. Transactions initially submitted later than 14 days after issuance, renewal or endorsement shall be considered late even if resubmitted and accepted by the Board within 30 days after the TR acknowledgement code is sent by the Board.
 - (3) For notices filed after the period specified in subsection (1)(A)(2) of this section, the required notice must be filed with the Board no later than 14 days after issuance, renewal or endorsement.
- B.
 - (1) The Board, at its discretion by majority vote of its membership, may grant an insurer a waiver of the filing requirements of this section if the insurer establishes to the satisfaction of the Board that compliance with these requirements would cause undue hardship. For purposes of this section, undue hardship means significant difficulty or expense. Requests for waivers must be submitted in writing and addressed to the Chair of the Workers' Compensation Board, 27 State House Station, Augusta, Maine 04333-0027.

(2) Individual waiver. An individual notice of Proof of Coverage can be filed by paper or fax if the Executive Director or the Executive Director's designee finds that the insurer was prevented from complying with this section because of circumstances beyond the control of the insurer. A decision by the Executive Director or the Executive Director's designee may be appealed to the Board of Directors. The appeal must be in writing; must set forth the reasons why the appealing party believes the decision should be reversed; and must be filed within 7 (seven) days of the date of the decision appealed from.

2. Definitions

- A.** Application acknowledgement codes. A code used to identify whether or not a transaction has been accepted by the Board. A sender will receive one of the following codes after submitting a transaction:
- (1) HD. The transmission was rejected and the Proof of Coverage is not filed.
 - (2) TA (Transaction accepted). The transaction was accepted and the Proof of Coverage is filed.
 - (3) TE (Transaction accepted with errors). The transaction was accepted with errors and the Proof of Coverage is filed. The error or errors will be identified in the acknowledgement transmission that is sent by the Board. All identified errors must be corrected within 14 days after the date the acknowledgement transmission was sent by the Board.
 - (4) TR (Transaction rejected). The entire transaction has been rejected and the Proof of Coverage is not filed.
 - (5) TW and TN. These application acknowledgement codes are not used.
- B.** Data element. A single piece of information (for example, policy effective date). Each data element is assigned a name and a number. Except as modified in this rule, data element names and numbers are as defined in IAIABC Proof of Coverage Release 2.1, Data Dictionary June 1, 2007 Edition (Appendix XI).
- C.** Data element requirement code. A code used to designate whether or not a data element has to be included in a transaction. Each data element is assigned one of the following data element requirement codes:
- (1) M (Mandatory). The data element must be present and must be in a valid format or the transaction will be rejected.
 - (2) MC (Mandatory/Conditional). The data element is mandatory if the conditions defined in the Maine Workers' Compensation Board Proof of

Coverage Release 2.1 Conditional Requirement Table (Appendix X) exist.

- (3) E (Expected). The data element is expected when a transaction is submitted. The transaction will be accepted without the data element and the notice of Proof of Coverage is filed but is incomplete. The entity submitting the transaction will receive a message indicating the transaction was accepted with errors and identifying the missing or incorrect data element or elements. The notice of Proof of Coverage must be completed by submitting the missing or corrected data element or elements within 14 days after the error message is sent by the Board or prior to any subsequent submission for the same policy, whichever is sooner.
 - (4) EC (Expected/Conditional). The data element is expected if the conditions defined in the Maine Workers' Compensation Board Proof of Coverage Release 2.1 Conditional Requirement Table (Appendix X) exist. The transaction will be accepted without the data element and the notice of Proof of Coverage is filed but is incomplete. The entity submitting the transaction will receive a message indicating the transaction was accepted with errors and identifying the missing or incorrect data element or elements. The notice of Proof of Coverage must be completed by submitting the missing or corrected data element or elements within 14 days after the error message is sent by the Board or prior to any subsequent submission for the same policy, whichever is sooner.
 - (5) IA (If Available). The data element should be sent if available. If the data element is sent, the Workers' Compensation Board may edit the data to ensure valid value and format. A filing will not be rejected if the only error is a missing data element designated IA.
 - (6) NA (Not Applicable). The data element does not apply to the triplicate code and does not have to be sent. The Board will not edit these data elements.
 - (7) R (Restricted).
 - (8) F or FT (Fatal Technical). Data elements that must be sent. If a data element designated F is not present and in a valid format, the filing will be rejected.
 - (9) X (Exclude). The data element does not apply to the triplicate code and does not have to be sent. The Board will not edit these data elements.
- D.** Record. A defined group of data elements that is identified by the transaction set identifier.
- E.** Report. A report is equivalent to a transaction.

- F.** Transaction. The communication of data that represents a single business event. A transaction consists of one or more records.
 - G.** Triplicate code. The triplicate code defines the specific purpose for which the transaction is being sent. It is a combination of the Transaction Set Purpose Code (DN0300), Transaction Set Type Code (DN0334) and Transaction Reason Code (DN0303).
- 3. Requirements for filing using IAIABC Proof of Coverage Release 2.1**
- A.** Triplicate code. One of the triplicate codes contained in the MWCB Proof of Coverage Element Requirement Table shall be used when transmitting Proof of Coverage.
 - B.** Data element requirements. Data element requirements are as set forth in the Maine Workers' Compensation Board IAIABC Proof of Coverage Release 2.1 Element Requirement Table contained in Appendix IX of this rule.
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STATUTORY AUTHORITY: 39-A M.R.S.A. § 152(2); § 303

EFFECTIVE DATE:

March 4, 2001

AMENDED:

September 29, 2002 - Sections 2 and 3 added, filing 2002-359.

NON-SUBSTANTIVE CORRECTIONS:

January 8, 2003 - character spacing only.

AMENDED:

June 1, 2004 - filing 2004-176, § 4 added.

June 24, 2007 – Section 4 replaced & Appendices I-VIII replaced/added.

August 22, 2009 - Section 5 Electronic Filing of Proof of Coverage & Appendices IX - XI added; Filing 2009-442

**90-351
MAINE WORKERS' COMPENSATION BOARD**

**RULE CHAPTER 3 FORM FILING
SECTION 4 ELECTRONIC FILING
SECTION 5 ELECTRONIC FILING OF PROOF OF COVERAGE**

LIST OF APPENDICES

- I. Maine Workers' Compensation Board (MWCB)
Claims Release 3 (CR 3), First Report of Injury (FROI),
Element Requirement Table, Revised 01/25/2007
- II. MWCB CR 3, Subsequent Report of Injury (SROI),
Element Requirement Table
- III. MWCB CR 3, FROI, Conditional Requirement Table
- IV. MWCB CR 3, SROI, Conditional Requirement Table
- V. Proprietary EDI, FROI, File Layout Table
- VI. Proprietary EDI, FROI, Element Requirement Table
- VII. Proprietary EDI, FROI, Error Message Table
- VIII. IAIABC CR 3, Data Dictionary, 06/01/2006 Edition with 12/01/2006 Supplement
- IX. MWCB Proof of Coverage Element Requirement Table
- X. MWCB Proof of Coverage Conditional Requirement Table
- XI. IAIABC Proof of Coverage Release 2.1 Data Dictionary, 06/01/07 Edition

Copies of the Appendices may be requested by contacting the:

Workers' Compensation Board
27 State House Station
Augusta ME 04333-0027
Tel: 207-287-3818

or on the Board's website at:

www.maine.gov/wcb and clicking on the Electronic Filing link

CHAPTER 4 INDEPENDENT MEDICAL EXAMINER

§ 1. Creation of Independent Medical Examiner System Pursuant to 39-A M.R.S.A. § 312.

1. To be eligible to participate in the Board appointed independent medical examiner program, health care providers must meet the criteria of this subsection.
 - A. The provider must be licensed/certified by the State of Maine.
 - B. The provider must have an active, treating practice, be Board certified, and demonstrate experience in the treatment of work-related injuries.
 - C. The provider must demonstrate superior qualifications and experience in their particular fields of expertise.
2. Participation of health care providers in the independent medical examiner system is limited to those providers practicing in health care specialties most commonly used by injured employees. The Deputy Director of Medical/ Rehabilitation Services may submit for the Board's review and approval a breakdown of specialists within the 50 slots. Geography may also be a consideration for initial appointment.
3. All health care providers interested in participating in the independent medical examiner system must file an updated curriculum vitae with the Office of Medical/Rehabilitation Services, Workers' Compensation Board, 27 State House Station, Augusta, Maine 04333. At the Board's direction, the Deputy Director of Medical/ Rehabilitation Services will forward curriculum vitae to the Board when vacancies occur. Examiner candidate applications are considered public information. The Board may request additional information from applicants. The Board may conduct its selection process in executive session consistent with the public right to know statute. Not more than 50 health care providers will be selected to serve at any given time.
4. The Deputy Director of Medical/Rehabilitation Services will annually review the performance of independent medical examiners for compliance with the criteria contained in this subsection and forward any concerns in a report to the Board. The Board may contract for additional services to assist in the evaluation process. Failure by the examiner to adhere to the following criteria may result in their removal at any time from the independent medical examiner list. Affirmative action of the Board is necessary to remove an independent medical examiner from the panel.

- A. Reports must be submitted in a timely manner.
- B. Reports must contain the examiner's findings on the medical issues raised by the case.
- C. Reports must provide a description of findings sufficient to explain the medical basis of those findings.
- D. Examiners must consider all of the medical evidence submitted by the parties.
- E. Examiners must act in compliance with the requirements of the law and these regulations.

§ 2. Assignment of Independent Medical Examiners Pursuant to 39-A M.R.S.A. § 312

1. If the parties agree to the selection of a particular independent medical examiner, they shall file a form prescribed by the Board with the Office of Medical/Rehabilitation Services, Workers' Compensation Board, 27 State House Station, Augusta, Maine 04333. If the employee is unrepresented by counsel, the independent medical examiner agreed upon must be chosen from the Board's list of independent medical examiners or approved by the Deputy Director of Medical/Rehabilitation Services.
2. If the parties do not agree to the selection of a particular independent medical examiner, the Board through the Deputy Director of Medical/Rehabilitation Services shall assign one from the list of qualified examiners. If the list does not contain a qualified examiner, the Deputy Director of Medical/Rehabilitation Services may select a qualified medical examiner of his/her choice. A hearing officer may also request an independent medical examination. The requesting party must:
 - A. Complete Board Form M-2 and file it with the Office of Medical/Rehabilitation Services, Workers' Compensation Board, 27 State House Station, Augusta, Maine 04333.
 - B. Attach to Board Form M-2 a joint medical stipulation containing all medical records and other pertinent information, including an index of all treating health care providers and examinations performed under 39-A M.R.S.A. § 207 since the date of injury.
3. Assignment of a Board appointed independent medical examiner in a particular case will be performed by the Deputy Director of Medical/ Rehabilitation Services from the list of Board approved independent medical examiners with possible input from the individual hearing officer. The assignment will be made from a

relevant area of specialty for the medical issues in question. The time it takes to schedule an examination may be a consideration in the selection. If a particular provider on the independent medical examiner list is precluded by rule or statute from acting as an independent medical examiner in the parties' case, the parties should notify the Board prior to the selection process.

4. A Board appointed independent medical examination under 39-A M.R.S.A. § 312 may be requested only after an unsuccessful mediation or after a request for a provisional order has been acted on and the case must be proceeding to the formal hearing level.
5. Parties are limited to one Board appointed independent medical examiner per medical issue unless significant medical change can be shown.
6. Disqualification and Disclosure in Individual Cases.
 - A. The independent medical examiner in a case may not be the employee's treating health care provider and may not have treated the employee with respect to the injury for which the claim is being made or benefits are being paid.
 - B. A physician who has examined the employee at the request of an insurance company, employer, or employee in accordance with 39 A M.R.S.A. § 207 during the previous 52 weeks is not eligible to serve as the independent medical examiner.
 - C. The independent medical examiner must disclose potential conflicts of interest that may result from a relationship(s) with industry, insurance companies, and labor groups. A potential conflict of interest exists when the examiner, or someone in their immediate family, receives something of value from one of these groups in the form of an equity position, royalties, consultantship, funding by a research grant, or payment for some other service. If the independent medical examiner performs equivalent examinations as an employee of another organization, potential conflicts of interest may arise from that organization's contracts with industry, insurance companies, and labor groups. The Executive Director or the Executive Director's designee shall determine whether any conflict of interest is sufficiently material as to require disqualification in the event of initial disclosure. In the event an undisclosed conflict of interest is revealed during the hearing process, the hearing officer may disqualify the independent medical examiner and order a new examiner which shall be assigned in accordance to this rule.

§ 3. Procedures for Independent Medical Examinations Pursuant to 39-A M.R.S.A. § 312

1. Questions relating to the medical condition of the employee may be requested by use of Board Form M-2. The requesting and opposing parties must set forth the questions they wish to ask the examiner on the Board's Form M-2.
2. Except in fatality cases, the independent medical examiner is required to perform at least one examination of the employee.
3. Contacts with the employee by the Board appointed independent medical examiner will be limited to the scheduling of examinations and actual examinations. All communication between the examiner and the parties must be in writing and except for questions which a party requests that the examiner address in the report, may only occur by agreement or with the permission of the hearing officer. Any such communication must be copied to all opposing parties not later than seven (7) days prior to any examination. This communication must be forwarded to the examiner through the Office of Medical/Rehabilitation Services.
4. The parties shall submit a joint medical stipulation containing all medical records and other pertinent information, including an index of all treating health care providers and examinations performed under 39-A M.R.S.A. § 207 since the date of injury to the Office of Medical/Rehabilitation Services with the M-2. All medical records must be in chronological order, or chronological order by provider. All medical information will be submitted to the selected physician by the Office of Medical/Rehabilitation Services.
5. Upon completion of the final examination and all pertinent and indicated testing, the examiner shall submit a written report to the Board no later than fourteen (14) days after completion of the examination. The Board will distribute copies of the report to the employer and the employee.
6. A party may set a deposition of the independent medical examiner only with permission of the hearing officer.
7. Pursuant to 39A M.R.S.A. § 312(6), all subsequent medical evidence submitted to the examiner must be exchanged with the opposing party no later than fourteen (14) days prior to the hearing, unless this timeframe is varied by order of the hearing officer. If the examiner issues a supplemental report, a supplemental deposition may be permitted at the discretion of the hearing officer.

§ 4. Expenses and Fees for Independent Medical Examinations under 39-A M.R.S.A. § 312

1. Expenses incurred by the employee attending an independent medical examination are to be paid for by the employer. The following rates of reimbursement shall apply for travel:

- A. \$.44 per mile for mileage reimbursements.
 - B. Actual costs or a maximum of \$120.00 per evening for overnight lodging. Reimbursement for overnight lodging is allowed only when the employee has traveled 100 miles or more, one way, from the employee's place of residence.
 - C. \$6.00 for breakfast, \$6.00 for lunch, and \$16.00 for dinner. Reimbursement for meals is allowed only when the employee has traveled 50 miles or more, one way, from the employee's place of residence.
 - D. Actual charges for tolls, accompanied by a receipt.
- 2. Independent medical examinations will have a maximum charge of \$300.00 per hour up to a maximum of five hours for review of records and information, the performance of any necessary examinations, and the preparation of the written report. This charge does not include such diagnostic testing as may be necessary. Additional charges may be allowed with the consent of both parties or by the Deputy Director of Medical/Rehabilitation Services for good cause shown. The fee for the examination and report must be paid by the employer.
 - 3. If additional diagnostic tests are required, payment for such tests whether performed by the independent medical examiner or by another health care provider at the request of the examiner, shall be in accordance with the Board's Medical Fee Schedule and paid for by the employer.
 - 4. If the employee fails to attend the independent medical examination or if an examination is cancelled by the employee or employer within 48 hours of the scheduled time, the independent medical examiner may charge and receive up to \$200, to be paid initially by the employer, subject to the right of the employer to be reimbursed by the employee if the failure to appear or the cancellation by the employee was without good cause. This determination shall be made by the hearing officer.
 - 5. The reasonable costs of depositions of examiners, including the examiner's fees, court reporter's fees, and transcript costs, shall be borne by the requesting party.

STATUTORY AUTHORITY: 39-A M.R.S.A. §§ 152(2) and 312

EFFECTIVE DATE:

January 13, 1996

EFFECTIVE DATE (ELECTRONIC CONVERSION):

April 28, 1996

NON-SUBSTANTIVE CORRECTIONS:

September 12 and October 9, 1996 -- header added, minor spelling and formatting.

AMENDED:

November 1, 2001

NON-SUBSTANTIVE CORRECTIONS:

January 8, 2003 - character spacing only.

March 17, 2004 - numbering and punctuation only.

AMENDED:

October 11, 2009 - Sections 4(4)(1) & (2) - fees increased; Filing 2009-535

**CHAPTER 5 MEDICAL FEES; REIMBURSEMENT LEVELS; REPORTING
REQUIREMENTS**

(For a complete copy, please
see separate Publication entitled:
"Medical Fee Schedule".)

**MAINE WORKERS' COMPENSATION BOARD
MEDICAL FEE SCHEDULE**

The Maine Workers' Compensation Board Medical Fee Schedule incorporates portions of the following documents:

1. The Physician's Current Procedural Terminology, Fourth Edition, copyright 2004 (a.k.a. CPT 2005) by the American Medical Association.
2. Medicare RBRVS REPORT: The Physician's Guide 2005, copyright 2005, by the American Medical Association.

Some of the most important revisions that have been incorporated within this Fee Schedule are as follows:

1. Appropriate text changes inclusive of any changes to Unit Values and/or Maximum Allowances.
2. Add definition of TC modifier, replace -27 modifier with "TC"
3. Clarification of -50 modifier
4. Standardizes mileage reimbursement, lodging and meals
5. Omit Quick Reference Guide

Chapter 5: MEDICAL FEES; REIMBURSEMENT LEVELS; REPORTING REQUIREMENTS

SUMMARY: This Chapter outlines billing procedures and reimbursement levels for health care providers who treat injured employees. It also describes the dispute resolution process when there is a dispute regarding reimbursement and/or appropriateness of care. Finally, this Chapter sets standards for health care reporting.

§ 1. DATE OF INJURY

This Chapter is promulgated pursuant to 39-A M.R.S.A. §§208 and 209. It shall apply to all bills for medical services provided on or after the effective date of this rule, regardless of the employee's date of injury.

§ 2. PAYMENT UNDER PILOT PROJECTS

Payment of medical costs for a work related injury made pursuant to a comprehensive health insurance policy created pursuant to 39-A M.R.S.A. §403(2) shall be considered a payment under a decision pursuant to a petition for purposes of 39-A M.R.S.A. §306.

§ 3. PAYMENT TO HOSPITALS

Hospital out-patient charges only are subject to this fee schedule to the extent that those services can be identified by CPT code.

Hospital reimbursement for services provided to an injured worker who is an inpatient at a hospital shall be discounted at 5% based on payment received within 30 days of the original billing date. Full hospital rates will apply when payment is not made within the 30-day period. Services will be identified by the appropriate revenue codes on HCFA 1450 (UB 92) Uniform Billing claim form.

The Workers' Compensation medical fee schedule for surgical procedures was intended to cover the professional component of those services only. It is not intended to cover the facility charges for those same services. Surgical CPT codes are those codes within the range 10000-69999. Facility fees, not subject to the fee schedule for those surgical codes, may be billed under the following revenue codes: 360, 361, 369, 450, 481, 490, and 761.

Reimbursement for services provided to an injured worker who is an outpatient at a surgical center shall be discounted at 5% based on payments received within 30 days of the original billing date. Full rates will apply when payment is not made within the 30 day period.

§ 4. PROCEDURE CODES

1. For purposes of this chapter, health care services shall be described in accordance with current procedural terminology codes (CPT codes) and descriptions listed in the 2005 edition of the Physicians' Current Procedural Terminology published by the American Medical Association, P.O. Box 10946, Chicago, Illinois.
2. The five-digit numeric codes and descriptions included in the Maine Workers' Compensation Medical Fee Schedule are obtained from the Physicians' Current Procedural Terminology, Copyright 2004 by the American Medical Association (CPT). CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.
3. This publication includes only CPT numeric identifying codes and modifiers for reporting medical services and procedures that were selected by the Maine Workers' Compensation Board. Any use of CPT outside the fee schedule should refer to the Physicians' Current Procedural Terminology, Copyright 2004 American Medical Association and any update thereto. These CPT publications contain the complete and most current listings of CPT descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.
4. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of the Physicians' Current Procedural Terminology, Copyright 2004, by the American Medical Association. All rights reserved.
5. Any standards that are found in the right hand column of the Appendix were developed by the Maine Workers' Compensation Board, Office of Medical/Rehabilitation Services.

§ 5. REVISIONS

1. The Board shall revise the medical fee schedule annually. Until revisions are adopted, the current medical fee schedule remains in force. The Board may revise the schedule at any time, pursuant to 5 M.R.S.A. §§8001 et seq., to:
 - A. Improve the schedule's accuracy;
 - B. Simplify the use and administration of the schedule;
 - C. Encourage providers to develop and deliver services; or
 - D. To accommodate improvement or correct deficiencies of data base.
2. Any person concerned with a particular rate established pursuant to these rules may suggest an amendment to the rules. Those suggestions will be considered in the annual revision process.

§ 6. DEFINITIONS

1. "Bill": request by a health care provider that is submitted to an employer/insurer for payment of services provided in relationship to a compensable injury or illness.
2. "Board": the Maine Workers' Compensation Board pursuant to 39-A M.R.S.A. §151.
3. "By Report" (BR): when a procedure has not been assigned a maximum allowable payment amount, designated by an "*", it shall be justified by a written report.
4. "CPT code" means a numeric code, included in the *Current Procedural Terminology* coding system manual, used to identify a specific medical service, article or supply. The CPT manual is published by and may be purchased from the American Medical Association, PO Box 930876, Atlanta, GA 31193-0876.
5. "Follow-up Days" (FUD): the maximum number of days of care following a surgical procedure that are included in the procedures maximum allowable payment but does not include care for complications, exacerbations, recurrence, or other diseases or injuries.
6. "Health Care Provider/Practitioner": a person who is licensed, registered, or certified by the State of Maine as any of the following:
 - A. Acupuncturist
 - B. Audiologist
 - C. Doctor of Chiropractic
 - D. Doctor of Dental Surgery
 - E. Doctor of Medicine
 - F. Doctor of Osteopathy
 - G. Doctor of Podiatry
 - H. Registered Nurse
 - I. Certified Registered Nurse Anesthetist
 - J. Nurse Practitioner
 - K. Occupational Therapist
 - L. Optometrist
 - M. Orthotist
 - N. Physical Therapist
 - O. Physician's Assistant
 - P. Psychologist
 - Q. Chiropractic Acupuncturist
7. "Hospital": any acute care institution required to be licensed pursuant to 22 M.R.S.A. §382.

8. "Incidental Surgery": a surgery which is performed on the same patient, on the same day, by the same doctor but is not related to the diagnosis.
9. "Maximum Allowable Payment" (MAP): the maximum fee for a procedure listed in appendix III which has been established by the Maine Workers' Compensation Board or the provider's usual and customary charge, whichever is less.
10. "Modifier" means a two-digit number that is added to a procedure code to indicate that the service rendered differs in some material respect from the service described in this rule or in the CPT manual in effect on the date the service was rendered.

§ 7. REIMBURSEMENT

1. An employer is not liable under the Workers' Compensation Act for charges for health care services to an injured employee in excess of amounts listed in Appendix III of this chapter.
2. The employer/insurer shall pay the health care provider's charge or the maximum allowable payment under this fee schedule, whichever is less, within 30 days of receipt of a bill unless the bill or previous bills from the same provider or the underlying injury has been controverted or denied. If an employer/insurer controverts whether a health care provider's bill is reasonable and proper under §206 of the Act, the employer/insurer shall send a copy of the notice of controversy to the health care provider. If an employer/insurer controverts whether a health care provider's bill is reasonable and proper under §206 of the Act, the employer/insurer shall send a copy of the Notice of Controversy to the health care provider.
3. Payment of a medical bill is not an admission by the employer or insurer as to the reasonableness of subsequent medical bills.

§ 8. MEDICAL EXAMINATIONS

Medical examinations not for purposes of treatment are not subject to this fee schedule.

§ 9. BILLING PROCEDURES

1. Bills submitted by employees, their representatives or health care providers to insurers or employers for reimbursement of medical services must specify the date and type of service, the appropriate procedure code, the condition treated, and the charges for each service.

Bills properly submitted on forms mandated by the Bureau of Insurance pursuant

to 24-A M.R.S.A. §2753, shall be sufficient to comply with this requirement. Uncoded bills may be returned for coding.

2. The amount billed for a procedure, for which the medical fee schedule does not provide a maximum allowable payment amount, as indicated by an "*", shall be justified by a written report. The health care provider may not charge a fee for this report.
3. The insurer shall undertake reasonable investigations to ascertain whether a service is subject to the maximum allowable payment. A service is subject to the maximum allowable payment if it conforms to a description contained in the medical fee schedule. When there is a dispute regarding medical bills and the provision of medical services, the employer shall pay the undisputed amount, if any.

The insurer shall send written notice to the health care provider from whom the bill originated that the requested fee has been adjusted and the explanation for such adjustment. Notice is not required when bills are reduced to the fee schedule maximum allowable payment.

The employer's notification to the health care provider shall be made at the time the employer pays the fee to which it believes the health care provider is entitled.

4. If the health care provider disputes any payment received or denied, the health care provider, employee or other interested party shall be entitled to file Form 190 or 190(A), Petition to Fix the Amount to be Allowed.

Any health care provider, employee, or other interested party shall be entitled to file Form 190 or Form 190(A) for determination of any issue regarding medical services and/or medical billing.

Forms 190 and 190 (A) may be obtained by contacting the Workers' Compensation Board, Office of Medical/Rehabilitation Services, 27 State House Station, Augusta, Maine 04333-0027, Tel: 207-287-7080.

5. The injured employee is not liable for payment of any health care services for the treatment of a work-related injury or disease. Except as provided by 39-A M.R.S.A. §206(2) (B), the health care provider may charge the patient directly only for the treatment of conditions that are unrelated to the compensable injury or disease. See 39-A M.R.S.A. §206 (13).

NOTE [Providers may use the most current AMA CPT codes when billing workers' compensation claims. If the codes utilized are not included in the current Medical Fee Schedule, the item will be considered a starred procedure,

one which is not assigned a maximum allowable payment, and must be justified by report.]

§ 10. MODIFIERS

1. A modifier code shall be used to describe any unusual circumstances or services that arise in the treatment of a work related injury or illness.
2. The modifier codes recognized by these are as follows:

-21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or greater than usually required for the highest level of evaluation in management service within a category, modifier -21 may be added to the evaluation and management code. A report may also be appropriate.

-22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it shall be identified by adding modifier -22 to the usual procedure code. A report may also be appropriate.

-23 Unusual Anesthesia: Occasionally, a procedure, which usually requires no anesthesia or local anesthesia due to the unusual circumstances must be done under general anesthesia. The procedure shall be reported by adding modifier -23 to the procedure code.

-24 Unrelated Evaluation and Management Services by the Same Physician During a Post Operative Period: The health care provider may need to indicate that an evaluation and management service was performed during a post operative period for a reason(s) unrelated to the original procedure. This procedure shall be reported by adding modifier -24.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Health Care Provider on the Day of a Procedure: The health care provider may need to indicate on the day a procedure or service was performed, that the patient's condition required a separate identifiable evaluation and management service above and beyond usual and customary pre-operative and post-operative care. This procedure shall be reported by adding modifier -25 to the appropriate evaluation and management service. A report must be submitted when using this modifier. **NOTE:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier -57.

-26 Professional Component: Certain procedures are combinations of a professional component and a technical component. When the professional component is reported separately, the service shall be identified by adding the modifier -26 to the usual procedure code.

-32 Mandated Services: Services related to mandated consultation, related services and/or medical examinations not for the purpose of treatment, shall be identified by adding the modifier -32 to the basic procedure.

-47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier -47 to the basic procedure. (This does not include local anesthesia.) **NOTE:** Modifier -47 would not be used as a modifier for the anesthesia procedures 00100-01999.

-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, requiring a separate incision, shall be identified by the appropriate CPT code for the first procedure. The second procedure shall be identified by adding modifier -50 to the procedure code.

-51 Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the major procedure or service may be reported as listed. The secondary, additional or lesser procedures, or service(s) may be identified by adding the modifier -51 to the secondary surgical procedure or code. **Note:** This modifier should not be appended to designated "add-on" codes.

-52 Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the health care provider's election. Under these circumstances, the service provided shall be identified by the usual procedure code and the modifier -52. **NOTE:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers -73 and -74.

-53 Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier -53 to the code **reported by the physician** for the discontinued procedure. **NOTE:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

-54 Surgical Care Only: When a surgeon performs a surgical procedure and another practitioner provides the pre-operative and post-operative management or both, the surgical procedure or services shall be identified by using the usual procedure code and the modifier -54.

-55 Post-Operative Management Only: When one practitioner performs the post-operative management and another surgeon has performed the surgical procedure, the post-operative component shall be identified by using the usual procedure number and the modifier -55.

-56 Preoperative Management Only: When one practitioner performs the pre-operative care and a surgeon performs the surgical procedure, the pre-operative component shall be identified by using the usual procedure code and the modifier -56.

-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier -57 to the appropriate level of E/M service.

-58 Staged or Related Procedure or Service by the same physician During the Postoperative Period. The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier -58 to the staged or related procedure may be used. **NOTE:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier -78.

-59 Distinct Procedural Service. Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used

-62 Two Surgeons: Under certain circumstances, the skills of two surgeons, usually with different specialties, may be required to complete a surgical procedure. The health care services shall be identified by the procedure code and the modifier -62. **NOTE:** If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using procedure code(s) with the modifier -80 or modifier -81 added, as appropriate.

-66 Surgical Team: Some complex procedures require concomitant services of several health care providers, often from different specialties. Such complex services may also involve other highly skilled and specially trained personnel, as well as various types of sophisticated equipment. This type of complicated procedure may be carried out under the "surgical team" concept. Such circumstances shall be identified by each participating health care provider with a basic procedure code and the modifier -66.

-76 Repeat Procedure by same Practitioner: When the health care provider needs to indicate that a procedure or service was repeated subsequent to the original service, they shall report this by the procedure code and modifier -76.

-77 Repeat Procedure by another Practitioner: When the health care provider indicates that a basic procedure performed by another practitioner had to be repeated, that procedure shall be reported by using the procedure code and modifier -77.

-78 Return to the Operating Room for Related Procedure During the Post-Operative Period: When the surgeon indicates that another procedure was performed during the post-operative period of the initial procedure, and when this subsequent procedure is related to the first and requires the use of the operating room, it shall be reported by the procedure code and modifier -78. (For repeat procedures on the same day, see -76).

-79 Unrelated Procedure or Service by the Same Health Care Provider During the Post-Operative Period: When the health care provider indicates that the performance of a procedure or service during the post-operative period was not related to the original procedure, this procedure shall be reported by using the procedure code and the modifier -79. (For repeat procedures on the same day, see -76).

-80 Assistant Surgeon: Surgical assistant services shall be identified by the usual procedural code and the modifier -80.

-81 Minimum Assistant Surgeon: When minimum surgical assistant services are performed, they shall be reported using the procedural code and modifier -81.

-82 Assistant Surgeon: Modifier -82 shall be used when a qualified resident surgeon is not available to perform the procedure. Modifier -82 and the usual procedure code shall be used to report this service.

-90 Reference (outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting practitioner, the procedure shall be identified by the usual procedure code and modifier -90.

-91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier '-91'. **NOTE:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

-99 Multiple Modifiers: When two or more modifiers are necessary to delineate a service, it shall be reported using the procedure code and modifier -99 in conjunction with the other appropriate modifiers.

-TC: Technical Component: Certain procedures are a combination of a professional component and technical component. When the technical component is reported separately, the service shall be identified by adding the modifier -TC to the usual procedure code.

3. A modifier code shall be used to describe any unusual circumstances or services that arise in the treatment of a work related injury or illness. Modifiers which affect reimbursement are as follows:

-22 Unusual Procedural Services: If the provider charge is greater than the Maximum Allowable Fee, office notes are required and the bill must be reviewed to determine if the provider charge is appropriate.

-50 Bilateral Procedure: Pay at 150% of the Maximum Allowable Fee for both procedures combined.

-51 Multiple Procedures: Pay at 50% of the Maximum Allowable Fee.

-52 Reduced Services: The means of reporting a reduced service without disturbing the identification of the basic service.

-62 Two Surgeons: Pay each surgeon at 75% of the Maximum Allowable Fee.

-66 Surgical Team: Pay at 100% of the Maximum Allowable Fee for the surgical procedure and 25% of the Maximum Allowable Fee for surgical procedure for each additional surgeon in the same specialty as the primary surgeon. If the surgeons are of two different specialties, each surgeon shall be paid at 100% of the Maximum Allowable Fee.

-80 Assistant Surgeon: pay at 25% of the Maximum Allowable Fee.

-81 Minimum Assistant Surgeon: Pay at 10% of the Maximum Allowable Fee.

-82 Assistant Surgeon: Pay at 25% of the Maximum Allowable Fee.

§ 11. FEES FOR REPORTS

1. A health care provider may not charge a fee for completing the Practitioner's Report (Form M-1) required by the Workers' Compensation Board pursuant to 39-A M.R.S.A. §208.
2. The maximum fee for copies shall be \$10 for the first page and 35 cents per page thereafter. An itemized invoice shall accompany the copies. The copying charge shall be paid by the party requesting the records.
3. A health care provider or facility shall, at the written request of the employer or the employee, furnish copies of the health care records for that particular worker's compensation injury or illness within 10 business days from receipt of the request. Supplemental reports shall be identified by using CPT Code 99080 and appropriately billed on a HCFA 1500 form.
4. The maximum fee for preparing a narrative report shall be:

Each 10 minutes:	\$15.00
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§ 12. FEES FOR DEPOSITIONS

1. The maximum fee for preparing to testify at depositions and hearings shall be:

First ½ hour:	\$90.00
Each subsequent 1/4 hour:	\$45.00
2. Maximum fees for attendance at depositions and hearings for the purposes of giving testimony shall be:

First hour or any fraction thereof:	\$300.00
Each subsequent 1/4 hour:	\$ 75.00

(Use Code 99075)
3. "Portal-to-portal" reimbursement is permitted. Fees for "portal-to-portal" travel should be limited to:
 - A. Actual, reasonable and necessary travel costs. Travel costs must be agreed upon in advance by the employer/insurer.

- B. Actual and necessary travel time reimbursed based on levels outlined in Section 12(1) of the fee schedule (\$180.00 per hour).

These reimbursement levels apply when a deposition is more than ten miles from the practitioner's home base.

- 4. Health care providers shall receive a maximum of \$250.00 per canceled deposition when the cancellation occurs less than 24 hours prior to the scheduled start of the deposition. Health care providers shall receive a maximum of \$150 per canceled deposition when the cancellation takes place less than 48 but more than 24 hours prior to the scheduled start of the deposition. The party canceling the deposition is responsible for the incurred cost.

§ 13. EXPENSES

- 1. The employer must pay the employee's travel-related expenses incurred for treatment related to the claimed injury as follows:
 - A. Mileage must be paid at the standard rate for business travel set by the Internal Revenue Service pursuant to 26 U.S.C.S. § 162(a)(1) and established in the most recent revenue procedure as published in the Internal Revenue Service Bulletin.
 - B. Actual costs or a maximum of \$120.00 per evening for overnight lodging. Reimbursement for overnight lodging is allowed only when the employee has traveled 100 miles or more, one way, from the employee's place of residence.
 - C. \$6.00 for breakfast, \$6.00 for lunch, and \$16.00 for dinner. Reimbursement for meals is allowed only when the employee has traveled 50 miles or more, one way, from the employee's place of residence.
 - D. Actual charges for tolls, accompanied by a receipt.

§ 14. ANESTHESIA GUIDELINES

- 1. Reimbursement to the physician applies only when anesthesia care is provided by or under the medical direction of a physician anesthesiologist.
- 2. To be eligible for reimbursement, the anesthesia service shall include: performance of a pre-anesthetic examination and evaluation; prescription of the anesthesia care required; personal participation in, or medical direction of, the entire plan of care; continuous physical presence of the anesthesiologist or, in the case of medical direction, of the qualified individual (one who is qualified to

perform those tasks not personally performed by the anesthesiologist, such as a CRNA, resident or other individual authorized by the hospital or facility to perform such services) being medically directed; proximate presence or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies and medical direction of not more than four concurrent anesthesia procedures.

3. Reimbursement will be determined by the addition of the relative unit value, time units and modifying units (if any) and multiplying this sum by a conversion factor of \$40.00 per unit. The definition of the unit components will follow.
4. The anesthesia care may include, but is not limited to general, regional, monitored anesthesia care, supplementation of local anesthesia, or other supportive services in order to afford the patient the optimal anesthesia care prescribed by the anesthesiologist during any procedure.
5. Specialized forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included and will be reimbursed separately based on the appropriate medical or surgical fee schedule.
6. With respect to anesthesia care team payments for claims from two separate billing entities, the total payment to the anesthesia care team is the same as the payment level for an individually performing anesthesiologist or health care provider, with 50 percent of the total payment paid to each of the billing entities.
7. Definition of the Unit Components.
 - A. Relative Unit Value: The relative unit value (RUV) includes usual pre and post-operative visits, the administration of fluids and/or blood incident to the anesthesia care and interpretation of noninvasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during a single anesthetic administration the highest relative unit value should be used. The relative unit value will be applied to each CPT anesthesia code as outlined at the conclusion of this section.
 - B. Time Units; Anesthesia time begins when the anesthesiologist, or other qualified individual, physically starts to prepare the patient for induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist, or other qualified individual, is no longer in constant attendance (when the patient may be safely under post-operative supervision).

One time unit is allowed for each 15 minute time interval, or fraction thereof.

- C. Modifying Units: Physical status modifying units will be reimbursed if the patient is ranked in one of the following three categories:

<u>RANK</u>		<u>UNIT VALUE</u>
P-1 -	A normal healthy patient	0
P-2 -	A patient with mild systemic disease	0
P-3 -	A patient with severe systemic disease.	1
P-4 -	A patient with severe systemic disease that is a constant threat to life.	2
P-5 -	A moribund patient who is not expected to survive without the operation.	3

Other modifying units will be available for the following qualifying circumstances described in the CPT:

<u>CPT</u>		<u>UNIT VALUE</u>
999100 -	Anesthesia for a patient of extreme age, under one year and over seventy	1
999116 -	Anesthesia complicated by utilization of total body hypothermia.	5
999135 -	Anesthesia complicated by utilization of controlled hypotension.	5
999140 -	Anesthesia complicated by emergency conditions (an emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part).	2

8. Reimbursement for Pain Management Services: Reimbursement for pain management services (evaluation and management, medical or surgical services) will be separate from any reimbursement for anesthesia services. Reimbursement for services for pain management will be based on the appropriate evaluation and management, medical or surgical fee schedule.

§ 15. SURGICAL GUIDELINES

1. For surgical procedures that usually mandate a variety of attendant services, the reimbursement allowances are based on a global reimbursement concept. Global reimbursement covers the performance of the basic service and the normal range of care required before and after surgery. The normal range of post-surgical care is indicated at the right hand column under follow-up days (FUD) in Appendix III. A surgical procedure shall include all of the following:

- A. All office and hospital visits which occur after the need for surgery is determined and are related to or preparatory to the surgery.

- B. Surgery.
 - C. Post surgical care. The number of follow-up days is indicated in the fee schedule which will determine the normal range of post surgical care for that particular procedure.
 - D. Removal of sutures.
- 2. An office visit shall not be billed in addition to the surgical procedure when the principal function of the office visit is the determination that the surgical procedure is needed.
 - 3. The following four exceptions to the global reimbursement policy may warrant additional reimbursement for services provided before surgery:
 - A. When a pre-operative visit is the initial visit and prolonged detention or evaluation is necessary to prepare the patient or to establish the need for a particular type of surgery.
 - B. When the pre-operative visit is a Consultation.
 - C. When pre-operative services are provided that are usually not part of the preparation for a particular surgical procedure. For example, bronchoscopy prior to chest surgery.
 - D. When a procedure would normally be performed in the office, but circumstances mandate hospitalization.
 - 4. Additional charges and reimbursement may be warranted for additional services rendered to treat complications, exacerbation, recurrence, or other diseases and injuries. Under such circumstances, additional reimbursement may be requested. Documentation substantiating the medical necessity of the additional services rendered must be submitted with the medical bill.
 - 5. An incidental surgery which is not part of the primary procedure performed and for which there is no diagnostic evidence relating it to the injury, shall not be paid under the Workers' Compensation system.
 - 6. Reimbursement for the concurrent services of two or more health care providers may be warranted for:
 - A. Identifiable medical services provided preoperatively, during the surgical procedure or in the post-operative period.

- B. Modifier code -80 shall identify the procedure or the procedures which may be performed by the Surgical Assistant. Reimbursement for surgical assistants is limited to health care providers who assist with surgery and must not exceed 25% of the total surgical procedure.
- C. Two Surgeons
 - (1) Under certain circumstances, the skills of two surgeons (usually with different specialties) may be required to complete a surgery. For example, a neurosurgeon and an orthopedist to complete a laminectomy and an arthrodesis.
 - (2) Reimbursement will be made according to the information on the provider's medical bill and the substantiating documentation submitted. Each provider must submit an individual claim for services.
- D. A Surgical Team. Some highly complex procedures require the concomitant services of several physicians, often of different specialties. Such complex services may also involve other highly skilled and specially trained personnel, as well as various types of sophisticated equipment. This type of complicated procedure may be carried out under the "surgical team" concept with a single, global reimbursement for the total service. The services included in the global reimbursement vary widely. The charges should be supported "By Report" and include itemization of the physician services, paramedical personnel and equipment included in the charge.

7. Multiple or Bilateral Procedures

- A. When multiple or bilateral procedures are provided at the same operative session, the first major procedure should be coded as listed on one line of the HCFA 1500 claim form and the additional procedure(s) on the following line(s) with modifier -50 or -51.
- B. The total reimbursement for all services shall be the maximum reimbursement allowance of the major procedure in addition to 50% for the secondary procedure, 25% for the tertiary procedure and 10% for each lesser procedure thereafter. The lesser procedure(s) should be coded using the appropriate modifier -50 (bilateral procedure) or -51 (multiple procedures).
- C. Except when specifically stated, initial dressings, immobilization, or casting is included in the basic allowance for the basic procedure.

§ 16. RADIOLOGY GUIDELINES

1. The maximum allowable payment for a radiology procedure includes the professional component identified by the modifier (-26) and the technical component identified by the modifier (-TC). These are found in Appendix III under Radiology.
2. Bills from one entity do not need to indicate the breakdown of the technical and professional components. These charges shall be reimbursed as indicated by the total maximum allowable payment in radiology.
3. When two bills are submitted for radiological procedure, the professional component shall be identified by using modifier code -26. The technical component, identified by modifier code -TC, covers materials and facilities/space for the diagnostic or therapeutic service.
4. Billings for radiologic services are not reimbursable without a report of findings.

§ 17. PHYSICAL MEDICINE GUIDELINES

1. Reimbursement of physical medicine services, procedure code 97010-97999, applies when the care is provided by, under the direct supervision of or upon written referral by the Primary Health Care Provider as defined in Section 6 and in full when the care is provided by any of the following:
 - A. A doctor of medicine.
 - B. A doctor of osteopathic medicine.
 - C. A doctor of dental surgery.
 - D. A doctor of chiropractic and chiropractic assistant.
 - E. A doctor of podiatric medicine.
 - F. A physical therapist and physical therapist assistant.
 - G. An occupational therapist and occupational therapy assistant.
 - H. A physician's assistant.
 - I. A registered nurse.
 - J. A nurse practitioner.
 - K. A massage therapist.
 - L. An acupuncturist.
 - M. A chiropractic acupuncturist.
2. The license number or certificate number of the health care provider providing physical medicine services shall be included on each bill for services rendered.
3. The amendments to Section 17 will have a retroactive effective date of April 4, 1994.

§ 18. RESERVED

§ 19. HEALTH CARE REPORTING OF PROVIDERS PURSUANT TO TITLE 39-A
M.R.S.A. § 208

1. Except for medical only claims, the health care provider shall submit medical reports for the initial service/visit to the employer and employee on the Practitioner's Report (Form M-1) within five days pursuant to 39-A M.R.S.A. §208(2)(A). Failure to submit the Practitioner's Report (Form M1) within the five business day time line may result in assessment of penalties up to \$500.00 per violation.
2. The primary health care provider shall submit updated medical reports to the employer and the employee on the Practitioner's Report (Form M-1) every 30 days as long as the health care provider has evaluated/treated the patient within the previous 30 days.
3. Within five business days from the termination of treatment, a final medical report shall be submitted by the health care provider to the employer and employee on the Practitioner's Report (Form M-1).
4. If the treating health care provider refuses to release information, the health care provider shall notify the employer/insurer of the reasons for withholding this information.
5. Health care providers are permitted to reproduce the Practitioner's Report (Form M-1) for their use.

STATUTORY AUTHORITY: 39-A M.R.S.A. §§ 152(2) and 209

EFFECTIVE DATE:

January 15, 1993 (EMERGENCY)

EFFECTIVE DATE OF PERMANENT RULE:

April 17, 1993

REPEALED AND REPLACED:

April 4, 1994

EFFECTIVE DATE (ELECTRONIC CONVERSION):

April 28, 1996

AMENDED:

January 1, 1997 - agency asserts § 16 as effective retroactively to April 4, 1994.

July 1, 1997 - changed address in § 9 (4), replaced Appendix III.
May 1, 1999 - updated CPT copyright year, replaced Appendices I, II, & III.

NON-SUBSTANTIVE CORRECTIONS:

October 25, 1999 - minor formatting; date corrections from paper filing in 4.1 - 4.4.

AMENDED:

July 1, 2001

July 1, 2002 - refiled June 13, 2002 to include some codes missing from the
previous filing.

September 24, 2002 - filing 2002-349 affecting § 7 sub-§ 2.

NON-SUBSTANTIVE CORRECTIONS:

January 8, 2003 - character spacing only in §§ 1-19.

AMENDED:

November 5, 2006 - Amendments to Secs. 4, 6(4), 10, Section 13 Expenses added,
remaining sections renumbered, & replaced Appendix III

CHAPTER 6 REHABILITATION

§ 1. Services

1. A. Pursuant to 39-A M.R.S.A. § 152(7), the Maine Workers' Compensation Board delegates to the Executive Director or the Executive Director's designee the authority, pursuant to 39-A M.R.S.A. § 217(1), to refer an employee to a board-approved facility for evaluation of the need for any kind of service, treatment, or training necessary and appropriate to return the employee to suitable employment.
- B. A Board-approved facility is defined as a facility in which those providing direct services to employees have at least (1) a Bachelor's degree in Rehabilitation Counseling or a closely related field with five years of experience in the profession of Rehabilitation Counseling; or (2) a CRC (Certified Rehabilitation Counseling); or (3) a Master's degree in Rehabilitation Counseling or a closely related field.
2. Decisions pursuant to this section shall be based on the written submissions of the parties according to a schedule set by the Executive Director or the Executive Director's designee in each case. Absent extraordinary circumstances, no testimonial hearing will be held.

§ 2. Plan Ordered

1. Any dispute which arises concerning an employee's entitlement to rehabilitation services pursuant to 39-A M.R.S.A. § 217(2) shall be referred to formal hearing.
2. WCB Rules Chapters 11 and 12 shall govern the course of proceedings.

STATUTORY AUTHORITY: 39-A M.R.S.A. Sec. 152, 217

EFFECTIVE DATE: January 15, 1993 (EMERGENCY)

EFFECTIVE DATE OF PERMANENT RULE: April 7, 1993

EFFECTIVE DATE (ELECTRONIC CONVERSION): April 28, 1996

MINOR NON-SUBSTANTIVE CORRECTIONS: September 12 and October 9, 1996 --
addition of header, changed "Sec." to §, minor spelling.

AMENDED: July 4, 2001 - (Repealed Secs. 1-3 and replaced with Secs. 1(1) & (2))

**CHAPTER 7 UTILIZATION REVIEW, TREATMENT GUIDELINES,
PERMANENT IMPAIRMENT**

This rule establishes the appropriate use of Treatment Guidelines for determining the extent and duration of treatment provided to injured workers. It outlines the process for Board certification of entities to perform utilization review activities, sets forth Utilization Review procedures, and designates the Board's appeal process. Additionally, this rule includes the requirements for determining permanent impairment.

§ 1. Certification

1. An entity may conduct utilization review only if that entity is certified by the Board.
2. An Insurer, Self-Insurer or Group Self-Insurer which contracts with another entity to perform utilization review activities, maintains full responsibility for compliance with Maine Workers' Compensation law and Board Rules.
3. To become certified by the Board, interested parties shall file an application with the Board's Office of Medical/Rehabilitation Services for Conditional or Unconditional Certification and show proof of one the following by attaching the appropriate documentation:
 - A. Unconditional Certification: Accreditation by the Utilization Review Accreditation Commission (URAC) under URAC's National Workers' Compensation Utilization Management Standards by providing a copy of the accreditation letter, a copy of the Certificate of Accreditation and any other documents/information as requested by the Office of Medical/Rehabilitation Services; or
 - B. Conditional Certification: Verification that an Application For Accreditation under URAC's National Workers' Compensation Utilization Management Standards has been submitted to URAC by providing a copy of the URAC confirmation letter indicating the application is under review and any other documents/information as requested by the Office of Medical/Rehabilitation Services.
 - (1) When an application for Conditional Certification is filed, the entity requesting Board certification shall advise the Board if the URAC application is withdrawn or denied. Withdrawal or denial of the URAC application shall result in immediate revocation of Board certification.

- (2) Within six months of applying for a Conditional Certification, an entity must submit proof of accreditation as outlined in A above and achieve Unconditional Certification. If proof of accreditation is not provided, immediate revocation of Board certification will result. Entities may re-apply for Board certification as outlined in this Chapter at any time.
4. An Unconditional Board certification shall expire for entities upon the date of their URAC certification expiration date unless an application for re-certification is made. An application for re-certification shall be granted upon proof that URAC certification has been renewed and the new expiration date.
5. The Office of Medical/Rehabilitation Services may at any time revoke certification to perform Utilization Review upon findings that an entity is not in compliance with any portion of 39-A M.R.S.A. Sec. 210 or Workers' Compensation Board Rule Chapter 7.
6. The Office of Medical/Rehabilitation Services may at any time request case records for purposes of investigating Insurers/Utilization Review Agents compliance with 39-A M.R.S.A. Sec. 210 and Board Rules.
7. The Office of Medical/Rehabilitation Services shall make available the list of entities certified by the Board to perform utilization review activities.

§ 2. Utilization Review; Treatment Guidelines

Utilization Review Agents providing or performing UR services shall utilize Treatment Guidelines approved by the Workers' Compensation Board. The following guidelines are approved by the Board and incorporated by reference herein:

1. Bigos S, Bowyer O, Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December 1994.
2. Pain Treatment Guideline, comprised of the following two parts:
 - A. Guidelines for Outpatient Prescription of Controlled Substances, Schedules II-IV, for Workers on Lost Time from Work Injury.
 - B. Pain Treatment in Maine Workers' Compensation, Maine Workers' Compensation Board, Office of Medical/Rehabilitation Services.
3. Carpal Tunnel Syndrome: Diagnosis and Treatment Guidelines.

§ 3. Utilization Review; Procedures

1. When an employer/insurer requests Utilization Review, the employer/ insurer must notify the injured employee that it intends to initiate Utilization Review.
2. Notice to the employee must, at a minimum, contain:
 - A. An explanation of the reason(s) Utilization Review is being requested;
 - B. Identification of the Utilization Review Agent that has been selected; and
 - C. Notice that the injured employee can send a letter to the Utilization Review Agent, within 10 days, explaining why the contested treatment is appropriate.
3. If the employer/insurer fails to send the required notice to the injured worker, the employer/insurer will be precluded from entering the Utilization Review determination into evidence in any subsequent Board proceeding.
4. If the Insurer/Utilization Review Agent makes a request for records, the health care provider may insist the request be submitted in writing. The provider shall in turn provide the requested information within ten (10) business days. A fee for medical records or narratives shall be paid in accordance with Workers' Compensation Board Rule Chapter 5.
5. After each level of Utilization Review, the Utilization Review Agent shall provide notice to the injured employee, the affected health care provider(s), and the employer/insurer of the Utilization Review Agent's determination. This notice must include an explanation of each party's appeal rights.
6. Within one business day of the completion of the final level of Utilization Review, the Utilization Review Agent shall send a report to the injured employee, the affected health care provider, and the employer/insurer. This report must include, at a minimum, the Utilization Review Agent's determination, and the reasons therefore.
7. If the Insurer/Utilization Review Agent determines that the provider of record has made any excessive charges or required unjustified treatment, hospitalization or visits, the health facility or health care provider may not receive payment for those health care services from the Insurer and is liable to return to the Insurer any such fees or charges already collected.
8. Except as ordered pursuant to 39-A M.R.S.A. Sec. 206(2)(B), the injured employee is not liable for any portion of the cost of any provided medical or health care services.

§ 4 Board Appeals

1. Once a health care provider or an employee has received final notification that health care services will not be certified by the UR Agent, the health care provider, employee or their representative may initiate a Board Appeal by submitting a copy of the notification not to certify to the Board. This submission shall be referred to the appropriate Claims Resolution Specialist. If the Claims Resolution Specialist is unable to informally resolve the dispute, it shall be scheduled for mediation.
2. Once a provider receives notification that they are liable for the return of any fees, the provider may submit a copy of the notification to the Board. This submission shall be referred to the appropriate Claims Resolution Specialist. If the Claims Resolution Specialist is unable to informally resolve the dispute, it shall be scheduled for mediation.
3. If the mediator is unable to informally resolve the dispute, the matter shall, upon appropriate petition, be scheduled for a formal hearing.
4. Except as provided in Section 3.3, a Utilization Review report is admissible as evidence of the appropriateness in terms of both the level and quality of health care and health care services provided an injured employee, but is not binding on these issues.

§ 5. Definitions

1. **Board Appeal:** If a health care provider or injured employee disagrees with the determination rendered in the utilization review process, that party may appeal to the Board by submitting a copy of the notification not to certify.
2. **Conditional Certification:** Certification by the Board of an entity to perform utilization review activities that requires proof of application for accreditation with the Utilization Review Accreditation Commission (URAC) under URAC's National Workers' Compensation Utilization Management Standards.
3. **Insurer:** An insurance carrier, self-insurer or group self-insurer.
4. **Treatment Guidelines:** Standards of care and clinical pathways approved by the Workers' Compensation Board.
5. **Unconditional Certification:** Certification by the Board of an entity to perform utilization review activities that requires proof of accreditation by the Utilization Review Accreditation Commission (URAC) under URAC's National Workers' Compensation Utilization Management Standards.

6. Utilization Review (UR): The initial prospective, concurrent or retrospective evaluation of the appropriateness in terms of both the level and the quality of health care and health services provided an injured employee, based on the appropriate Maine Workers' Compensation Board Treatment Guidelines.
7. Utilization Review Accreditation Commission (URAC): a non-profit organization established to encourage efficient and effective utilization management processes and to develop and provide a method of evaluation and accreditation of utilization management programs.
8. Utilization Review Agent: Any person or entity, including insurance carriers, self-insurers, and group self-insurers, certified by the Board, to perform utilization review activities.

§ 6. Permanent Impairment

1. Determination of the employee's right to receipt of payment for permanent impairment benefits shall be governed by the law in effect at the time of the employee's injury.
2. Permanent impairment shall be determined after the effective date of this rule by use of the American Medical Association's "Guides to the Evaluation of Permanent Impairment," 4th edition, copyright 1993.

CHAPTER 7 EFFECTIVE DATE: April 2, 1997

AMENDED: July 28, 1998 - Guidelines appended.

NON-SUBSTANTIVE CORRECTIONS: August 18, 1998 -
added missing chart page at end.

AMENDED: February 23, 1999 – Amendments to Section 2(2), 3, 4, & 5.

Maine Workers' Compensation Board
Office of Medical/Rehabilitation Services
September 25, 1997

Guidelines for Outpatient Prescription of Controlled Substances, Schedules II-IV, for
Workers on Lost Time from Work Injury

Introduction

Purpose

Repeated, long-term use of prescription controlled substances for nonmalignant pain may be a factor in the development of long-term disability. This condition may be preventable if at-risk patients and practices are proactively identified and managed appropriately.

It is hoped that the prescribing guidelines listed below will lead to more accurate and timely identification of workers at risk for the development of long-term disability. These guidelines may also be a component of future intervention strategies aimed at preventing long-term disability.

Development

These guidelines are based on information from existing prescription guidelines, literature reviews, pharmacologic and medical references, seminars, interviews of experts and consultations with physicians who have private practices in a wide variety of specialties.

Application of the Guidelines

The guidelines are intended primarily for use in the treatment of pain persisting beyond the expected normal healing time for a given injury, for which traditional medical approaches have been unsuccessful. Application of these guidelines is intended only for outpatient prescriptions of non-parental controlled substances. The non-parental routes of administration are considered the only acceptable routes for treating such pain in the Maine Workers' Compensation system.

It is recognized that the guidelines cannot apply uniformly to every patient. Also, the guidelines cannot be the sole determining basis for identifying patients at risk for a drug use problem, or currently experiencing a drug use problem. Mere application of the guidelines cannot substitute for a thorough assessment of the patient by qualified health care professionals. For example, it may be appropriate in some select situations to prescribe opioid medication to workers who are gainfully employed and not on lost time from work.

These guidelines cannot substitute for detailed prescribing information found in medical and pharmacologic references.

These guidelines will be applied in the workers' compensation setting only. They will apply only to workers whose injuries occurred after these guidelines are adopted, and after sufficient notice of these guidelines has been given to health care providers.

The Maine Workers' Compensation Board may impose sanctions if the guidelines are not followed.

The guidelines are intended for use by legally authorized prescribing health care providers who begin treatment within six months of the worker's injury. Patients who have been on controlled substances for prolonged periods and come under the care of a new health care provider present special problems. These and other problems will be dealt with under the Maine Workers' Compensation Board's treatment protocol, Pain Treatment in Maine Workers' Compensation.

Finally, while the guidelines may not conflict with state or federal laws, by necessity they cannot cover in detail all of the many rules, regulations, and policies published by the various agencies enacting and enforcing these laws.

Relative contraindications for Use of Controlled Substances

1. History of alcohol or other substance abuse, or history of chronic or high dose benzodiazepine use.
2. Active alcohol or other substance abuse.
3. Borderline Personality disorder.
4. Mood disorders.
5. Other disorders that are primarily depressive in nature.
6. Off Work for more than six months.

Note: When special circumstances seem to warrant use of these drugs in these types of patients, referral to a comprehensive pain treatment program for review is required.

Examples of Controlled Substances

Schedule II	Schedule III	Schedule IV
Codeine	codeine with	propoxyphene (Darvon)
Fentanyl	acetaminophen	propoxyphene with
Oxycodone alone or with	codeine with aspirin	acetaminophen or aspirin
acetaminophen or aspirin	hydrocodone	pentazocine
(Tylox, Percodan, Percocet)	hydrocodone combined	
(Talwin) meperidine	with other drugs (Vicodin,	
(Demerol)	Lortab)	
morphine	paregoric	

*This table is not intended as an exhaustive listing. Some trade names have been given as examples. This listing is in no way to be considered an endorsement of any medication for any particular use, by legally authorized, prescribing health care providers.

1. GENERAL INFORMATION

- A. Physicians and other legally authorized prescribers may be held accountable if their prescribing patterns fall outside these guidelines.

2. DOCUMENTATION RECOMMENDATIONS

The following documentation recommendations should be followed at all times, especially whenever the prescribing health care provider departs from any of the other listed guidelines:

- A. A thorough medical history and physical examination and medical decision-making plan should be documented, with particular attention focused on determining the cause(s) of the patient's pain.
- B. A written treatment plan should be documented and should include the following information:
- * A finite treatment plan that does not exceed six weeks
 - * Clearly stated, measurable objectives
 - * A list of all current medications (with doses), including medications prescribed by other physicians (whenever possible).
 - * Description of reported pain relief from each medication
 - * Justification of the continued use of controlled substances
 - * Documentation of attempts at weaning the patient from controlled substances.
 - * Explanation of why weaning attempts have failed (including a detailed history to elicit information regarding the patient's possible use of alcohol or illegal drugs)
 - * How the patient's response to medication will be assessed
 - * Further planned diagnostic evaluation
 - * Alternative treatments under consideration
- C. The risks and benefits of prescribed medications should be explained to the patient and the explanation should be documented, along with expected outcomes, duration of treatment, and prescribing limitations.
- D. The treatment plan should be revised as new information develops which alters the plan of care.

3. TREATMENT OF ACUTE PAIN FROM TRAUMATIC INJURIES OR SURGERY (POST-DISCHARGE)

- A. Schedule II drugs should be prescribed for no longer than two weeks.
- B. Schedule III and Schedule IV drugs should be prescribed for no longer than six weeks.

4. REFERRAL TO A COMPREHENSIVE PAIN TREATMENT PROGRAM SHOULD OCCUR WHEN ANY OF THE FOLLOWING CONDITIONS EXIST:

- A. Underlying tissue pathology is minimal or absent, AND correlation between the structural derangement caused by the original injury and the severity of impairment is not clear.
- B. Suffering and pain behaviors are present, and the patient continues to request medication.
- C. Standard treatment measures have not been successful or are not indicated.

Maine Workers' Compensation Board
Office of Medical/Rehabilitation Services
September 24, 1997

Pain Treatment
In Maine Workers' Compensation

Any injured Maine worker receiving indemnity payments, who after six weeks of any treatment is still complaining of pain, or who after six weeks of any treatment is still receiving prescription controlled substances for nonmalignant pain (Schedule II, III or IV drugs), must be referred to a Comprehensive Pain Management Program approved by the Maine Workers' Compensation Board.

Comprehensive Pain Management Programs in Maine Workers' Compensation consist of multidisciplinary teams of at least the following:

Medical Director:

1. A physician, board-certified in their practice specialty.
2. Two years of experience in an interdisciplinary comprehensive pain management program.
3. Member in good standing of a national pain society.
4. Must attain a minimum of 20 (twenty) hours of Continuing Medical Education in pain-management-related topics per year.

Other Core Team Members must include:

1. The injured employee.
2. The Pain Team Physician (this person may be the Medical Director).
3. A Ph.D. level psychologist.
4. An appropriate supervisor from the injured employee's work place. (This can include any *bona fide* direct representative of the company, such as: a direct supervisor, a Human Resources Department representative, the injured employee's Department Head, etc.)
5. The injured employee's attending physician will be offered the opportunity to be a core team member.

Additionally, At Least Three Other Team Members from the Following List must be employed by, or have a Formal Arrangement (Contract or Affiliation) with the Program (depending on the needs of the injured employee):

1. Case Manager
2. Nurse Practitioner
3. Occupational Therapist
4. Pharmacist
5. Physical Therapist
6. Physician Assistant
7. Psychologist
8. Registered Nurse
9. Social Worker
10. Vocational Specialist
11. Chiropractor

Every such program must provide goal-oriented services which focus not only on pain amelioration, but on improving the ability of each patient to function, assisting them to return to work and reducing inappropriate dependence on the health system.

All such programs must either provide directly, or must assure access to the following services, (based on the documented needs of each individual patient and only if necessary): physical rehabilitation, pain education, relaxation training, psychosocial counseling, medical evaluation and chemical dependency evaluation.

(1) Recommended indications for referral for inpatient treatment:

Because inpatient chronic pain management care centers are multi-disciplinary by definition, there is no attempt in this document to address treatment parameters for these comprehensive treatment programs. However, the decision to initiate inpatient treatment must be based on documented health needs of each individual patient. The health care provider must be able to document how the use of outpatient treatment would place the patient in jeopardy, in order to support the rationale for inpatient treatment.

- (2) A. The patient's level of functioning has not responded to outpatient medical and/or mental health treatment within six weeks, and/or;
- B. The patient exhibits pain behavior, functional limitations, and/or mental/emotional dysfunction, which are disruptive to their activities of daily living, or;
 - 1. The patient is facing significant potentially permanent loss of functioning that requires major physical, vocational and psychological readjustment;
 - 2. Diagnostic findings are insufficient to explain the pain, or other invasive medical treatment is not an option;
 - 3. Pain has persisted beyond the expected healing time for the condition;
 - 4. The patient has pain linked to adverse interpersonal relationships which interfere with rehabilitation;
 - 5. The patient has physical/mental impairment greater than expected on the basis of the diagnosed medical condition and treatment or diagnosis and treatment are required in a more structured/supervised setting;
 - 6. There is documented history of inappropriate and excessive use of health care services by the injured worker, such as frequent emergency room visits for non-emergency complaints.
 - 7. There is documented history of inappropriate and excessive use of narcotics, sedative/hypnotic medications, and/or alcohol.
 - 8. The patient continues to express unrealistic expectations regarding the outcome of medical/psychiatric intervention in relief of their own symptoms.

(3) Program requirements:

An admission evaluation must be performed by a health care provider or a licensed mental health professional with at least two years experience in evaluation of chronic pain patients and chronic pain treatment, or one year of formal training in a pain fellowship program, and with extensive knowledge of the Maine Workers' Compensation system.

The evaluation must elicit a willingness and perceived ability of the patient to benefit from a pain management program. There must be an individualized treatment plan for each patient, involving active treatment by the program staff, and active participation by the patient.

There must be scheduled hours of attendance and the program must maintain adequate documentation of attendance.

(4) Treatment Period:

Minimum treatment is defined as six or more sessions, or a two week period. Patients who are not showing signs of active participation in their treatment will have their treatment terminated by the end of the sixth session, or the end of the second week. Active participation is determined by the treating health care provider, and must be reflected in the provider's documentation of care, as outlined below.

Patients who show observable signs of active participation and increase in their functioning may continue treatment until there is no further documented functional progress. Health care professionals treating individuals with on-going, problematic pain will document at each session whether or not there are objective signs of active participation by each patient. Additionally, each individual patient's progress notes must address the patient's level of function in some measurable way preferably weekly, but at least within every two week period of treatment.

Patients who do not benefit from treatment initially may return at a later date, if the health care provider believes they are willing to actively participate in subsequent treatment.

Carpal Tunnel Syndrome

Definition

Carpal tunnel syndrome (CTS) is a common disorder with symptoms involving the median nerve. The median nerve is vulnerable to compression and injury in the palm and at the wrist, where it is bounded by the wrist (carpal) bones and the transverse carpal ligament. CTS is a combination of finger, hand and arm distress with symptoms that reflect sensory or motor compromise. It most commonly occurs in adults over age 30, particularly in women.

History

A detailed history considering work and non-work activities is essential and should include duration, evolution and anatomic location of all symptoms.

A history of suspected CTS should elicit the following details:

1. Character of symptoms: Tingling, swelling, numbness, pain (dull, aching discomfort), hand weakness.
2. Frequency: Episodic or constant, nocturnal.
3. Duration: Days, weeks, months.
4. Location: Anatomic correlation, unilateral or bilateral.
5. Association with hand positions or activity: Repetitive forceful wrist motions, vibrating/oscillating tools, static postures with extremes of wrist flexion or extension.
6. Onset: Relation to specific work and/or non-work activities.
7. Relief: Shaking the hand, vacation (time away from work and/or aggravating non-work activities), hanging the hand over the edge of the bed.
8. Review of systems: CTS can be associated with other medical conditions including, but not limited to: endocrine disorders (diabetes, thyroid disease), pregnancy, obesity, rheumatologic conditions (arthritis), trauma, multiple sclerosis.
9. Work and non-work activities: Type of work, length of time in this particular job, recent changes in work or unaccustomed work, relationship between work and onset of symptoms, relief with vacation, other work (second job, self-employment), hobbies (biking, crocheting).

A patient-completed hand diagram (copy attached) describing the location and quality of sensory symptoms is recommended.

Carpal tunnel syndrome represents a clinical diagnosis that can be confirmed with diagnostic testing.

Carpal tunnel syndrome represents a clinical diagnosis that can be confirmed with diagnostic testing.

- * Patients who do not improve with 1-4 weeks of conservative treatment.
- * When surgery is being considered.
- * To rule out other nerve entrapment or radiculopathy.

- * May localize source of CTS symptoms/signs and confirm the clinical diagnosis.
- * May be normal in small percentage of actual CTS cases.
- * If NCS are normal, the diagnosis of CTS must be supported by accurate history and physical findings.

- * Abnormalities of the median distal sensory and/or motor latencies or conduction through the carpal tunnel region.
- * Electro-myographic changes in the thenar eminence in the absence of proximal abnormalities (less common).
- * Guidelines to upper limits of normal latencies:

- | | |
|--|----------------|
| - Median distal motor latency | 4.2 msec/8 cm |
| - Median distal sensory latency (wrist-digit) | 3.5 msec/14 cm |
| - Median intrapalmar latency (palm-wrist) | 2.2 msec/8 cm |
| - Median segmental difference (cm-cm, "inching") | .04 msec/cm |

Electromyographers may use different distances and/or latency values; normative data should be available from these laboratories to establish the criteria for CTS.

Therapeutic Modalities

Non-Operative Treatment (may include concurrent use of the following)

1. Splinting of the Wrist:

- * Neutral position or slight extension.
- * Should fit appropriately and comfortably without significant compression of the wrist or limitation of hand function.
- * Specific instructions must be provided to the patient about when and how the splint is to be worn.
- * May be more useful at night.
- * If a rigid splint is used initially, the patients should be weaned to a soft splint after 2-4 weeks.
- * Reassessment is indicated if no improvement after 3-4 weeks.
- * Document/verify patient compliance.

Time to produce effects3-4 weeks

Frequency of treatmentcontinuous, at night, task related

Optimum duration.....4-8 weeks

Maximum duration12 weeks

2. Modification of Activities:

- * Provider must evaluate the patient's current job description (including specific job tasks).
- * Worksite and/or ergonomic evaluation may be indicated.
- * Evaluation of both work and non-work activities should address repetitive, forceful wrist motions and extremes of flexion/extension; consider all the following activities: lifting, pushing, pulling, awkward and/or sustained postures, hot and cold environments, repetitive motions tasks, sustained hand grip, tool usage, and exposure to vibration.
- * Provider should document all recommended job/activity modifications in detail for patient and/or employer.

Referral Criteria

Consistent with accepted medical practice, consultation with other health-care providers may be initiated at any time by the attending physician.

If the worker is not improving and/or has a documented, well defined clinical and electro-physiological carpal tunnel syndrome, the attending physician should refer the worker for surgical consideration.

Surgical Intervention

Surgical intervention should be considered only if the worker has a positive history and physical exam and abnormal nerve conduction studies and failure of conservative management.

1. Criteria for surgical decompression of the median nerve at the carpal tunnel might include:
 - a. Severe compression of the median nerve as documented by motor and sensory nerve dysfunction associated with electro-diagnostic signs of denervation of thenar muscles.
 - b. Persistence of pain, numbness or dysesthesia in the median nerve distribution with accompanying sensory or motor signs despite appropriate conservative treatment.
 - c. Repeated improvements of symptoms/signs with conservative treatment followed by flare-ups with return to full-work status; this may be an indication for a permanent change in work rather than an indication for surgery.
2. There are two accepted techniques of surgical release: open or endoscopic. These can be performed under local, regional, or general anesthesia. Exploration and decompression of the median nerve is the most commonly performed surgery. Additional surgical procedures such as tenosynovectomy, opponensplasty, simultaneous Guyon's canal exploration, and neurolysis are seldom indicated in initial onset carpal tunnel syndrome. Indications for any of these additional procedures must be completely documented.
 - * If surgery is contemplated in a patient with normal nerve conduction studies, a second opinion should be obtained prior to the surgery.
 - * The majority of carpal tunnel surgeries take place in an outpatient setting; however, under certain circumstances an inpatient setting may be appropriate.

Hand Diagram

Please draw on the hand diagram the areas of each hand where pain, numbness, tingling, or other types of discomfort have occurred in a typical day during the past two (2) weeks.

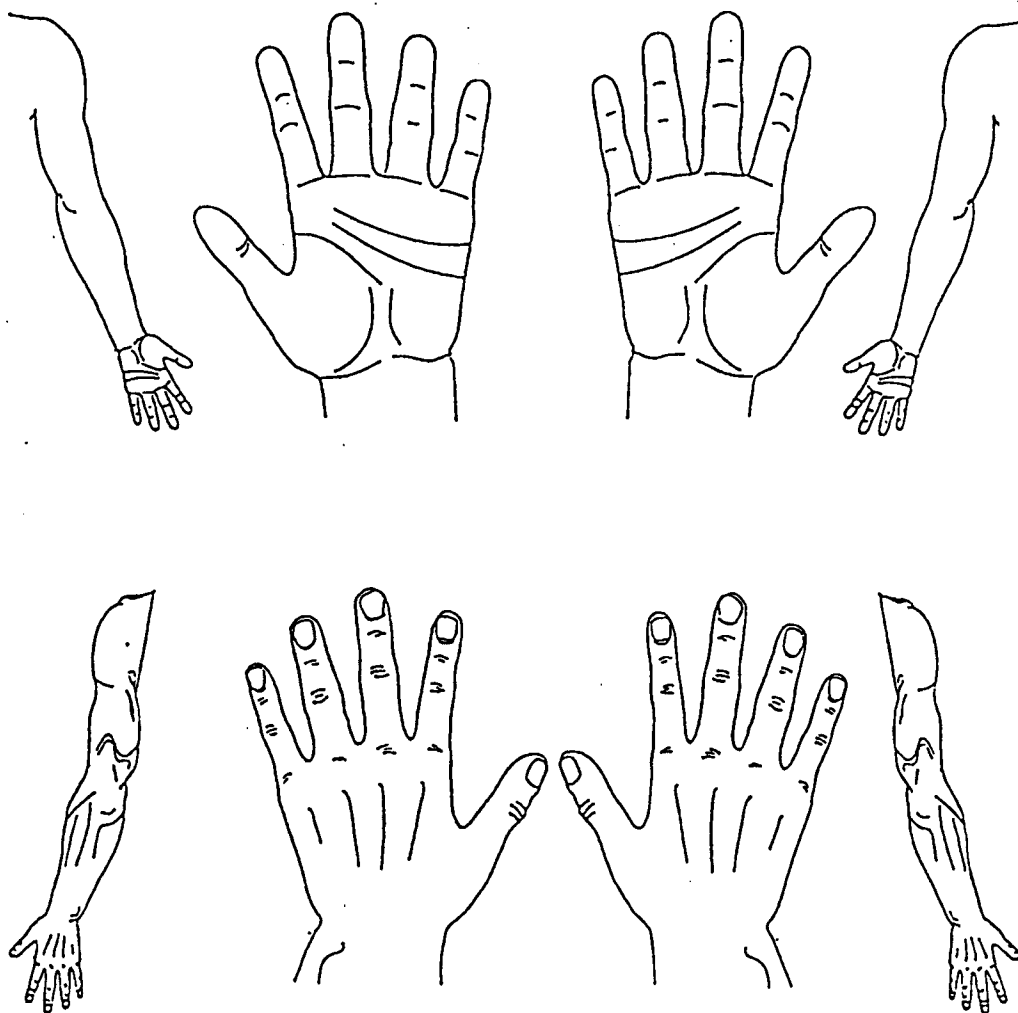
Key: xxxx - pain

//// - numbness/tingling

0000 - other discomfort (please describe)

Left Hand

Right Hand

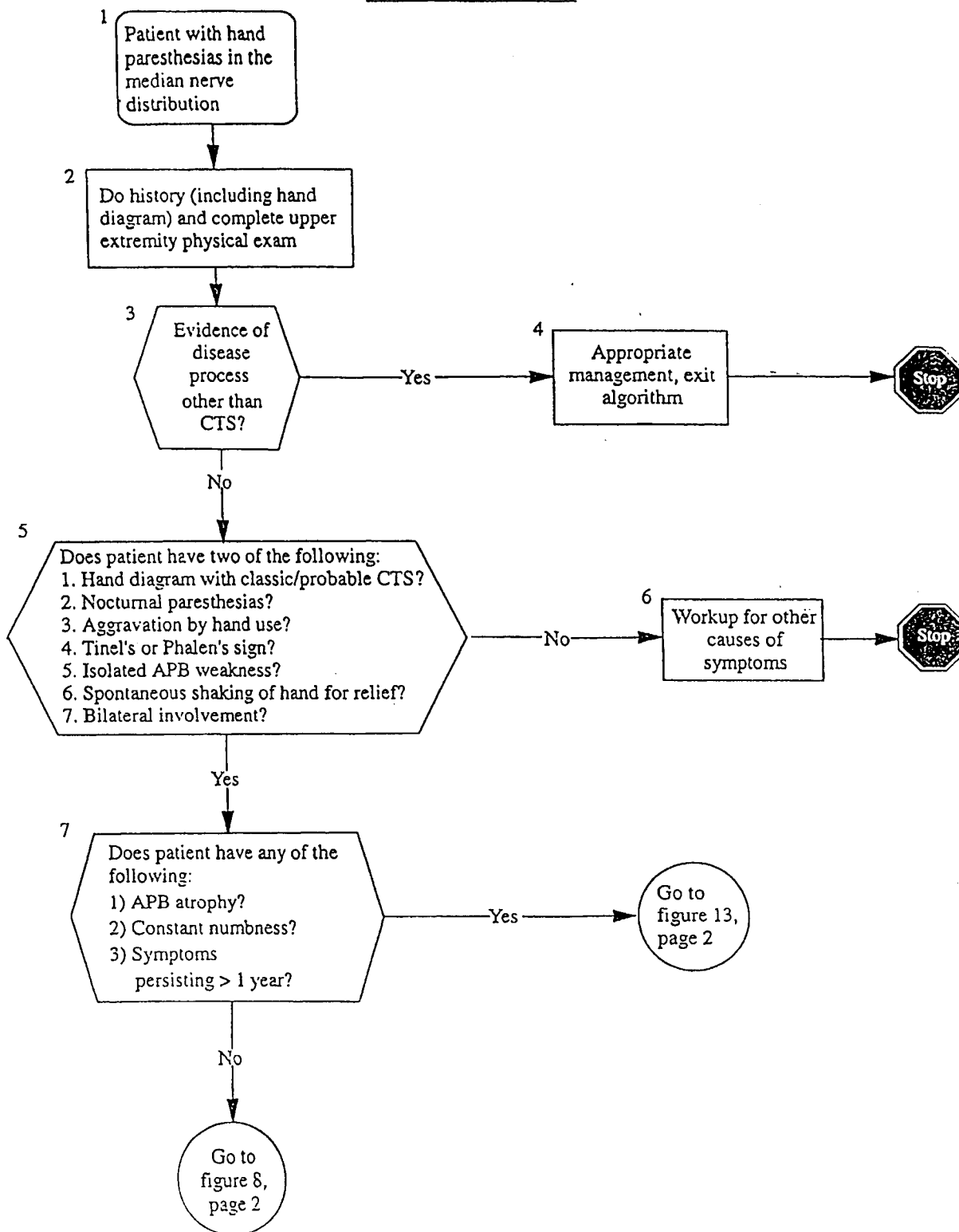


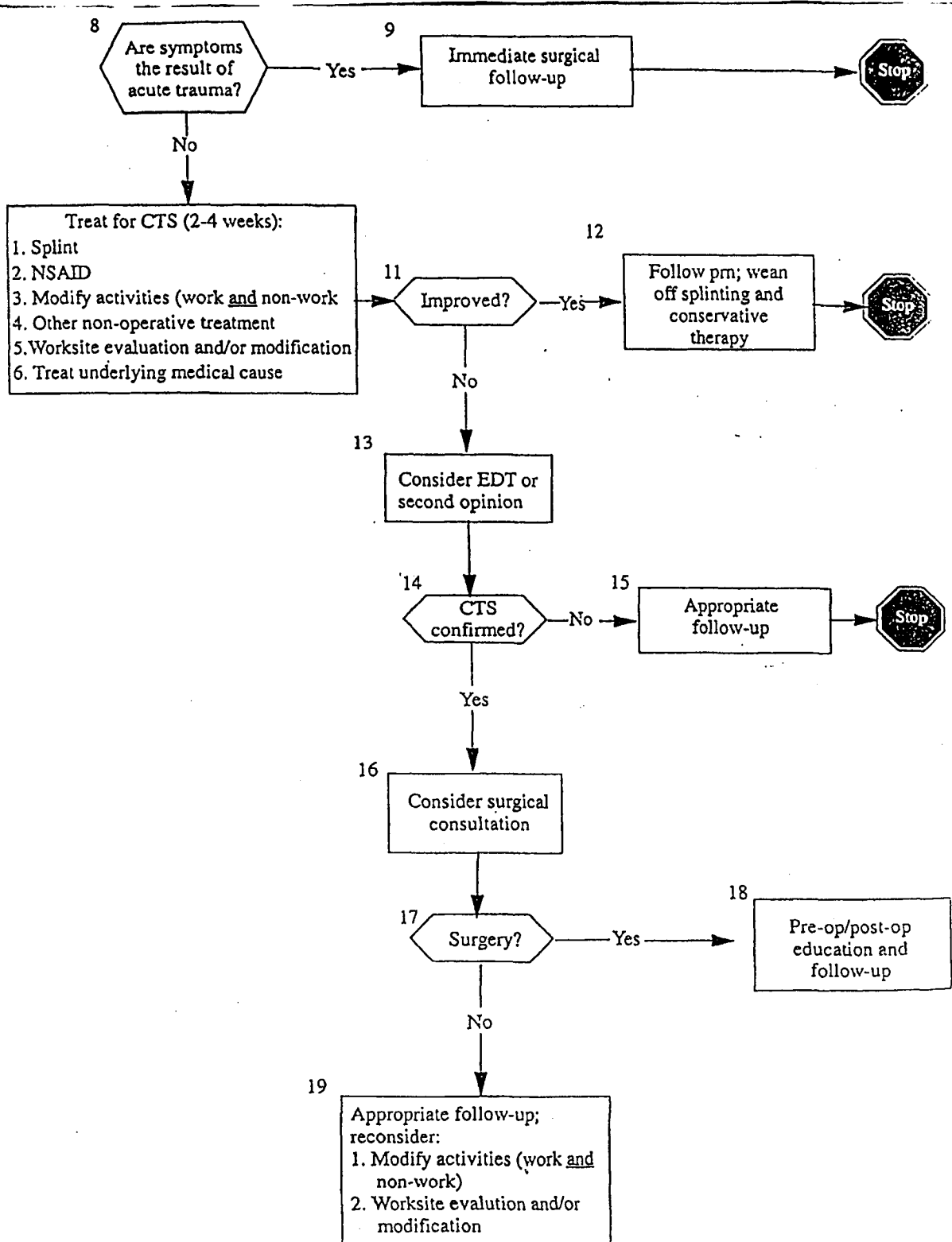
For Physician Use

Rating System for Hand Diagrams:

- 1) Classic - tingling, numbness, or decreased sensation with or without pain in at least two of the digits 1, 2, or 3. Palm and dorsum of the hand excluded; wrist pain or radiation proximal to the wrist allowed.
- 2) Probable - same as for classic, except palmar symptoms allowed unless confined solely to ulnar aspect.
- 3) Possible - tingling, numbness, decreased sensation and/or pain in at least one of digits 1, 2, or 3.
- 4) Unlikely - no symptoms in digits 1, 2, or 3.

Management of Patients with First Onset Carpal Tunnel Syndrome Algorithm

Refer to text for details



CHAPTER 8 PROCEDURES FOR PAYMENT

This rule clarifies the procedures for payment of compensation required by the Act.

- § 1. The initial Statement of Compensation Paid, Interim Report (WCB-11) shall be filed with the Board within 195 days of the date of an injury where indemnity payments have been made, and as a Final Report when no further payments are anticipated. Subsequent Statements of Compensation Paid (WCB-11) shall thereafter be filed with the Board within fifteen (15) days of each anniversary date of an injury when payments of any type have been made since the previous Statement of Compensation Paid (WCB-11). The Statement of Compensation Paid (WCB-11) is required when only medical payments are made subsequent to the filing of a Final Report. There is no requirement to file the Statement of Compensation Paid on claims when payments are made for medical only services and no indemnity was ever paid on the claim.
- § 2. In cases in which the employee's claim is only for medical expenses, the employer may file a single Notice of Controversy for purposes of contesting all present and future claims for medical expenses accrued until the Board enters an order resolving the Notice of Controversy. A copy of this Notice of Controversy must be sent to health care provider if the reasonableness of the health care provider's bill is being contested. Except as provided in W.C.B. Rule Ch. 5, § 7(2), the employer is not required to file a Notice of Controversy contesting a claim for medical expenses if there is already a pending Notice of Controversy indicating a dispute on the employee's claim for compensation for the same date of injury.
- § 3. When an employee is paid 1/2 day or more wages on the date of injury, the date of injury will not be considered a day of incapacity.
- § 4. Incapacity compensation benefit payments shall be paid weekly and directly to the employee entitled to that compensation at that employee's last known mailing address, or at any place that employee designates.
- § 5. Reserved.
- § 6. The employer is obligated to make all payments of benefits ordered by a hearing officer of the Workers' Compensation Board pending the issuance of further findings of fact and conclusions of law requested pursuant to 39-A M.R.S.A. § 318 and pending any appellate process.
- § 7. Interest on awards of compensation must be calculated by the employer and paid to the employee pursuant to 39-A M.R.S.A. § 205(6). Interest must be paid to the employee even if there is no express language in the decision of the mediator or hearing officer ordering such payment. Interest must be calculated using the formulae and Table contained in Appendix I.

- § 8. Partial benefits are calculated at a rate of 80% of the difference between the employee's after-tax average weekly wage before the injury and the after-tax average weekly wage that the employee is able to earn after the injury. To calculate partial benefits:
 1. Determine the 80% rate for the employee's pre-injury average weekly wage using the Weekly Benefit Table in effect at the time of the employee's injury.
 2. Determine the 80% rate for the employee's post-injury weekly earnings using the Benefit Table used in step 1 above.
 3. The difference between the post-injury rate and the pre-injury rate is the partial benefit amount.
- § 9. Form WCB-2A shall be completed based on the employee's federal tax return filed for the calendar year prior to the employee's date of injury, unless the employee demonstrates a change in marital status or number of dependents since the calendar year for which the tax return was filed.
- § 10. No Wage Statement (WCB-2) nor Schedule of Dependent(s) and Filing Status Statement (WCB-2A) shall be filed when payments are made for medical only services and no indemnity was ever paid on the claim pursuant to 39-A M.R.S.A. § 205(8).
- § 11. The Discontinuance or Modification of Compensation (WCB-4) shall be filed by the employer or insurer when the employee returns to work or receives an increase in pay pursuant to 39-A M.R.S.A. § 205(9)(A).
- § 12. When an employer or insurer makes payments of compensation pursuant to an agreement by the parties or a decision of the Board, the employer or insurer shall document such payments by completing the appropriate sections of Form WCB-3, Form WCB-4, and/or Form WCB-11.
- § 13. If the employer or insurer disputes a medical bill on a claim for which a First Report was never filed, the employer or insurer shall file a First Report with the Notice of Controversy as set forth in W.C.B. Rule Ch. 3, § 4.
- § 14. All parties shall utilize forms and instructions prescribed by the Board.
- § 15. Reserved.
- § 16. When an employee loses a day or more from work that does not result in the filing of a Memorandum of Payment or a Notice of Controversy, the employer/insurer shall notify the Board of the employee's return to work date, if the date was not included on the original First Report, by filing either an 02 First Report using the IAIABC Claims Release 3 format or an amended First Report of Injury using the State of Maine Proprietary Electronic Data Interchange format. The employee's return to work date shall be filed

within seven (7) days of the employee's return to work or periods of subsequent incapacity.

§ 17. The employer/insurer shall send the Employee's Return to Work Report (WCB-231) to the employee when filing the Memorandum of Payment pursuant to 39-A M.R.S.A. § 205(7).

§ 18.

1. If the parties agree to a voluntary payment of a closed-end period of incapacity, modification, reduction or discontinuance, then the Consent Between Employer and Employee, WCB-4A, shall be filed with the Board upon the signatures of the parties.
2. The employer or insurance carrier shall make compensation payments within 10 calendar days after the WCB-4A is signed by the parties.
3. Signing the WCB-4A does not by itself create a compensation payment scheme.
4. The WCB-4A shall be distributed as follows: (1) Workers' Compensation Board; (2) Employee; (3) Insurer; (4) Employer.
5. Upon request by any of the parties, the Consent Between Employer and Employee, WCB-4A, shall be reviewed within 14 calendar days by an agent at the Board's regional offices in order to answer any relevant questions prior to the employer and employee signing this form.
6. The Consent Between Employer and Employee, WCB-4A, shall not be used when an ongoing order, award of compensation, or a compensation payment scheme is entered under § 205(9)(B)(2).
7. The Payments Division will review the filed Consent Between Employer and Employee, WCB-4A, in order to verify that the agreed upon benefits were correctly determined.
8. The Deputy Director of Benefits Administration will refer abuses of the Consent Between Employer and Employee, WCB-4A, to the Workers' Compensation Abuse Investigation Unit.

STATUTORY AUTHORITY: 39-A MRSA § 152

EFFECTIVE DATE:

January 15, 1993 (Emergency)

EFFECTIVE DATE OF PERMANENT RULE:

April 7, 1993

AMENDED:

March 1, 1995

EFFECTIVE DATE (ELECTRONIC CONVERSION):

April 28, 1996

NON-SUBSTANTIVE CORRECTIONS:

September 12 and October 9, 1996 - header added, minor formatting.

AMENDED:

April 2, 1997 - Section 18

May 23, 1999 - Section 7 (Calculation of Interest), Appendix I, and Table A added.

NON-SUBSTANTIVE CORRECTIONS:

October 26, 1999 - minor formatting.

AMENDED:

March 4, 2001 - Sections 1, 8, 16

September 24, 2002 - filing 2002-349 affecting Section 2.

NON-SUBSTANTIVE CORRECTIONS:

January 9, 2003 - character spacing only.

AMENDED:

June 24, 2007 - Secs. 13 & 16 amendments (delete 16.2)

CHAPTER 8, SECTION 7
APPENDIX I

The following formulae only apply to continuous compensation payments where the weekly benefit amount remains constant. If the weekly benefit amount changes, and/or there is a break in the period of compensation, the formulae must be applied to each continuous period of equal payments. The interest due from each period must then be added to determine the total interest due.

FORMULAE

(A) To calculate interest when payment is made during the period of entitlement to benefits, the following formula shall be used:

(Weekly compensation x weeks of benefits) x Factor from Table A = Interest due.

For example: A decree dated September 4, 1998 awards compensation at a rate of \$300.00 per week from February 2, 1997 to the present and continuing. On September 5, 1998, compensation is paid for incapacity from February 2, 1997 through September 5, 1998. Calculate interest due as follows:

$$(\$300.00 \times 83) \times 0.079084 = \$1,969.19$$

(B) To calculate interest due between the date last payment was due, and the date of payment, the following formula shall be used:

First, determine the amount of interest due for the period of incapacity using formula (A) above. Then apply the following formula:

Amount of interest due between date last payment due and date of payment =

$$\frac{((\text{Weekly compensation} \times \text{weeks of benefits}) + \text{Interest due}) \times \text{days} \times 10\%}{365}$$

The total amount of interest due will equal the sum of formula (A) and formula (B).

For example: A decree dated September 4, 1998 awards compensation at a rate of \$300.00 per week from February 2, 1997 through July 26, 1997. On September 9, 1998, compensation is paid for incapacity from February 2, 1997 through July 26, 1997. Calculate interest as follows:

First calculate the interest due for the period of incapacity:

$$(\$300.00 \times 25) \times 0.022328 = \$167.46 \text{ (The interest due through July 26, 1997.)}$$

Then, calculate the interest due between the date the last payment was due and the payment date:

$$\frac{((\$300.00 \times 25) + \$167.46) \times 405 \times 10\%}{365} = \$850.77 \text{ (The interest due from August 1, 1997 through September 9, 1998)}$$

Last, calculate the total amount of interest due:

$$\$167.46 + \$850.77 = \$1,018.23$$

TABLE A

# WKS	Factor		# WKS	Factor		# WKS	Factor
1	0.000000		53	0.049221		105	0.101698
2	0.000917		54	0.050199		106	0.102741
3	0.001836		55	0.051178		107	0.103785
4	0.002755		56	0.052158		108	0.104830
5	0.003676		57	0.053139		109	0.105877
6	0.004598		58	0.054122		110	0.106924
7	0.005521		59	0.055106		111	0.107974
8	0.006445		60	0.056091		112	0.109024
9	0.007370		61	0.057077		113	0.110076
10	0.008296		62	0.058064		114	0.111129
11	0.009224		63	0.059053		115	0.112183
12	0.010152		64	0.060043		116	0.113239
13	0.011082		65	0.061034		117	0.114296
14	0.012013		66	0.062026		118	0.115354
15	0.012945		67	0.063020		119	0.116414
16	0.013878		68	0.064014		120	0.117475
17	0.014812		69	0.065010		121	0.118537
18	0.015747		70	0.066007		122	0.119601
19	0.016684		71	0.067006		123	0.120666
20	0.017622		72	0.068006		124	0.121732
21	0.018561		73	0.069006		125	0.122800
22	0.019501		74	0.070009		126	0.123868
23	0.020442		75	0.071012		127	0.124939
24	0.021384		76	0.072017		128	0.126010
25	0.022328		77	0.073022		129	0.127083
26	0.023272		78	0.074030		130	0.128157
27	0.024218		79	0.075038		131	0.129233
28	0.025165		80	0.076048		132	0.130310
29	0.026113		81	0.077058		133	0.131388
30	0.027062		82	0.078070		134	0.132468
31	0.028013		83	0.079084		135	0.133549
32	0.028965		84	0.080098		136	0.134631
33	0.029917		85	0.081114		137	0.135715
34	0.030871		86	0.082131		138	0.136800
35	0.031826		87	0.083150		139	0.137886
36	0.032783		88	0.084169		140	0.138974
37	0.033740		89	0.085190		141	0.140063
38	0.034699		90	0.086213		142	0.141153
39	0.035659		91	0.087236		143	0.142245
40	0.036620		92	0.088261		144	0.143338
41	0.037582		93	0.089287		145	0.144433
42	0.038545		94	0.090314		146	0.145529
43	0.039510		95	0.091342		147	0.146626
44	0.040476		96	0.092372		148	0.147725
45	0.041443		97	0.093403		149	0.148825
46	0.042411		98	0.094436		150	0.149926
47	0.043380		99	0.095469		151	0.151029
48	0.044351		100	0.096504		152	0.152133
49	0.045322		101	0.097541		153	0.153238
50	0.046295		102	0.098578		154	0.154345
51	0.047269		103	0.099617		155	0.155454
52	0.048245		104	0.100657		156	0.156563

TABLE A

# WKS	Factor		# WKS	Factor		# WKS	Factor
157	0.157674		209	0.217412		261	0.281194
158	0.158787		210	0.218599		262	0.282462
159	0.159901		211	0.219788		263	0.283732
160	0.161016		212	0.220979		264	0.285004
161	0.162132		213	0.222171		265	0.286277
162	0.163251		214	0.223364		266	0.287551
163	0.164370		215	0.224559		267	0.288828
164	0.165491		216	0.225756		268	0.290106
165	0.166613		217	0.226954		269	0.291385
166	0.167737		218	0.228153		270	0.292666
167	0.168862		219	0.229354		271	0.293949
168	0.169988		220	0.230557		272	0.295233
169	0.171116		221	0.231761		273	0.296520
170	0.172245		222	0.232967		274	0.297807
171	0.173376		223	0.234174		275	0.299097
172	0.174508		224	0.235382		276	0.300388
173	0.175642		225	0.236593		277	0.301680
174	0.176777		226	0.237804		278	0.302974
175	0.177913		227	0.239018		279	0.304270
176	0.179051		228	0.240232		280	0.305568
177	0.180190		229	0.241449		281	0.306867
178	0.181331		230	0.242666		282	0.308168
179	0.182473		231	0.243886		283	0.309470
180	0.183616		232	0.245107		284	0.310775
181	0.184761		233	0.246329		285	0.312080
182	0.185908		234	0.247553		286	0.313388
183	0.187056		235	0.248779		287	0.314697
184	0.188205		236	0.250006		288	0.316008
185	0.189356		237	0.251235		289	0.317320
186	0.190508		238	0.252465		290	0.318635
187	0.191662		239	0.253697		291	0.319950
188	0.192817		240	0.254930		292	0.321268
189	0.193973		241	0.256165		293	0.322587
190	0.195131		242	0.257401		294	0.323908
191	0.196291		243	0.258639		295	0.325231
192	0.197451		244	0.259879		296	0.326555
193	0.198614		245	0.261120		297	0.327881
194	0.199778		246	0.262363		298	0.329208
195	0.200943		247	0.263607		299	0.330538
196	0.202110		248	0.264853		300	0.331869
197	0.203278		249	0.266101		301	0.333202
198	0.204448		250	0.267350		302	0.334536
199	0.205619		251	0.268600		303	0.335872
200	0.206791		252	0.269852		304	0.337210
201	0.207966		253	0.271106		305	0.338550
202	0.209141		254	0.272362		306	0.339891
203	0.210318		255	0.273619		307	0.341234
204	0.211497		256	0.274877		308	0.342578
205	0.212677		257	0.276137		309	0.343925
206	0.213858		258	0.277399		310	0.345273
207	0.215041		259	0.278663		311	0.346623
208	0.216226		260	0.279928		312	0.347974

CHAPTER 9 PROCEDURE FOR COORDINATION OF BENEFITS

This rule describes the procedures to be followed in calculating and performing the coordination of benefits required under 39-A M.R.S. § 221.

- § 1. Any reduction in weekly workers, compensation benefits which results from the coordination of benefits described in Title 39-A shall be indicated on the Discontinuance or Modification of Compensation (WCB-4) filed pursuant to Rule 8.1. The employer or insurer shall indicate which type of benefit is the subject of coordination and the mathematical calculations used in determining the new level of weekly compensation benefits.
- § 2. Coordination of benefits pursuant to § 221(3).
- (A) Except as provided in paragraph (B) of this section, when an employee receives payments pursuant to a plan or policy subject to § 221(1)(B) or (C), the amount of the reduction to the employee's weekly benefits is calculated by converting the weekly payment into an after-tax amount using the tables of average weekly wage and 80% of the after tax average weekly wage published by the Board pursuant to 39-A M.R.S. § 102(1) and then multiplying the applicable 80% of the after-tax amount by 1.25.
- (B) When an employee receives a benefit that is intended to be paid over the employee's lifetime in a lump sum or a periodic payment for a permanent or lifetime condition paid over a period less than the employee's life expectancy pursuant to a plan or policy subject to § 221(1)(B) or (C), the amount of the reduction to the employee's weekly benefits is calculated by:
- (1) determining the employee's life expectancy based on standard actuarial tables in weeks;
 - (2) determining a weekly benefit amount by dividing the lump sum amount by the number of weeks of life expectancy determined pursuant to sub-section B paragraph (1) of this section;
 - (3) converting the weekly benefit amount determined pursuant to sub-section B paragraph (2) of this section into an after-tax amount using the tables of average weekly wage and 80% of the after tax average weekly wage published by the Board pursuant to 39-A M.R.S. § 102(1); and,
 - (4) multiplying the applicable 80% of the after-tax amount by 1.25.
- (C) This regulation applies retroactively to all pending cases including those on appeal.
-

STATUTORY AUTHORITY: 39-A MRSA § 152(2), 221

EFFECTIVE DATE:

January 15, 1993 (Emergency)

EFFECTIVE DATE OF PERMANENT RULE:

April 7, 1993

AMENDED:

March 1, 1995

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April 28, 1996

NON-SUBSTANTIVE CORRECTIONS:

September 12 and October 9, 1996 -- header added, minor formatting.

January 9, 2003 - character spacing only.

September 16, 2009 - Section 2 added; filing 2009- 451

CHAPTER 10 ATTORNEY'S FEES

§ 1. Attorney's Fees

1. An attorney may charge an employee a fee for services, capped at 30% of benefits accrued.
2. If an attorney wishes to collect more than 30% of benefits accrued, he or she may do so only with pre-approval of a hearing officer.
3. "Benefits accrued" includes benefits past due, benefits paid without prejudice acquired and/or retained through the services of an attorney and unpaid medical bills. In no case, shall the employer/insurer be required to pay an amount for medical services in excess of the medical fee schedule regulations or the provider's charges, whichever is less.
4. If a case is in litigation and is lump sum settled prior to decree, attorney's fees may be collected from the employee as follows, subject to the approval of the hearing officer: the attorney's fee capped at 30% of benefits accrued in addition to the designated percentage set forth in 39-A M.R.S.A. Sec. 325(4)(B).

§ 2. Disputed Fees

1. If attorney's fees are charged in accordance with 39-A M.R.S.A. Sec. 325 and the provisions of this rule and there is no dispute with respect to payment of the fee, then board approval of the fee is not necessary.
2. If a dispute arises between an employee and his or her attorney regarding the payment of attorney's fees, either the employee or his or her counsel may file a motion with a hearing officer. The motion must be served on the opposing party and must be filed in the appropriate regional office. Within 30 days following the receipt of this motion, the opposing party shall submit a written statement of objections to the fee for which payment is sought. In issuing an order, the hearing officer shall consider the following factors: (1) the complexity of the issues presented; (2) the novelty of the questions raised; (3) the quality of the representation; (4) the time and labor required; (5) the skills and experience of the attorney; and (6) the benefits to the employee.
3. Hearings will be held on fee motions only at the discretion of the hearing officer.

§ 3. Multiple Dates of Injury

1. If there are multiple dates of injury and at least one date of injury pre-dates and at least one date of injury post-dates January 1, 1993, the provisions of this subsection apply. Attorney's fees must be allocated in proportion to one or more of the following factors: (1) the role each date of injury played in the litigation; (2) the extent to which each party precipitated the need for litigation; and (3) the ultimate success of the petition(s) alleging a particular date of injury. This analysis must be performed on a case-by-case basis.
2. Once the allocation has been made, the employer/insurer must pay attorney's fees for any injuries that pre-date January 1, 1993 in accordance with 39 M.R.S.A. Sec. 110. For injuries that post-date January 1, 1993, the attorney may charge the employee a fee in accordance with section 1 of this rule.
3. Disputes regarding the appropriate allocation of fees must be resolved by motion pursuant to subsection 2 of this rule.

§ 4. Other Matters

1. The employee may designate his or her attorney's office as the location where checks are to be sent in accordance with 39-A M.R.S.A. Sec. 205(1).

CHAPTER 10, EFFECTIVE DATE: April 14, 1998

CHAPTER 11 MEDIATION

This chapter sets forth the procedure of the parties in preparation for and attendance at mediation and protects the confidentiality of information discussed at mediation.

§ 1.

Assignment of Cases - Except as provided in 39-A M.R.S.A. Sec. 205, subsection 9, paragraph D, upon receipt of a Notice of Controversy which was unable to be resolved by the Office of Troubleshooters, or other indication of controversy, the Board shall refer the matter to a mediator who shall mediate the dispute in an expeditious manner. The initial referral and assignment of such disputes shall be based on the residence of the employee as indicated on the Notice of Controversy. The Board will keep a list of towns indicating which areas shall be assigned to the respective regional offices.

In cases where the convenience of the parties or the interest of justice require, a party may make a written request to the Board for the matter to be reassigned or transferred to a different mediator and regional office. Such reassignments and transfers shall be made by the Executive Director. If the written request is not by stipulation of all the parties involved in the proceeding, the Executive Director shall give any party opposing the reassignment or transfer of the case 10 days in which to respond to the moving party's request.

§ 2. Confidentiality of Mediation

Mediation is most successful when the parties are free to speak candidly and openly about their interests, needs, and desires. Confidentiality also protects unrepresented parties from exploitation by individuals who use mediation for discovery.

1. All statements made during the course of mediation are made without prejudice to any party's legal position in the dispute being mediated.
2. No aspect of a mediation, other than the Record of Mediation, shall be discoverable or admissible in any proceeding, other than a Penalty referral, governed by the Workers' Compensation Act. Limitations on admissibility and discoverability include, but are not limited to, the following:
 - A. The mediator shall not be called as a witness, nor shall discovery be taken from the mediator, nor shall a mediator be compelled to produce notes or other evidence of what transpired at mediation.
 - B. Views expressed or suggestions made by a party with respect to a possible resolution of the dispute, admissions made during mediation, proposals

made or views expressed by the mediator, or the response of any party to the mediator's proposals are not discoverable or admissible.

3. Mediators shall not disclose any information provided to them by one party in private to any other party in the mediation without authorization from the disclosing party, except to the extent that such disclosure is required by law.
 4. The mediator may restrict attendance at mediation and participation by individuals who are not parties to the dispute.
 5. Mediation sessions shall not be recorded or transcribed.
 6. Information discussed during mediation may be disclosed if required by superseding state or federal law or codes of professional conduct.
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STATUTORY AUTHORITY: 39-A M.R.S.A. Secs. 152, 153

EFFECTIVE DATE: January 15, 1993 (EMERGENCY)

EFFECTIVE DATE OF PERMANENT RULE: April 2, 1993

AMENDED: March 11, 1996

EFFECTIVE DATE (ELECTRONIC CONVERSION): April 28, 1996

NON-SUBSTANTIVE CORRECTIONS: September 12 and October 9, 1996 --
header added, "Sec." changed to §, minor formatting.

AMENDED: November 20, 1999 (Section 1 Amendments)

CHAPTER 12 FORMAL HEARINGS

This chapter sets forth the procedure of the parties in preparation for attendance at formal hearings.

§ 1.

1. Petitions and other notifications of disputes shall be filed with the Board's central office in Augusta, Maine.
2. Reasonable mileage expense reimbursement pursuant to 39-A M.R.S.A. § 315 shall be 44 cents per mile.
3. Except as specifically provided in 39-A M.R.S.A. § 101 *et seq.* or in these rules, any party opposing a motion shall file a response not later than 7 days after the filing of the motion.

§ 2.

In all petitions for payment or reimbursement of medical bills, itemized bills must be filed with the petition and made a part thereof.

§ 3.

1. All parties shall be prepared and ready for hearing. When the petitioning party is unprepared, the matter will be dismissed by order of the Board.
2. The Board, on its own motion, after notice to the parties, and in the absence of a showing of good cause to the contrary, shall dismiss an action for want of prosecution at any time more than two years after the last docket entry showing any action taken therein by the petitioning party. Such dismissal shall operate as an adjudication upon the merits.

§ 4. Continuances

1. Continuances must be requested in writing at least 14 days before the date of the scheduled hearing or conference. Shorter notice will be allowed only for sudden emergencies or other exceptional circumstances, but in all cases a request for a continuance shall be filed as soon as reasonably possible.
2. A request for a continuance must indicate the reason(s) for the request and whether the opposing party or parties object to the request
3. In granting or denying a request for a continuance, the Hearing Officer shall consider whether the employee is working and whether weekly benefits are being paid.
4. A request for a continuance that does not comply with this part will be

automatically denied.

5. Parties cannot assume a continuance has been granted until so notified by the Board.

§ 5. Proposed findings of fact and conclusions of law shall be filed by an interested party within 15 days following the filing of a motion for additional findings filed pursuant to 39-A M.R.S.A. § 318. Failure by the moving party to file such proposed findings timely may be grounds for a written order of the Hearing Officer dismissing the motion.

§ 6. Lump sum settlements; record of proceedings

1. Proceedings held to approve a settlement pursuant to 39-A M.R.S.A. § 352 shall be recorded and become a part of the official record of the case.

2. A. Hearing Officers are authorized by the Board to conduct hearings and issue decisions on the approval of lump sum settlements pursuant to 39-A M.R.S.A. § 352.

B. When making findings pursuant to 39-A M.R.S.A. § 352 (3)(A) relating to the release of an employer's liability for future medical expenses, Hearing Officers shall make a determination regarding expected future medical costs related to the injury.

§ 7. Unless otherwise provided or indicated, the dismissal of any petition shall be without prejudice.

§ 8. The Hearing Officer presiding at the hearing may appoint an interpreter, including an interpreter for the deaf. Interpreters shall be appropriately sworn.

§ 9. Conferences

1. Unrepresented parties should not fill out the Joint Scheduling Memo form as described in Rule 12.13. They will be called in for a conference with the opposing parties before a hearing date is set. The Joint Scheduling Memo form will be filled out at the conference with the Hearing Officer and the hearing will be held on a different day.

2. When all parties are represented, cases will not be set for an initial formal conference but the parties will be required to complete a Joint Scheduling Memo as described in Rule 12.13.

3. Conferences will be held in cases where both parties are represented only if both parties request a conference or if the Hearing Officer sets a conference on a motion of a party made for good cause and not for purposes of delay. Hearing Officers, when ruling if a conference should be held despite opposition by the petitioning

party shall consider the impact on the petitioning party of further delay.

§ 10. Formal Hearings

1. Each case will be scheduled for a formal hearing as soon as practicable, depending on the time required as set forth in the Joint Scheduling Memo. If no time requirements are indicated by the parties, the Hearing Officer will assume that the combined testimony of all witnesses will take no longer than 30 minutes. The Hearing Officer will have ultimate control over the length of each hearing. The time allotted for the hearing in each case will be strictly enforced.
2. Any party seeking additional hearings must make a timely motion with the Hearing Officer setting forth specifically the reasons that an additional formal hearing is needed. Said motion shall also recite whether or not weekly benefits are being paid either under a compensation payment scheme or without prejudice and the amount of the weekly payment. An additional hearing will be allowed only if the Hearing Officer finds such hearing is necessary and that the need for the additional hearing did not arise because of the lack of timely and adequate preparation by the party seeking an additional hearing. In granting or denying a request for an additional hearing, the Hearing Officer shall also consider whether or not weekly benefits are being paid or will be paid without prejudice if an additional hearing is ordered.
In the event that both parties request an additional hearing, it shall be granted unless the Hearing Officer denies it for good and sufficient cause.

§ 11. Close of Evidence and Position Papers

1. Evidence will typically close in all cases at the testimonial hearing unless an additional hearing is granted under Section 10 of these rules. The parties may, with the consent of the Hearing Officer submit stipulations and documentary (including prescheduled medical depositions as provided in Section 15 of this rule) or tangible evidence to the Hearing Officer within a reasonable time after the close of testimonial evidence.
2. In lieu of position papers, oral arguments at the close of the final hearing are encouraged. If position papers are necessary, they must be submitted within 2 weeks of hearing or simultaneous with the close of evidence, absent exceptional circumstances. Additional time will be allowed only with express authorization of the Hearing Officer.

§ 12. Sanctions

Parties in violation of these rules may be subject to sanctions, following reasonable opportunity to be heard, including dismissal of pending petitions, granting relief requested in the petitions, exclusion of evidence, and such other temporary relief as the Hearing Officer may order. Such temporary relief may include payment or discontinuance of weekly benefits without prejudice until such time as the violating party comes into compliance or a final decision is issued.

§ 13. The Joint Scheduling Memo

Subject to the provisions of Section 9.1 no action will be taken on any petition until a Joint Scheduling Memo has been filed. Upon timely request from any party and for good cause shown, the Hearing Officer may hold a conference if necessary.

1. The parties or their representatives must confer and prepare a Joint Scheduling Memo to be filed with the Board as provided in this part. The petitioning party must file the Joint Scheduling Memo within 45 days after mediation or the filing of a petition, whichever is later.
2. The Joint Scheduling Memo must faithfully reflect the representations of the parties and include, at a minimum, the following:
 - A. The names of all witnesses the parties will call and the amount of time required for the testimony of each witness, including direct and cross-examination;
 - B. The total amount of time required for the hearing;
 - C. Affirmative defenses; and
 - D. Whether or not a Section 312 examination has been or will be requested.
3. Any affirmative defenses must be raised in the Joint Scheduling Memo or will be deemed waived.
4. If the Joint Scheduling Memo is not received in a timely fashion, the Hearing Officer may dismiss the pending petitions.
5. The Joint Scheduling Memo must be filed in the appropriate regional office and not in the Augusta Central Office. Any objection to the memo shall be filed within 10 days of its submission.
6. The case may be scheduled for hearing as soon as the Joint Scheduling Memo is received.

7. A sample Joint Scheduling Memo form is included in Appendix I.

§ 14. Work Search, Labor Market and Surveillance Evidence

In cases in which work search, labor market or surveillance evidence is relevant, the parties must abide by the time limits established in this rule.

1. Within 30 days after mediation or the filing of a petition, whichever is later, the employee must provide the employer with any work search or labor market evidence that the employee intends to introduce into evidence.
2. Within 21 days after receipt of this information, the employer must provide the employee with any labor market evidence that the employer intends to introduce into evidence.
3. The employer must turn over all surveillance information to the employee. Existing surveillance information must be turned over within 14 days after the employer receives information from the employee under Appendix II, subsection 1 of this rule and Rule 12.15(1). Surveillance information obtained after the submission of the Joint Scheduling Memo must be turned over within 14 days after the employer receives it, in any event at least 7 days before the hearing.
4. The employer's requirement to turn all surveillance evidence and information over to the employee may be stayed upon a timely motion to and Order by the Executive Director or his/her designee if he/she find from a review of the employee provided information and the surveillance reports and evidence that the surveillance evidence gives rise to significant inconsistencies. The motion need not be copied to the employee or the employee's representative but the cover letter accompanying such motion must be copied to the other side and to the presiding Hearing Officer. In such case, the Executive Director or his/her designee may permit deferral of the provision by the employer to the employee of surveillance information until immediately after the employee's sworn testimony. The review of the motion must be completed by the Executive Director or his/her designee within 14 days of receipt of the motion.
5. Should the Executive Director or his/her designee permit deferral of the exchange of surveillance information, the employee's sworn testimony may be taken by deposition pursuant to Rule 12.15 or at formal hearing. Depositions taken under this subsection may be limited by the Hearing Officer in scope, time, and place.
6. At least 7 days before the hearing, the employee must provide an update on any additional work search or labor market evidence that he or she intends to introduce into evidence.

§ 15. Exchange of Information

1. The parties must provide the information required in the exchange of information form found in Appendix II of these rules, when relevant, within 30 days after mediation or the filing of a petition, whichever is later, and then on a continuing basis. The information must be sworn to by a party if that party is represented by counsel, the signature of counsel constitutes his/her representation that after due inquiry he/she believes the information to be accurate and complete. If a party, in good faith, needs relevant information not covered in the questions contained in the exchange of information form, that party may ask not more than 3 additional non-complex questions of reasonable length, subject to objection by the opposing parties and review by the Board. The three additional questions shall not constitute follow-up questions to information already received. Subject to the limitations set forth in this rule, other exchanges of information may be had by agreement.
2. Discovery motions will be decided without a hearing unless a party requests a hearing and the Hearing Officer determines that such a hearing is necessary. All discovery motions must be filed in the appropriate local regional office. The Board will assume that the opponent objects to the requested discovery. Parties seeking to file specific objections to requested discovery must file such objections within 5 business days of receipt of the motion.
3. Only essential witnesses may be deposed. These depositions may be taken by agreement or by Motion pursuant to subsection 2. Depositions of unrepresented employees may not be used at any subsequent proceeding, either for purposes of impeachment or in lieu of testimony unless the Board orders otherwise in advance of the deposition.
4. Depositions of experts must be scheduled before the testimonial hearing and must be completed within 45 days after the hearing. Additional time will only be allowed on written motion to the Hearing Officer. At the hearing, the parties must tell the Board the date of any depositions that have been scheduled but are not yet available.

§ 16. Exhibits

1. The parties must mark exhibits by number and date of hearing and exchange those exhibits before the time for which the hearing is scheduled.
2. All medical records and reports must be introduced together as a single, indexed exhibit at the hearing or at a conference. The reports and records must be either in chronological order or grouped together by health care provider.
3. Exhibits to which there is an objection must be marked separately.

4. Violation of this rule may result in the exclusions of the exhibit from evidence.

§ 17. Alternative Procedures or Timeframes

The requirements or timeframes set forth in these rules may be altered by a Hearing Officer upon notice to the parties and for good cause. In determining whether there is good cause to order alternative procedures or time frames, the Hearing Officer may consider the relative efficiency of alternative procedures, fairness to the parties, and the needs of unrepresented parties.

§ 18. Limited Authorization for the Release of Certain Written Medical Information

1. In the event that the employer contends that the medical records and information, pre-existing and subsequent to the workplace injury, for which claim is being made are relevant for determination of compensability and disability, it may obtain from the employee and the employee is obliged to within a reasonable time to execute a limited authorization for focused written medical records only employing the form set forth in Appendix III.
2. In the event that the employer contends that medical or counseling records related to psychological matters, substance abuse, or sexually transmitted disease matters are relevant to issues in the workers' compensation case, it may obtain such specific additional medical and other information as agreed upon among represented parties. In all other cases, specific additional medical and other information may be requested on written motion to the Hearing Officer showing the need for the information. The Hearing Officer may authorize the release of this information subject to appropriate terms and conditions as to reasonable protection of confidentiality.

§ 19. Disposition of Evidence

1. When no appeal has been filed with the Law Court from a Hearing Officer's decision, findings of fact and conclusions of law, or a decision of the Board reviewing a Hearing Officer's decision, all evidence submitted by the parties and all transcripts of proceedings in the matter may be destroyed by the Board 60 (sixty) days after the expiration of the time for appeal set forth in 39-A M.R.S.A. § 322. Parties wishing the return of that evidence or those transcripts must request such return in writing and enclose a postage pre-paid envelope or schedule a time to pick up the file materials. This rule applies to all cases decided by the former Commission and the Board. Evidence and transcripts in cases that are appealed to the Law Court may be destroyed 60 (sixty) days after the Law Court denies appellate review. This rule must be executed in accordance with 5 M.R.S.A. § 95(9).

2. Notification of the anticipated time of file destruction shall be clearly indicated on all decrees and findings of fact and conclusions of law issued after the effective date of this rule.
 3. Audio tapes of hearings shall be preserved for 6 (six) years from the date on which the testimony was presented, with the following exception: audio tapes of lump sum settlement conferences shall be preserved indefinitely.
-

STATUTORY AUTHORITY: 39-A M.R.S.A. §§ 152, 315

EFFECTIVE DATE:

January 15, 1993 (EMERGENCY)

EFFECTIVE DATE OF PERMANENT RULE:

April 7, 1993

AMENDED:

November 27, 1994

EFFECTIVE DATE (ELECTRONIC CONVERSION):

April 28, 1996

NON-SUBSTANTIVE CORRECTIONS:

September 12 and October 9, 1996 - header added, "Sec." changed to §, spelling corrections, minor formatting.

AMENDED:

October 6, 1997 - Section 19.

May 23, 1999 - changes to Sections 4, 11, 14, Joint Scheduling Memorandum.

NON-SUBSTANTIVE CORRECTIONS:

October 26, 1999 - minor punctuation and formatting.

AMENDED:

November 20, 1999 - Sections 8 and 9(2).

September 29, 2002 - Section 1, filing 2002-359

NON-SUBSTANTIVE CORRECTIONS:

January 9, 2003 - character spacing, capitalization only.

AMENDED:

December 26, 2007 - Sec. 6(2)(B) added, filing 2007-531

October 11, 2009 - Sec 1(2) amended - fees increased; filing 2009-536

Appendix I: Joint Scheduling Memorandum

Appendix II: Exchange of Information Form

Appendix III: Limited Certificate Authorizing Written Release of Medical Health Care
Information Only

Chapter 12

APPENDIX I

Hearing Officer

STATE OF MAINE
WORKERS' COMPENSATION BOARD

v.

DOI

SSN

JOINT SCHEDULING MEMORANDUM

1. Name of each witness to be called to testify and the amount of time required for each witness' testimony:

Employee:

Employer:

2. Total amount of time required for hearing in ¼ hours: _____.

3. Affirmative defenses:

4. Section 312 examination: Yes No When: _____

I represent that I have conferred with opposing parties or their representatives in preparation of this Joint Scheduling Memo and they agree with the contents except as follows:

Dated:

Petitioner or Petitioner's Representative

Chapter 12
APPENDIX II

EXCHANGE OF INFORMATION FORM

Information the Employee Must Supply to the Employer

(Please respond to all questions that are relevant to the pending proceeding.)

Write on separate sheets of paper the following information in your own words. Make your answers as complete as you can and send them to the employer/insurance carrier.

1. Give your full name, age, and your level of education/training.
2. Describe the injury: the nature of the injury, how and when it happened, when you realized that the injury result from your work, who at work you told about the injury, and when you told that person.
3. Tell whether you have worked since the injury and, if so, when, where, and how much you earned.
4. Describe the medical treatment that you have received as a result of your work injury including the names and addresses of doctors, hospitals, and other health care providers you have seen because of this work injury.
5. Tell whether you ever injured the same body part before you injured it at work.

Tell whether you suffered any earlier injuries to any other parts of the body that have affected the part of your body that you injured at work. Tell whether you had any other medical conditions before you were injured at work.

If you have suffered any earlier injuries, or have any pre-existing medical conditions, you must write down when and how each earlier injured happened and the names and addresses of doctors and hospitals and any other health care providers that you saw because of that earlier injury or because of the earlier medical condition. You must also put down when the injury happened and how long you were treated for it.

6. State all periods of time during which you were or are either partially or totally unable to work since your injury.
7. Please state what your average weekly wage was when you were injured: how much did you earn each week?
8. Please tell whether you have any vocational training of any sort and please describe all jobs you have had, when you had them, and what your duties were, since you left school.
9. State whether you are asking to be reinstated to the job you were working at when you were injured or to another job for the same employer.
10. Please list all of your witnesses and give a short summary of their testimony.
11. Tell whether you have suffered any injuries since the date you say you were injured at work. If you have, you must write down when and how each injury happened and give the names and addresses of doctors and hospitals and any other health care providers that you saw because of those injuries.
12. Provide a brief description of your regular daily activities.
13. Tell whether you have engaged in any sports, recreational or home maintenance activities since you were injured at work. If you have, tell what sports or activities and when you took part in them.

EXCHANGE OF INFORMATION FORM

**Information Employer/Insurance Carrier
Must Supply to the Employee**

(Please respond to all questions that are
relevant to the pending proceeding.)

1. Supply any information you have about work available at the present time within the employee's limitations and within a reasonable distance from the employee's residence. State whether you have offered the employee his or her old position back or whether you have offered reinstatement to another position.
2. If you have offered to reinstate the employee to a position other than the employee's former position, state the title, duties and physical requirements of the new position.
3. State whether there are any jobs vacant at your establishment. If there are vacancies, please describe the job(s) and attach a copy of the job description. For each job you contend is unsuitable, explain why.
4. State whether the employer agrees that the employee has physical and/or mental limitations and the basis for your response. State whether the employer agrees that these limitations are related to the employee's work injury that is the subject of this claim and give the basis for your response.
5. State whether the employer has any evidence that the employee's reports of limitations or other history given to any person in this case is inaccurate and state the basis for that contention. Provide relevant documentary and written information.
6. Supply all relevant wage information including a wage statement and complete fringe benefit information. State what the employee's average weekly wage was at the time of the injury and supply wage statements for comparable employees if the petitioning employee was employed by you for less than 6 (six) months.
7. Supply a copy of the employee's personnel file.
8. State the legal name of your business, the number of employees it employs, and the nature of your operation.
9. List your witnesses and give a summary of their testimony.
10. Give the name(s) and the position(s) of the person(s) supplying this information.

CHAPTER 12
Appendix III

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE
OF MEDICAL / HEALTH CARE INFORMATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE: _____ ADDRESS: _____

DATE OF INJURY: _____ SOCIAL SECURITY NUMBER: _____

BRIEF DESCRIPTION OF BODY PART(S) INJURED: _____

EMPLOYER: _____ ADDRESS: _____

INSURER: _____ ADDRESS: _____

ATTORNEY: _____ ADDRESS: _____

I hereby authorize the above employer, insurer, or their attorney to obtain from any hospital, physician, osteopath, chiropractor, or other health care provider, after payment to the provider of a reasonable fee, any written information only which is or has been prepared in connection with my examination or treatment regardless of date which relates to my _____ (i.e. body part and/or condition) only. This certificate of authorization remains valid and must be honored for as long as I continue to make any claim for compensation, any compensation payment scheme remains in effect, or I receive compensation. This certificate of authorization does NOT permit the release of any information regarding psychological, substance abuse, sexually transmitted disease treatment, testing, or counseling and does NOT authorize oral communication with or by any health care provider.

EMPLOYEE SIGNATURE

DATE

NOTICE TO THE EMPLOYEE

YOU HAVE 20 DAYS FROM RECEIPT OF THIS CERTIFICATE TO SIGN AND RETURN IT TO THE EMPLOYER OR INSURER. FAILURE TO SIGN AND RETURN THIS CERTIFICATE MAY RESULT IN A SUSPENSION OF ACTIVITY ON YOUR CLAIM FOR COMPENSATION, OR IF YOU ARE CURRENTLY RECEIVING COMPENSATION, YOUR PAYMENTS OF COMPENSATION MAY BE SUSPENDED UNTIL YOU SIGN AND RETURN THIS CERTIFICATE.

THIS IS THE AUTHORIZED FORM FOR THE RELEASE OF MEDICAL AND RELATED INFORMATION UNDER THE MAINE WORKERS' COMPENSATION ACT AND IS INTENDED TO SUPPLEMENT THE RIGHTS TO SECURE MEDICAL INFORMATION SET FORTH BY TITLE 39-A OF THE MAINE REVISED STATUTES ANNOTATED AND CHAPTER 12, SECTION 18 OF THE BOARD'S RULES AND REGULATIONS.

THIS DOCUMENT MAY BE REPRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-220(4/96) DISTRIBUTION: COPY (1) INSURER, (2) EMPLOYER, (3) EMPLOYEE

CHAPTER 13 RESERVED

CHAPTER 14 REVIEW BY FULL BOARD

The rules of this chapter shall govern the procedures for obtaining a review of a hearing officer's decision by the Board pursuant to 39-A M.R.S.A. §320.

- § 1. A hearing officer may request the Board to review a decision of that hearing officer pursuant to 39-A M.R.S.A. §320 by filing Form 300 with the Board within 5 days of issuing a decision. A copy of the decision for which review is sought shall be attached to Form 300. The Board will distribute copies of the decision attached to Form 300 to all Board members within 5 working days of receipt of Form 300. The Board shall also distribute notice of the request for review to the Law Court.
- § 2.
1. Except as provided in paragraph 2 of this section, the Board shall vote to grant or deny a Request for Review Pursuant to 39-A M.R.S.A. §320 within 30 days after receipt of Form WCB-300.
 2. If a Motion for Findings of Fact and Conclusions of Law is filed after a Hearing Officer has requested review pursuant to 39-A M.R.S.A. §320, the Board shall vote to grant or deny a request for review pursuant to 39-A M.R.S.A. §320 within 30 days after receipt of the Hearing Officer's Decision on the Motion for Findings of Fact and Conclusions of Law.
 3. The vote shall be conducted during a public meeting of the Board. In voting to grant or deny a Request for Review Pursuant to 39-A M.R.S.A. §320, the Board shall only consider the decision from which review is sought, including a decision on a Motion for Findings of Fact, Form WCB-300, and, if requested by the Board, a summary provided by the Legal Division.
 4. Notice that the Board will vote on a request for review pursuant to Section 320 shall be accomplished as follows: The name of the case, along with an indication that the case is being reviewed pursuant to Section 320, shall be placed on the Board's agenda under the heading "General Counsel's report."
 5. The Board shall notify the hearing officer, parties, and the Law Court of the outcome of the vote of the Board.
 6. If a majority of the members of the Board vote to grant the review of the decision, the Chair of the Board shall order the preparation of the record.
- § 3. Responsibility for preparing the record shall be with the Board. The record shall consist of all evidence considered by the hearing officer in making the decision which is being reviewed by the Board. The record shall be prepared within 60 days of notice of the vote of the Board granting review of the decision. Copies of the record shall be distributed to the parties and to the panel members assigned by the Chair to review the decision. Upon completion of the record the Board shall issue a briefing schedule to the parties.

§ 4. Briefs.

1. Time for Filing Briefs.

The party or parties who received an unfavorable decision from the hearing officer shall be treated as the appellants. The other party or parties shall be treated as appellee(s). The appellant shall be given 30 days to file a brief. The appellee shall be given 20 days from receipt of the appellant's brief in which to file its brief. The appellant may file a reply brief within 15 days from receipt of the appellee's brief.

2. Additional Time to File Briefs.

Motions for extensions of time in which to file a brief shall be made in writing and filed with the Board. The motion shall be directed to the panel assigned to review the decision. Extensions for filing briefs shall only be granted in extraordinary circumstances.

3. Number of copies to be filed and served.

Ten copies of each brief shall be filed with the Board and one copy of each brief shall be served on counsel for each of the other parties separately represented. The Board will not accept a brief for filing unless it is accompanied by acknowledgment or certificate of service upon counsel for the other parties.

4. Form of Briefs.

A. Brief of Appellant.

The brief of the appellant shall contain under appropriate headings and in the order here indicated:

- (1) A table of contents, with page references, and a table of cases, statutes and other authorities cited.
- (2) A statement of the facts of the case.
- (3) A statement of the issues presented for review.
- (4) An argument. The argument may be preceded by a summary. The argument shall contain the contentions of the appellant with respect to the issues presented, and the reasons therefore, with citations to the authorities and particular pages of the record relied on.

B. Brief of the Appellee.

The brief of the appellee shall conform to the requirements of paragraph (A), except that a statement of the issues, or of the facts of the case, need not be made unless the appellee is dissatisfied with the statement of the appellant.

C. Reply Brief.

Any reply brief filed by the appellant must be strictly confined to replying to new matter raised in the brief of the appellee. No further briefs may be filed except by leave of the Board.

D. Format of Briefs.

Briefs may be reproduced by standard printing or by any duplicating or copying process capable of producing a clear black image on white paper. All printed matter must appear in at least 11 point type on opaque, unglazed paper. Briefs shall be bound in volumes having pages 8 1/2 X 11 inches and type matter not exceeding 6 1/6 X 9 1/2 inches, with double spacing between each line of text except for quotations. The front cover of the brief shall contain: (1) the docket number of the case as assigned by the Board; (2) the title of the case; (3) the title of the document (e.g., brief of appellant); and (4) the names and addresses of counsel representing the party on whose behalf the document is filed. The covers of the brief of the appellant shall be blue; that of the appellee, red; and that of any reply brief, gray.

STATUTORY AUTHORITY: 39-A M.R.S.A. §152, 320

EFFECTIVE DATE: January 15, 1993

EFFECTIVE DATE OF PERMANENT RULE: April 2, 1993

EFFECTIVE DATE (ELECTRONIC CONVERSION): April 28, 1996

NON-SUBSTANTIVE CORRECTIONS: September 12, 1996 --

header added, "Sec." changed to §, minor formatting.

AMENDED: August 22, 1998

NON-SUBSTANTIVE CORRECTIONS: November 23, 1998 -

"39A" changed to "39-A"; minor spelling and formatting.

AMENDED: July 24, 2000 - Section 2 Amendments

CHAPTER 15 PENALTIES

This chapter sets forth the delegation of authority to assess penalties under Title 39-A and specifies the procedures for assessing penalties.

§ 1. Place of Filing

Unless otherwise directed, all filings, responses to filings, position papers and correspondence relating to penalties and forfeitures under this chapter must be addressed to and filed with the Abuse Investigation Unit, Maine Workers' Compensation Board, 27 State House Station, Augusta, Maine, 04333-0027.

§ 2. Reserved

§ 3. Assessment of Penalties under 39-A M.R.S.A. § 205

1. Pursuant to 39-A M.R.S.A. § 152(7), the Maine Workers' Compensation Board delegates to the Executive Director or the Executive Director's designee the authority to assess penalties pursuant to Sections 205(3) and 205(4). Complaints under Section 205(3) may be filed by the Deputy Director of Benefits Administration or other interested party. Any interested party may file a complaint pursuant to Section 205(4).
2. For complaints involving Section 205(3), the Abuse Investigation Unit will obtain documentation of payments made pursuant to Sections 205(1) and 205(2). Parties will be given the opportunity to address, in writing, any issues regarding factual disputes prior to the imposition of a penalty.
3. After completion of the investigation, if it is determined that a violation has occurred, the Executive Director or the Executive Director's designee will issue an order assessing penalties as outlined in Section 205(3). The order will specify the factual findings upon which the penalty is based.
4. For complaints involving Section 205(4), the complaint must specify that there is no ongoing dispute regarding the claim for benefits and must include proof of service upon the insurance carrier, by certified mail, of notice of nonpayment of the medical bill in question. Parties will be given the opportunity to address, in writing, any issues regarding factual disputes prior to the imposition of a penalty.
5. After completion of the investigation, if it is determined that a violation has occurred, the Executive Director or the Executive Director's designee will issue an order assessing penalties as outlined in Section 205(4). The order will specify the factual findings upon which the penalty is based.

§ 4. Reserved

§ 5. Assessment of Sanctions and Forfeitures under 39-A M.R.S.A. §313

1. Pursuant to 39-A M.R.S.A. §152(7), the Maine Workers' Compensation Board delegates to the Executive Director or the Executive Director's designee and the Assistant Director of Mediation Services the authority to assess sanctions and forfeitures pursuant to Section 313.
2. The mediators will refer all recommendations for sanctions and forfeitures under Section 313 to the Assistant Director of Mediation Services. Referrals for sanctions and forfeitures must be in writing, must state the grounds for the referral, including the factual basis on which the referral is made, and must be served upon the party against whom the sanction or forfeiture is sought by certified mail, return receipt requested.
3. The Assistant Director will process all requests for penalties under Section 313(5) and is empowered to assess a forfeiture of \$100 against any employer or representative of the employee, employer or insurer for failure to be familiar with the claim or have full authority to make decisions regarding the claim. The Assistant Director is also empowered to impose a sanction against any party of up to \$100 under Section 313(4) for failure to attend a scheduled mediation.
4. All other Section 313(4) sanctions and any other forfeiture or sanction referral not falling within these prescribed categories will be referred for action by the Assistant Director to the Executive Director or the Executive Director's designee.
5. The Executive Director or the Executive Director's designee is empowered to impose sanctions under Section 313(4) which include assessment of costs and attorney's fees; reductions in attorney's fees; or suspension of proceedings until the moving party cooperates or produces the requested material. Where the facts warranted it, a hearing will be held prior to imposition of sanctions under Section 313(4).
6. Sanctions and forfeitures under both Section 313(4) and 313(5) will be imposed by written order. The order will specify the factual findings upon which the forfeiture or sanction is based.

§ 6. Assessment of Forfeitures under 39-A M.R.S.A. § 324(2)

1. Pursuant to 39-A M.R.S.A. § 152(7), the Maine Workers' Compensation Board delegates to the Executive Director or the Executive Director's designee the authority to assess forfeitures pursuant to Section 324(2) in amounts up to \$5000. The Board retains the authority to assess forfeitures in amounts greater than \$5000.

2. Procedures for assessment of forfeitures.

- A. Any party in interest may file a Petition for Forfeiture with the Abuse Investigation Unit pursuant to 39-A M.R.S.A. § 324(2)(A). A copy of the petition must be served by certified mail, return receipt requested, to the other parties named in the petition. A copy of the petition must be served upon the employer, employers' insurer or group self-insurer.
- B. No response to a petition filed under subsection A is required. It will be presumed by the Abuse Investigation Unit that all allegations are denied.
- C. The Abuse Investigation Unit will investigate the allegations contained in the Petition for Forfeiture. As part of its investigation, the Abuse Investigation Unit shall require any and all interested parties to submit written evidence concerning the petition, including but not limited to position papers, depositions and affidavits. The Abuse Investigation Unit will set forth a schedule for the submission of such evidence by the parties. Absent extraordinary circumstances, no testimonial hearing will be held.
- D. The moving party's failure to file requested documentation by the date specified by the Abuse Investigation Unit or to request and receive an extension in a timely fashion, shall result in the dismissal of the petition. Failure by the defending party to file requested documentation by the date specified, or to request and receive an extension in a timely fashion, shall result in the allegations submitted in the petition being accepted as true and a forfeiture being assessed based on these accepted facts. Absent extraordinary circumstances, no more than one extension of time will be granted.
- E. Voluntary dismissal of a Petition for Forfeiture at the moving party's request or by settlement agreement will not preclude the Abuse Investigation Unit from recommending the assessment of a forfeiture payable to the Workers' Compensation Board Administrative Fund pursuant to Section 324(2)(A)(1).
- F. Upon completion of its investigation, the Abuse Investigation Unit will provide the deciding authority with a recommended disposition of the case, which may include a suggested forfeiture amount. The deciding authority will review the recommendation as well as the parties' contentions and will issue an order either granting, denying or dismissing the petition. The Executive Director or the Executive Director's designee is the deciding authority on recommended forfeiture amounts of up to \$5000. Recommendations for forfeitures over \$5000 will be reviewed by the Workers' Compensation Board as the deciding authority.

- G. Orders assessing forfeitures will be based upon the results of the investigation and the written submissions of the parties. For purposes of determining whether a forfeiture will be assessed, circumstances beyond a party's control normally will not include turnovers in staff or problems with data processing systems which are of a short duration. In determining the amount of an assessed forfeiture, consideration will be given to prior forfeiture orders issued against the same party for similar offenses.
- H. If a petition is granted, attorneys fees in the amount of up to \$500, plus reasonable costs associated with the petition, will be awarded pursuant to Section 324(2)(A)(2).

§ 7. Assessment of Penalties under 39-A M.R.S.A. §324(3)

- 1. Pursuant to 39-A M.R.S.A. §152(7), the Maine Workers' Compensation Board delegates to the Workers' Compensation Board Abuse Investigation Unit the authority to recommend the imposition of penalties pursuant to Section 324(3) and delegates to the Executive Director or the Executive Director's designee the authority to assess civil penalties, after hearing, pursuant to Section 324(3).
- 2. The Deputy Director of Benefits Administration will report all instances of noncompliance with Sections 401 and 403 of the Act to the Abuse Investigation Unit, who will investigate the report of noncompliance.
- 3. Upon completion of the investigation, the Abuse Investigation Unit may refer the matter to the Executive Director or the Executive Director's designee for hearing and will notify the subject of the investigation of the referral. Hearings will be held in accordance with the provisions of Section 10.4 of these rules.
- 4. In addition to referral to the Executive Director or the Executive Director's designee for hearing, the Abuse Investigation Unit may pursue any of the sanctions contained in Section 324(3) where appropriate.

§ 8. Assessment of Penalties under 39-A M.R.S.A. §359(2)

- 1. Pursuant to 39-A M.R.S.A. §152(7), the Maine Workers' Compensation Board delegates to the Workers' Compensation Board Abuse Investigation Unit the authority to recommend the imposition of penalties pursuant to Section 359(2). The Board designates the Executive Director, or a Hearing Officer appointed by the Executive Director, to be the Presiding Officer for hearings conducted pursuant to this rule. The Presiding Officer shall have the authority to assess civil penalties, after hearing, pursuant to Section 359(2).

2. Any party in interest may file a Section 359(2) complaint with the Abuse Investigation Unit. The Abuse Investigation Unit may also initiate action, either on its own, or on referral from the Monitoring, Audit, and Enforcement (MAE) Program. The Abuse Investigation Unit will investigate all complaints and, as part of the investigation, may require the parties to submit written evidence concerning the complaint or complaints, including position papers.
3. Upon completion of the investigation, the Abuse Investigation Unit will determine whether the allegations, if true, demonstrate that an employer, insurer, or 3rd-party administrator for an employer has engaged in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims. For purposes of this rule, a claim is unreasonably contested if there is no articulable basis for contesting the claim, or the claim is contested upon a basis that is contrary to law or rule.
4. If so, the subject of the investigation will be notified that the matter is being referred for hearing and possible imposition of civil penalties. If not, further investigation under Section 359(2) will be denied.
5. The Presiding Officer will schedule and hold a hearing in referred cases. The Presiding Officer will issue a hearing order to the parties concerning the procedure to be followed before and during the hearing, including the submission of additional evidence and the filing of motions. In cases where a party is alleging that an employer, insurer, or 3rd-party administrator for an employer has engaged in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims, the burden will be upon the complaining party to prove its contentions. In cases where there is no specific complaining party, the Abuse Investigation Unit will present evidence acquired by the investigation. In all cases, the Presiding Officer will actively participate to ensure that all relevant information is considered prior to issuing findings. If necessary, the Presiding Officer may request further investigation by the Abuse Investigation Unit if circumstances warrant.
6. To prevail, the moving party must show by a preponderance of the evidence that an employer, insurer, or 3rd-party administrator for an employer has engaged in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims.
7. In cases where there is a finding that an employer, insurer, or 3rd-party administrator for an employer has engaged in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims, the Presiding Officer, in determining the amount of penalty to be assessed, shall consider the severity of the offense, and any previous adverse determinations under Section 359(2) against the employer, insurer, or 3rd-party administrator for an employer.

8. All findings and conclusions shall issue in a written order. Decisions rendered by the Presiding Officer shall be appealable to the Law Court as provided in 39-A M.R.S.A. §322.
9. All decisions rendered by the Presiding Officer shall be presented to the Board. The Board shall certify its findings to the Superintendent of Insurance. This certification by the Board is exempt from the provisions of the Maine Administrative Procedure Act.

§ 9. Assessment of Penalties under Section 360(1)

1. Pursuant to 39-A M.R.S.A. § 152(7), the Maine Workers' Compensation Board delegates to the Executive Director or the Executive Director's designee the authority to assess penalties pursuant to Section 360(1).
2. Any party in interest, including the Deputy Director of Benefits Administration or other interested party, may file a complaint under Section 360(1) with the Abuse Investigation Unit. The complaint must be in writing, must state the grounds for assessment of the penalty, including the factual basis on which the complaint is based, and must be served upon the party against whom the penalty is sought.
3. The party against whom the penalty is sought may respond to the complaint within 10 days of receipt of the complaint. Responses should be limited to addressing the factual issues invoked, and may include relevant exhibits.
4. After review of the submissions and the results of any investigation, the Executive Director or the Executive Director's designee will issue an order either assessing a penalty or dismissing the complaint.

§ 10. Assessment of Penalties under Section 360(2)

1. Pursuant to 39-A M.R.S.A. §152(7), the Maine Workers' Compensation Board delegates to the Workers' Compensation Board Abuse Investigation Unit the authority to recommend the imposition of penalties pursuant to Section 360(2) and delegates to the Executive Director, or a Hearing Officer appointed by the Executive Director, the authority to be the Presiding Officer for hearings conducted pursuant to this rule. The Presiding Officer shall have the authority to assess civil penalties, after hearing, pursuant to Section 360(2).
2. Any party in interest, including any deputy director or assistant director of the Workers' Compensation Board, may file a Section 360(2) complaint with the Abuse Investigation Unit. The Abuse Investigation Unit will investigate all complaints and, as part of the investigation, may require parties to submit written evidence concerning the complaint, including position papers.

3. Upon completion of the investigation, the Abuse Investigation Unit will determine whether the allegations, if true, rise to the level of willful violation, fraud or intentional misrepresentation. If so, the subject of the investigation will be notified that the matter is being referred for hearing and possible imposition of civil penalties. If not further investigation under Section 360(2) will be denied.
4. The Presiding Officer will schedule and hold a hearing in referred cases. The Presiding Officer will issue a hearing order to the parties concerning the procedure to be followed before and during the hearing, including the submission of additional evidence and the filing of motions. In cases where there are opposing parties, the burden will be upon the complaining party to prove its contentions, however, the Presiding Officer will actively participate to ensure that all relevant information is considered prior to issuing findings. In cases where there is no specific complaining party, the Abuse Investigation Unit will present evidence acquired by the investigation. If necessary, the Presiding Officer may request further investigation by the Abuse Investigation Unit in a case of circumstances warrant it.
5. The standard for determining whether a willful violation of the Act or intentional misrepresentation has occurred is by preponderance of the evidence. In the case of fraud, the standard is one of clear and convincing evidence.
6. In determining whether to assess a penalty or the amount to be assessed, the Presiding Officer will consider the severity of the offense, whether it is a repeated offense, and the amount of money at issue. The lack of a prior offense will not be a mitigating factor in determining the amount of the penalty assessed. Penalty amounts are limited to 50% of the monies at issue up to the statutory cap.
7. In considering whether to order the repayment of benefits wrongfully received, the Presiding Officer will consider the severity of the offense and will accept and consider evidence of financial ability to repay.
8. All findings and conclusions will issue in a written order. This order will constitute final agency action which is appealable in Superior Court.

EFFECTIVE DATE:

June 29, 1995 (EMERGENCY)

EFFECTIVE DATE:

October 29, 1995

EFFECTIVE DATE (ELECTRONIC CONVERSION):

April 28, 1996

NON-SUBSTANTIVE CORRECTIONS:

September 12, 1996 -- header added, "Sec." changed to §, minor spelling and formatting.

AMENDED:

May 23, 1999 - Section 8 added, § reverted to Sec.

NON-SUBSTANTIVE CORRECTIONS:

October 26, 1999 - minor punctuation and formatting.

AMENDED:

October 25, 2000 - Amendments to Secs. 5, 7, & 10 (DDDR references changed).

September 30, 2007 – Amendments to Secs. 3, 6, & 9 (ED designee)/Filing 2007-418

CHAPTER 16 CONFIDENTIALITY OF FILES

Pursuant to 39-A M.R.S.A. Sec. 152(2), these rules establish procedures to safeguard the confidentiality of the records of the former Workers' Compensation Commission and the Workers' Compensation Board pertaining to individual injured employees.

§ 1. Records

Records of the former Workers' Compensation Commission and Workers' Compensation Board providing a basis for identification of injured employees through name, address, social security or like means of identification are confidential and available on a need-to-know basis.

§ 2. Need-to-Know

For purposes of this rule, "need-to-know basis" shall include, but is not limited to, the following:

1. An injured person gives written authorization for disclosure;
2. An injured person asserts a claim and an employer or insurer potentially subject to liability for the claim requests disclosure directly or through an attorney or other agent;
3. A person asserts a workers' compensation claim, or asserts a claim through civil or other litigation and any other person or insurer potentially subject to liability for the claim requests disclosure directly or through an attorney or other agent;
4. A person, insurer, employer, or other involved party is the subject of a public agency investigation or prosecution for fraud or other impropriety, whether civil or criminal;
5. A hearing officer, mediator, arbitrator, an appointed or agreed upon Section 312 independent medical examiner with proper notification, or other employee of the Board requests records for the purpose of administering and decision-making under the Act;
6. A hearing officer, mediator, or arbitrator, or the General Counsel upon request, rules that disclosure is appropriate for any other reason, including the potential relevance of such records to a claim or proceeding, or the likelihood that such records may reasonably be expected to lead to relevant evidence. Any such ruling may limit further disclosure by a recipient as appropriate; or
7. Access is required by Maine or Federal statute, regulations, or court order.

§ 3. Methods for Requesting Information

The Workers' Compensation Board will release no individual identification information contained in individual injured workers files to individuals that do not meet the

need-to-know standard in Section 2. Individual identifying information includes name, social security number, claim, or employee number. If the request is made in person or over the telephone, and the individual is unknown to staff or the need-to-know is not established, a written request will be required. The written request shall state the relationship of the requesting party to the case, the specific information requested, and any other information the party believes helpful in establishing "need-to-know" as defined by these regulations. The written request shall become part of the individual file.

§ 4. Legitimate Research Purposes

1. Records of the former Workers' Compensation Commission and the Workers' Compensation Board which do not require the identification of individual injured employees are available for legitimate research purposes. For purposes of these rules, legitimate research purposes are defined as a study undertaken for academic purposes or by a bona fide organization or representative of an organization to discover facts, establish principles, review processes or evaluate outcomes regarding the administration and operations of activities relating to the workers' compensation system.
2. Public Access for Legitimate Research Purposes
 - A. Request to access the Workers' Compensation Board database for legitimate research purposes will be made in writing to the General Counsel who will review the request with appropriate staff to determine if:
 - (1) The request complies with applicable statutes and Workers' Compensation Board regulations;
 - (2) The request is technically feasible;
 - (3) The Workers' Compensation Board resources needed to comply with such a request are available without jeopardizing ongoing operations.
 - B. If the request seeks access to individual injured employee files, the need-to-know standard must also be met.
 - C. For requests needing technical assistance and support from Board staff, the General Counsel may prioritize or deny staff support and assistance for legitimate research proposals based on limited agency resources, higher Workers' Compensation Board data priorities, duplicative efforts, or other reasonable and stated reasons. This standard does not apply to requests based on a need-to-know basis, which will be complied with in all instances where the need-to-know standard is met.

- D. Individuals who are denied access may appeal the General Counsel's decision to the Workers' Compensation Board who must respond within 30 days.
- E. The Executive Director may enter into agreements with the Bureau of Insurance, Maine Department of Labor, and other appropriate state governmental agencies which allow access to the Workers' Compensation Board database for research purposes as long as the Board's requirements for confidentiality of individual files are maintained. Failure to maintain the standard may result in the revocation of access.

§ 5. Sensitive Records

Absent a ruling pursuant to Section 2, subsection 6 or a written authorization by an employee, "need-to-know" does not include the following:

1. Information designated confidential by any other State or Federal statute or regulation; or
2. Information sealed during the dispute resolution process by a Hearing Officer on his or her own motion or at the request of a party. Such information may include records relating to: abortion, AIDS or HIV test results and treatment, mental deficiency, or disease, substance abuse test results and treatment or sexually transmitted diseases.

- § 6. All Workers' Compensation Board and former Workers' Compensation Commission records not declared confidential are public records. Public records include, but are not limited to, Board decisions, transcripts of testimony, and exhibits admitted into evidence.

CHAPTER 16 EFFECTIVE DATE: June 20, 1995

CHAPTER 17 RESERVED

**CHAPTER 18 EXAMINATIONS BY IMPARTIAL PHYSICIAN(S) PURSUANT
TO 39-A M.R.S.A. SEC. 611**

§ 1. Administration

The Workers' Compensation Board delegates authority for administration of 39-A M.R.S.A. § 611 to the Deputy Director of Medical/Rehabilitation Services.

§ 2. Date of Injury

This Chapter is promulgated pursuant to 39-A M.R.S.A. § 611. It shall apply to all requests for appointment of an impartial physician under Section 611 on or after the effective date of this Chapter, regardless of the employee's date of injury.

§ 3. Assignment of Impartial Physician

1. Any party, including Hearing Officers, may request an examination by an impartial physician in a case involving occupational disease.
2. The request shall be submitted to the Deputy Director of Medical/Rehabilitation Services.
3. The Deputy Director of Medical/Rehabilitation Services shall verify that the claim involves occupational disease as defined by 39-A M.R.S.A. § 603 and determine the applicability under 39-A M.R.S.A. § 611.
4. If the Deputy Director of Medical/Rehabilitation Services determines that the claim does not conform to the definition of occupational disease according to 39-A M.R.S.A. § 603, the request shall be denied and the parties notified.
5. If the disease is deemed to conform to the definition in Section 603, the Deputy Director of Medical/Rehabilitation Services may consult with an expert in occupational diseases to determine an appropriate physician or physicians with the expertise to perform the examination depending on the particular occupational disease involved in the request.
6. The Deputy Director of Medical/Rehabilitation Services shall have the authority to schedule the appointment with an out of state physician whenever appropriate.
7. The parties shall submit any medical records or other pertinent information to the examiner a minimum of seven (7) days prior to a scheduled examination. The medical records shall be in chronological order or chronologically by provider and accompanied by an index.
8. The appointed physician shall examine the employee, inspect the industrial conditions under which the employee has worked and review submitted medical records to properly determine the nature, extent and probable duration of the

occupational disease. In the medical findings, the physician shall include the likelihood of the origin of the disease in the employee's work place and the date of incapacity.

9. Upon completion of the final examination, the examiner shall submit a written report to the employee, employer and the Office of Medical/Rehabilitation Services no later than fourteen (14) days after completion of the examination.
10. The fee for the examination shall be submitted to the Deputy Director Office of Medical/Rehabilitation Services for review and determination of reasonableness. After review, the bill shall be forwarded to the employer and payment shall be made within thirty (30) days of receipt.
11. The Deputy Director of Medical/Rehabilitation Services may order an autopsy be performed when a claim is made for death due to occupational disease taking into consideration the sensitivities of the family, religious attitudes, and normal human feeling against exhumation of remains when making the decision.

§ 4. Expenses and Fees for Employees Attending a Board Appointed Examination

1. Expenses incurred by the employee attending a Board appointed examination pursuant to Section 611 are to be paid for by the employer. The following rates of reimbursement shall apply for travel:
 - A. \$.44 per mile for mileage reimbursements.
 - B. Actual costs or a maximum of \$120.00 per evening for overnight lodging. Reimbursement for overnight lodging is allowed only when the employee has traveled 100 miles or more, one way, from the employee's place of residence.
 - C. \$6.00 for breakfast, \$6.00 for lunch, and \$16.00 for dinner. Reimbursement for meals is allowed only when the employee has traveled 50 miles or more, one way, from the employee's place of residence.
 - D. Actual charges for tolls, accompanied by a receipt.
 - E. Employees may be advanced funds to cover the expenses of travel by making a request to the employer. The employer shall make every effort to honor such requests in a timely manner.

STATUTORY AUTHORITY:

39-A M.R.S.A. §§ 152(2) and 611

EFFECTIVE DATE:

July 14, 1996

NON-SUBSTANTIVE CORRECTIONS:

January 9, 2003 - character spacing only.

AMENDED:

October 11, 2009 - Sec 4(1) & (2) - increased fees; filing 2009-537

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AMENDED 2/2/2010

G. COORDINATION WITH OTHER AGENCIES

The Board has been active its effort to coordinate and collaborate with other state and federal agencies.

An example of this effort is the Board's merging of its employer database to the Department of Labor's (DOL) database. For years, the agencies operated with separate databases which was inefficient and resulted in unnecessary work. Information that was updated on one system, for example, would not always be updated on the other system. Now, with the two databases merged, the Board can more accurately identify employers without coverage. Efforts are currently underway to coordinate other employer databases into one.

The Board also collects a significant amount of data on its forms to assist the Bureau of Labor Standards (BLS) in its task of producing statistical reports. An example of the Board's responsiveness in this area involves a form titled "Statement of Compensation Paid." At the request of BLS, for more detailed information, the Board implemented the requested changes.

The same holds true for the Occupational Safety and Health Administration (OSHA). Maine is currently one of the few states in the nation that captures OSHA required data on its First Report of Injury form. Therefore, Maine's employers only have to complete one form to meet both state and federal requirements. This has substantially reduced the paperwork burden on Maine's employers.

The Board collaborates with the Bureau of Insurance (BOI) for its annual assessment. BOI provides information on premiums written, predictions on market trends, and paid losses information for self-insured employers, which is utilized by the Board to calculate the annual assessment.

The Monitoring, Auditing, and Enforcement (MAE) Unit works directly with BOI on compliance and enforcement cases pursuant to 39-A M.R.S.A. § 359(2). The WCB certifies and forwards to BOI cases which involve questionable claims handling techniques or repeated unreasonable contested claims for appropriate action by BOI.

The Occupational Safety and Health Data Collection and Injury Prevention Group was formed in response to P.L. 2003 Ch. 471 to review various data collection and injury prevention efforts and to make recommendations to the Labor Committee. The Bureau of Labor Standards has coordinated this effort with assistance from the Workers' Compensation Board.

A coordinated effort is underway with Bureau of Information Services to upgrade the WCB's computer hardware and software. Upgrades include desktops, network servers, database server, network hubs, and a routed network. Major programming changes are underway and will continue into the foreseeable future.

The Board works with the Department of Health and Human Services (DHHS) to assist DHHS in recovering past due child support payments and to ensure that MaineCare is not paying for medical services that should be covered by workers' compensation insurance.

Pursuant to P.L. 2007 Ch. 311, the Board works with MaineCare to insure it receives appropriate reimbursement and notifies the Department of Health and Human Services within 10 days of an approved agreement or an order to pay compensation.

The Workers' Compensation Board has two representatives on the Governor's Task Force on Employee Misclassification which will certainly result in greater agency coordination and collaboration.

H. CONSTITUENCY SERVED BY THE BOARD, CHANGES OR PROJECTED CHANGES

The constituencies served by the Board are clearly identified in its Mission Statement found at 39-A M.R.S. § 151-A, which reads as follows:

The board's mission is to serve the **employees** and **employers** of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation.

There are no anticipated or projected changes leaving the constituencies served by the Board as the "employees" and "employers" of the State.

I. ALTERNATIVE DELIVERY SYSTEMS

The 121st Maine Legislature enacted legislation that required the Workers Compensation Board (WCB) to adopt rules mandating electronic filing. The legislation directed the Board to proceed by way of consensus based rulemaking. A committee was formed consisting of representatives from the insurance companies, self insureds, WCB Directors and staff. Recommendations were forwarded to and unanimously approved by the Board of Directors.

The WCB agreed on a three-phase project. First Reports of Injury and Denial submissions are currently being implemented as directed in the legislation. The WCB is currently engaged in completing the remaining payments phase. An internal group is near completion for the Trading Partner Tables which will provide a roadmap of the various payment functions and time frames required for each business event. The next step is to get shareholder review and comment before programming the necessary functions. The carriers require at least 12 months once the State's specifications are posted before they can initiate a test. Additionally, WCB Rules will be updated to take advantage of the new process. Testing is estimated to begin the Fall of 2010.

The WCB has also implemented the capability for insurers to electronically submit Proof of Coverage (POC) filings for employers. The WCB Rule for mandatory submission of POC was effective on August 22, 2009.

J. EMERGING ISSUES FOR THE BOARD

I. FACILITY FEE SCHEDULE.

In 2007, Maine WCB contracted with Ingenix to facilitate the creation of a facility fee rule for hospital inpatient, outpatient and ambulatory surgical care. After four meetings of the consensus-based rulemaking group, they were able to agree on a modified Medicare methodology because it is relatively transparent and widely understood, but they were unable to agree on several issues, including the base rate. The Board went to public hearing on August 17, 2009, and the deadline for written comments was August 27, 2009.

The goal of the facility fee schedule is to: reduce inequities in the system; eliminate bottlenecks and inefficiencies; ensure providers are paid fairly; create a system that payers can manage while producing the lowest rational cost system wide; and create clarity in rules and simplicity for maintenance.

The Board held a public hearing on Chapter 5 on August 17, 2009. During the public comment timeframe, there was data submitted which raised a number of questions. In order to respond to the public comments, the Board requested additional data from the Maine Health Data Organization. MHDO was unable to supply the data in a timely fashion, so the Board is attempting to obtain the data from OnPoint Health. The Board had until December 24th to take final action on the proposed changes to Chapter 5. Because no action was taken by that date, the timeframe for implementing the proposed fee schedule expired. As soon as the data is received from MHDO or OnPoint Health, Ingenix will provide its analysis, and the Board will propose a new fee schedule.

The Board anticipates that the rule will generate significant savings with respect to these medical costs. A safety net is built in to have Ingenix analyze the facility fee rule one year after implementation to identify savings or correct any negative impact.

II. LEGISLATIVE ACTIVITY.

Legislative initiatives for the Second Regular Session of the 124th Maine Legislature include bills that will ensure that penalties for not maintaining required workers' compensation coverage apply equally to all business entities; will enhance the Abuse Unit's ability to coordinate enforcement with other agencies; and, a bill that will reverse the Law Court's holding in *Nichols v. S.D. Warren*.

In the *Nichols* case, the Law Court held that a life insurance policy which had a disability feature was a wage continuation plan subject to an offset against workers' compensation benefits. The proposed legislation would clarify that such policies are not subject to offset.

The Board is also working to implement P.L. 2009, Ch. 452 (LD 1456). This Act creates a new definition of independent contractor for the construction industry. The Act aims to ensure that all construction workers are appropriately covered by workers'

compensation insurance. As part of its effort to implement Ch. 452, the Board, with the assistance of several interested parties, revised the application that is used to request a predetermination of independent status. The Board has also created a website where individuals can go to ascertain if specific employers have coverage or are self-insured.

III. DATA GATHERING - 39-A M.R.S. § 213.

The Board is studying whether and how to gather additional data to comply with the mandate contained in Section 213. A pilot project with MEMIC and BIW was successfully completed and a request has been sent to insurers to forward the data to the Board within 90 days. A report from Practical Actuarial Solutions has also been sent to Senator Peter Mills in regard to Section 213 considering whether to eliminate the threshold and extend weekly benefits.

IV. EMPLOYEE MISCLASSIFICATION.

The Workers' Compensation Board recommended to the Labor Committee and the Governor's Task Force that the Task Force consider the possibility of creating an Employee Misclassification Unit and determine whether this would lead to increased revenues and decreased premiums.

K. ANY OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION

- I. Additional information was requested dealing with 39-A M.R.S. § 213. A copy of the response is included in this section of the Report as Attachment I.
- II. Additional information was requested dealing with Public Law 2009 Chapter 452 (An Act To Ensure That Construction Workers Are Protected by Workers' Compensation Insurance). A copy of the Report is included in this section as Attachment II.



JOHN ELIAS BALDACCI
GOVERNOR

STATE OF MAINE
WORKERS' COMPENSATION BOARD
OFFICE OF EXECUTIVE DIRECTOR/CHAIR
DEERING BUILDING, AMHI COMPLEX
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

ATTACHMENT KI.

PAUL R. DIONNE
EXECUTIVE DIRECTOR/CHAIR

January 5, 2010

Senator Peter Mills
PO Box 9
Skowhegan ME 04976

3 State House Station
Augusta ME 04333-0003

Dear Senator Mills:

As per your request, we have asked Practical Actuarial Solutions, Inc. to review data pertaining to Section 213 of the Maine Workers' Compensation Act. The purpose of the review was to provide an estimate of a single benefit duration limit which would be revenue neutral when compared to the current cost of benefits paid under Section 213.

I have enclosed a copy of a letter from Practical Actuarial Solutions, Inc. that attempts to make the comparison and arrive at a revenue neutral situation. As you will ascertain from the letter, such a comparison is both complex and difficult. The difficulties arise, as stated in the letter, from "the slow rate with which permanent impairment ratings are promulgated, the uncertainty as to the actual as opposed to the maximum duration of claims, and the difficulty of determining how the elimination of the permanent impairment rating would offset lump sum benefits."

I, along with staff, will gladly meet with you to further discuss the contents of the letter and the potential for bringing about a solution to this difficult situation.

Sincerely,

Paul R. Dionne
Executive Director/Chair

PRD/llm

CC: Workers' Compensation Board Members & Sr. Staff
TEL: 207-287-7086
or toll-free within Maine:
1-888-801-9087

TTY: 877-832-5525

FAX: 207-287-7198



Report to the Committee on Labor

Pursuant to P.L. 2009, Ch. 452

**An Act To Ensure That Construction Workers Are Protected by
Workers' Compensation Insurance**

**Submitted by:
Maine Workers' Compensation Board
December 15, 2009**

REPORT TO THE JOINT STANDING COMMITTEE ON LABOR

December 15, 2009

P.L. 2009, Ch. 452 states that "(B)y December 15, 2009, the Workers' Compensation Board and the Department of Labor shall report to the Joint Standing Committee on Labor any recommended changes to the provisions established by this Act and the resources required by the board and the department, if any, for implementation of this Act. After receipt and review of the report, the joint standing committee may report out a bill to the Second Regular Session of the 124th Legislature."

On January 14, 2009, the Governor issued an Executive Order to establish a Joint Enforcement Task Force on Employee Misclassification. The purpose of the Task Force is to coordinate the investigation and enforcement of employee misclassification matters. As part of that effort, and in conjunction with P.L. 2009, Ch. 452, the Workers' Compensation Board is making the following recommendations to assist the Task Force.

I. Workers' Compensation Board Resources and Options.

There are a number of options available to the Maine Workers' Compensation Board in regard to the implementation of Chapter 452 and its coordination with the Governor's Task Force. We have outlined both the "options" and the "consequences" for the Labor Committee's consideration. It is our strong recommendation that any major changes be referred to the Governor's Task Force so there might be a coordinated effort in regard to the issue of "Employee Misclassification."

A. Maintain Status Quo.

Consequences:

1. No additional costs to the Maine Workers' Compensation Board budget.
2. No increase in identifying employers without workers' compensation insurance.
3. Consider mandating workers' compensation coverage for all construction contractors and increasing 14-day timeline in §105(3) to 30 or 45 days.

B. Reclassify Positions.

1. Reclassify two Workers' Compensation Specialists from Range 24-8 to Range 27-8 to have investigator authority and to present their findings before a Maine Workers' Compensation Board Hearing Officer to ensure compliance.
2. Reclassify Secretary Legal from Range 13-8 to Paralegal Range 20-8 to conduct legal research and related responsibilities.

Consequences.

1. Minimal impact on allocation.
2. Increase in prosecution of no coverage cases.
3. Likely to impact other AIU cases.
4. No increase in head count.
5. Consider mandating workers' compensation insurance for all construction contractors and increasing 14-day timeline in §105(3) to 30 or 45 days.

C. Reallocation of Positions.

Reallocate two Advocate Positions from the Maine Workers' Compensation Board Advocate Program and reclassify the three above positions. Utilize Mediators to process predeterminations.

Consequences.

1. Minimal impact on allocation.
2. No increase in head count.
3. Greater increase in prosecution of no coverage cases.
4. Likely to impact other AIU cases.
5. Consider mandating workers' compensation insurance for all construction contractors and increasing 14-day timeline in §105(3) to 30 or 45 days.

II. Task Force Resources and Options.

Consider the creation of an Employee Misclassification Unit.

Consequences.

1. Create a minimum of six new positions.
2. Significant additional costs (\$515,330).
3. Significant increase in compliance.
4. Revenue enhancements and cost reductions.
 - (a) Maine Revenue Services.
 - (b) Department of Labor, Unemployment Insurance.
 - (c) Support Enforcement.
 - (d) Premium Revenues and Reductions.

Attached are appendices reflecting the Proposed Costs, a Proposed Flow Chart, and a Maine Workers' Compensation Board Personnel Chart.

The Workers' Compensation Board recommends that the Labor Committee request that the Governor's Task Force consider the feasibility of creating an Employee Misclassification Unit and determine whether this would lead to increased revenues and decreased premiums.

Proposed Employee Misclassification Flow Chart Maine Workers' Compensation Board 12-11-2009

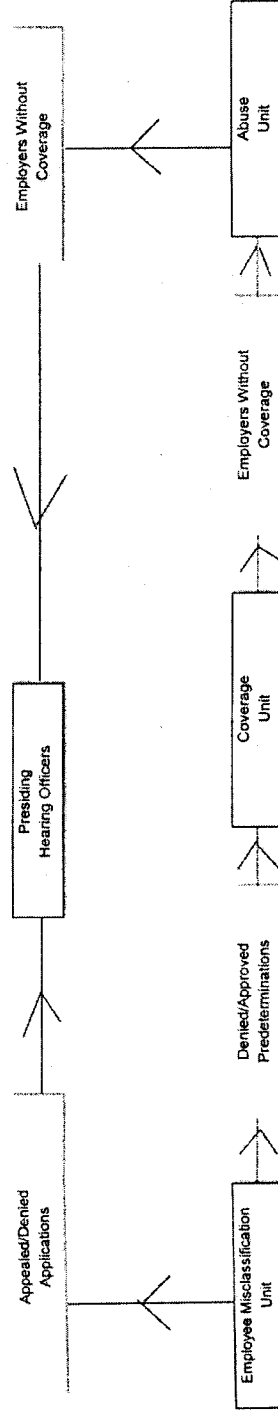
Office of Monitoring, Audit and Enforcement
Proposed Misclassification Unit

- Proposed MA II
- Proposed Auditor III
- Proposed Auditor II
- Proposed Auditor II
- Proposed Administrative Assistant

Abuse Investigation Unit

Assistant to the General Counsel

- WC Specialist
Proposed Reclass
- WC Specialist
Proposed Reclass
- Secretary Legal
Proposed reclass to Paralegal
- Advocate Position
- Advocate Position
- Proposed Paralegal



Proposed Cost

12/11/2009

Personal Services

New MA II (24-8)
New Auditor III (25-8)
New Auditor II (23-8)
New Auditor II (23-8)
New Admin Assistant (20-8)

78,604
83,169
72,818
72,818
63,907

Personal Services

Reclass WC specialist
Reclass WC specialist
Reclass Secretary Legal to Paralegal
New Paralegal (20-8)

5,824
5,824
10,121
67,245

Total

371,316

Total

89,014

All Other

training (\$250 ea)
travel (100 ea)
rent (1,000 for both units)
Insurance (150 ea)
general office (100 ea)
telephone (\$50 per month ea)
computer \$150 per month ea)
printer (2,000)
office supplies (100 ea)
equipment (\$2,900 ea)

750
300
7,500
450
300
1,800
5,400
2,000
300
8,700

All Other

training (\$250 ea)
travel (100 ea)
rent (1,000 for both units)
Insurance (150 ea)
general office (100 ea)
telephone (\$50 per month ea)
computer \$150 per month ea)
printer (2,000)
office supplies (100 ea)
equipment (\$2,900 ea)

750
300
7,500
450
300
1,800
5,400
2,000
300
8,700

Total

27,500

Total

398,816

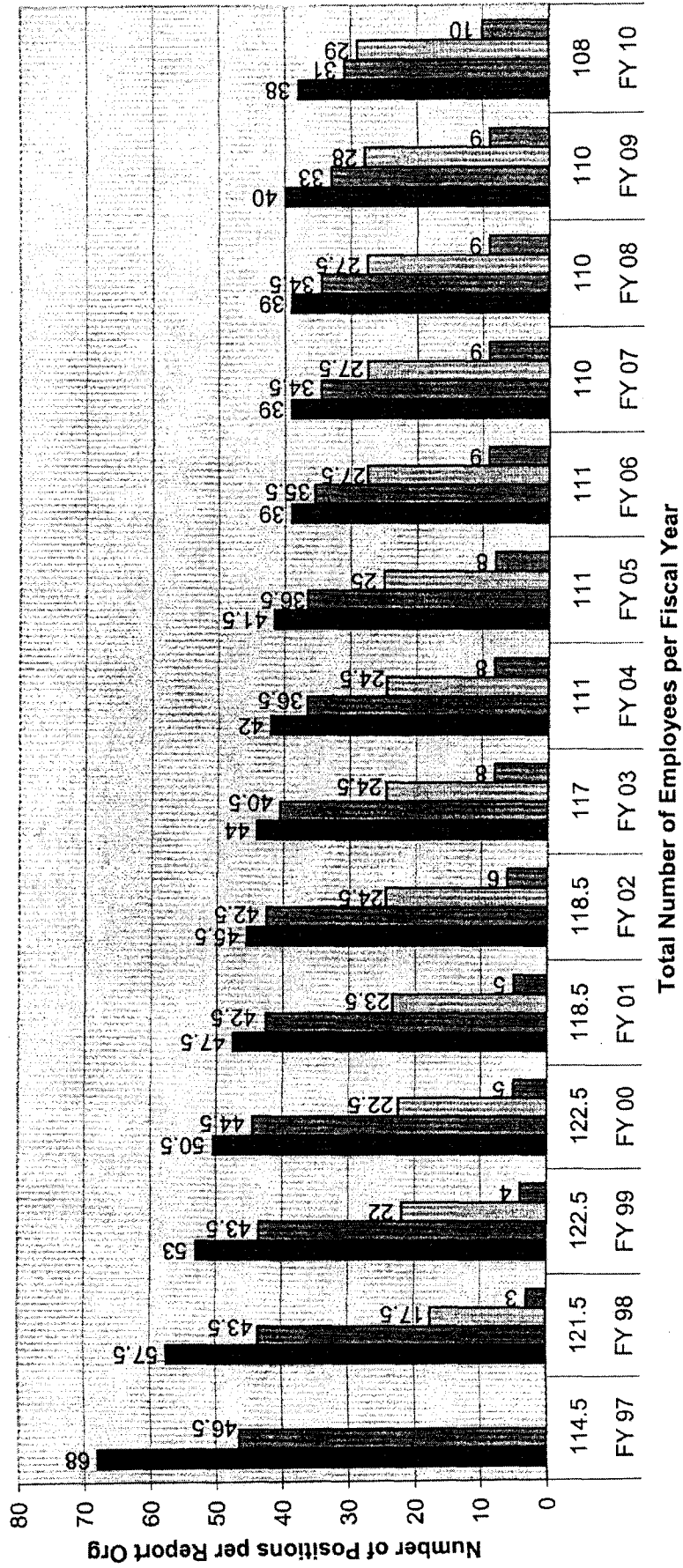
Total

116,514

Total

515,330

WCB - Personnel Changes Since FY 97
December 11, 2009



The MAE and Worker Advocate programs represent 36% of the agency's total number of employees.

■ Dispute Resolution ■ Central Services ■ Advocate Program ■ MAE Program

**L. A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE
STATE LAWS GOVERNING THE AGENCY OR PROGRAM
AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM**

The federal system (most particularly, the Longshore and Harbor Workers' Act) is significantly different than Maine workers' compensation system. The Board has, in appropriate situations, examined the federal system to see how it compares to Maine's. For instance, during the Board's recent effort to adopt a new rule governing fees for facilities, a suggestion was made by employer representatives that the Board adopt the fees used by the federal Office of Workers' Compensation Policy. The Board's examination (through its consultant) revealed that adopting the federal regulation, in addition to being exceedingly complex, would actually result in reimbursement rates that were higher than the Board's proposed rule. As a result, the Board decided not to use the federal system.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT

Access to Workers' Compensation Board records, which are stored on a secure server, concerning individual employees is strictly limited by both statute and regulation. Pursuant to 39-A M.R.S. § 152(2):

"The board shall adopt rules establishing a policy and procedures to safeguard the confidentiality of the records of the former Workers' Compensation Commission and the Workers' Compensation Board pertaining to individual injured employees. The policy must make records available on a need-to-know basis only and must include legitimate research purposes while protecting individual confidentiality."

The Board complied with this directive by adopting 90-351 COMAR Ch. 16.

Accordingly, the Board only releases records to those persons meeting these standards. To help ensure that records are not inadvertently released, the Board has assigned a single employee the overall responsibility for processing requests for records. If there are any questions as to whether information can be released and, if so, whether information identifying individual injured employees should be redacted, then the matter is referred to the Workers' Compensation Board's General Counsel who determines what, if any, information to release.

**N. A LIST OF REPORTS, APPLICATIONS AND OTHER SIMILAR PAPERWORK
REQUIRED TO BE FILED WITH THE AGENCY BY THE PUBLIC**

The list must include:

- (1) The statutory authority for each filing requirement;**
- (2) The date each filing requirement was adopted or last amended by the agency;**
- (3) The frequency that filing is required;**
- (4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and**
- (5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication.**

A. First Reports of Injury

- (1) Required pursuant to 39-A M.R.S. § 303.
- (2) Last substantive regulatory amendment: June 24, 2007
- (3) Per statute, First Reports of Injury must be filed within 7 days of notice or knowledge of an injury that causes an employee to lose a day's work.
- (4) (a) Filings previous two calendar years:
 - (i) 2008: 40,118
 - (ii) 2009: 37,463(b) Anticipated filings next two years: Approximately 35,970
- (5) The Board has implemented electronic filing of First Reports of Injury in an effort to minimize the paperwork associated with these reports.

B. Notices of Controversy

- (1) Notices of Controversy are required pursuant to 39-A M.R.S. § 205 which requires payment of incapacity within 14 days unless there is a dispute as to an employee's entitlement to benefits.
- (2) Last amendment to the filing requirement: June 24, 2007.
- (3) Pursuant to 39-A M.R.S. § 205(2) and Board Rule Ch. 1, section 1, Notices of Controversy must be filed within 14 days after notice or knowledge of a claim for incapacity.
- (4) (a) Filings previous two calendar years:
 - (i) 2008: 10,108
 - (ii) 2009: 9,733(b) Anticipated filings next two years: Approximately 10,272
- (5) The Board has implemented electronic filing of Notices of Controversy in an effort to minimize the paperwork associated with these reports.

C. Memorandum of Payment

- (1) Memoranda of Payment are required by 39-A M.R.S. § 205(7).
- (2) The Board adopted a rule pertaining to Memoranda of payment in March of 1995.

- (3) Pursuant to 39-A M.R.S. § 205(7), Memoranda of Payment must be filed immediately upon the first payment of benefits.
- (4) (a) Filings previous two calendar years:
 - (i) 2008: 7,409
 - (ii) 2009: 6,896
 (b) Anticipated filings next two years: Approximately 7,110
- (5) The Board is working on a rule/process for filing Memoranda of Payment electronically.

D. Discontinuances/Certificates of Reduction/Discontinuance

- (1) Required pursuant to 39-A M.R.S. § 205(9) which governs when and how benefits for incapacity may be reduced or discontinued.
- (2) The Board adopted a rule pertaining to Memoranda of payment in March of 1995.
- (3) Pursuant to 39-A M.R.S. § 205(9)(A), a Discontinuance of Modification must be filed with the Board when an employer/insurer reduces or discontinues an employees benefits because the employee returned to work for the employer that is paying the workers' compensation benefits.
 Pursuant to 39-A M.R.S. § 205(9)(B), a Certificate of Discontinuance or Reduction must be filed 21-days before the discontinuance or reduction takes place.
 Pursuant to P.L. 2009, Ch. 280, employers/insurers can reduce their benefit payment by the amount earned by an employee at a different employer. The reduction may be taken while a petition to reduce/discontinue benefits is pending, or during the 21-day period provided in 39-A M.R.S. § 205(9)(B). Ch. 280 requires that documentation supporting the reduction be filed with the Board. The Board is currently working on a rule to implement this filing requirement.
- (4) (a) Filings previous two calendar years:
 Discontinuances:
 - (i) 2008: 7,544
 - (ii) 2009: 6,514
 Certificates of Reduction/Discontinuance
 - (i) 2008: 618
 - (ii) 2009: 697
 (b) Anticipated filings next two years:
 - (i) Discontinuances:
 Approximately 7,125
 - (ii) Certificates of Reduction/Discontinuance:
 Approximately 656
- (5) The Board is working on a rule/process for filing Discontinuances electronically. The Board in drafting a rule to implement Ch. 280, is trying to minimize the employer/insurer's filing requirement while still collecting adequate information to effectively enforce the new law.

E. Proof of Coverage

- (1) Required pursuant to 39-A M.R.S. § 403(1).
- (2) The most recent amendment was adopted on August 22, 2009.
- (3) By rule, proof of coverage must be filed within 14 days after the issuance, renewal or endorsement of a policy.
- (4) (a) Filings previous two calendar years:
 - (i) 2008: 38,748
 - (ii) 2009: 47,674(b) Anticipated filings next two years: Approximately 41,185
- (5) The Board has implemented electronic filing of Proof of Coverage in an effort to minimize the paperwork associated with these reports.

F. Statement of Compensation Paid

- (1) Required pursuant to 39-A M.R.S.A. §§ 152(2), 152(7), 152(10), 153(1), 153(4) and 357(1).
- (2) The last amendment was adopted on March 4, 2001.
- (3) The First Statement of Compensation paid form must be filed within 195 days of an injury if incapacity payments are made, and then within 15 days of each anniversary date of the injury.
- (4) (a) Filings previous two calendar years:
 - (i) 2008: 15,096
 - (ii) 2009: 14,761(b) Anticipated filings next two years: Approximately 15,391
- (5) The Board is working on a rule/process for filing Statement of Compensation Paid forms electronically.

G. Wage Statements

- (1) Required pursuant to 39-A M.R.S. § 303.
- (2) No specific regulation has been adopted.
- (3) Wage Statements must be filed within 30 days of notice or knowledge of a claim for incapacity.
- (4) a) Filings previous two calendar years:
 - (i) 2008: 8,993
 - (ii) 2009: 9,020(b) Anticipated filings next two years: Approximately 9,061
- (5) The language enacted by the Legislature in section 303 was proposed by the Board several years ago in an effort to strike a balance between minimizing filing requirements while ensuring that sufficient information is available to adjust and monitor claims for incapacity.