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"; or

   B. Pay without prejudice and file a Memorandum of Payment checking "Voluntary Payment without Prejudice"; or

   C. Deny the claim and file a Notice of Controversy.

2. Notice of the claim must be provided consistent with 39-A M.R.S.A. § 301, or to the employer's insurance carrier at the address registered with the Bureau of Insurance.

3. If the employer fails to comply with subsection 1 of this section, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S.A. § 205(2) and in compliance with 39-A M.R.S.A. § 204. The employer may discontinue benefits under this subsection when both of the following requirements are met:

   A. The employer files a Notice of Controversy; and

   B. The employer pays benefits from the date the claim is made. If it is later determined that the average weekly wage/compensation rate used to compute the payment due was incorrect, and the amount paid was reasonable and based on the information gathered at the time, the violation of subsection 1 of this section is deemed to be cured.

4. Payment under subsection 3 of this section requires the filing of a Memorandum of Payment.

5. Benefits paid under this section are indemnity payments and are credited toward future benefits in the event that benefits are ordered or paid.

6. Failure to comply with the provisions of subsection 1 of this section may also result in the imposition of penalties pursuant to 39-A M.R.S.A. §§ 205(3), 359, and 360.

7. This rule applies to all dates of injury and all pending claims.

§ 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. § 205(9)(B)(1). The provisions of 39-A M.R.S.A. § 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. § 102(7).

§ 3. Provisional Orders

Mediation need not be held prior to issuance of an order under 39-A M.R.S.A. § 205(9)(D). All orders under 39-A M.R.S.A. § 205(9)(D) shall be issued only by Administrative Law Judges.

§ 4. *[Reserved]*

§ 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 § 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), 403(b), or equivalent plan matching funds that cease being paid because the employee is not working. The employer's obligation to include 401(k), 403(b), or equivalent plan matching funds ends when the employee returns to work for the employer;

      (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 § 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/insurer shall determine the value of all fringe benefits on the date of injury and shall file form WCB-2B within the timeframe established in 39-A M.R.S.A. § 303. The employer/insurer 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. The insurer or self-insured employer shall file form WCB-4 if the inclusion of fringe benefits results in increased compensation to the employee.

C. The employer/insurer may adjust the average weekly wage one time using form WCB-4 within 90 days after making the first lost time payment on a claim to correct an error or miscalculation. The employee may invoke dispute resolution if this adjustment results in decreased compensation. If greater than 90 days, the employer/insurer shall use form WCB-8.

3. Calculating benefits

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

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.

§ 10. Cancer Presumption for Firefighters

This rule applies to all cases now pending before the Workers' Compensation Board in which the evidence has not closed and in which the statute applies. For all dates of injury occurring before the effective date of these rules, sub-section 1 applies. For all dates of injury occurring on and after the effective date of these rules, sub-section 2 applies.

1. If a firefighter claims that he has contracted a cancer defined in § 328-B(1)(A), the firefighter shall be considered to have undergone a standard, medically acceptable test for evidence of the cancer for which the presumption is sought or evidence of the medical conditions derived from the disease, which test failed to indicate the presence or condition of the cancer for which the presumption is sought, if, during the time of employment as a firefighter, the firefighter underwent a standard physical exam with blood work and the examination and the blood work were not positive for the cancer for which the presumption is sought,

or if the examination or blood work were positive for the cancer for which the presumption is sought, follow up tests ordered by the physician conducting the physical were determined to be negative for the cancer for which the presumption is sought.

2. If a firefighter claims that he has contracted a cancer defined in § 328-B(1)(A), the firefighter shall be considered to have undergone a standard, medically acceptable test for evidence of the cancer for which the presumption is sought or evidence of the medical conditions derived from the disease, which test failed to indicate the presence or condition of the cancer for which the presumption is sought, if, during the time of employment as a firefighter, the firefighter underwent a physical examination which included a complete history and physical examination, which included a history of malignancies regarding the firefighter's blood-related parents, grandparents or siblings, and a history of the firefighter's previous malignancies. The physical examination shall be considered complete if it included a lymph node and neurologic exam, a breast examination, and a testicular examination if a male. To be considered complete, an examination shall include blood count testing (CBC), metastolic profile (CMP) testing, and urinalysis testing. If a female firefighter is 40 years or older, the examination should include a mammography, and if a female firefighter is 50 years or older, a colonoscopy. If a male firefighter is 50 years or older, the examination shall include prostate examination and a colonoscopy. If any abnormality is disclosed during the examination or blood work for the cancer for which the presumption is sought and further testing reveals that the cancer for which the presumption is sought is not present, the examination shall be considered adequate for purpose of the application of the presumption. For the purpose of determining the completeness of an exam or testing for application of the presumption, the firefighter's age at the time of the exam is determinative.

3. If an examination or blood work is determined to be incomplete or positive for one or more cancers but not for the cancer for which the presumption is sought and the examination and blood work were complete and not positive for the cancer for which the presumption is sought, the firefighter is entitled to the presumption provided the remaining requirements of § 328-B have been met.

§ 11. Post-Insolvency Meeting between the Board and the Maine Insurance Guaranty Association

1. Within 180 days of notice of insolvency to the Board or its designee and the Maine Insurance Guaranty Association ("MIGA"), the Executive Director or the Executive Director's designee shall schedule a meeting with MIGA.

2. During the meeting, MIGA shall provide the Board with a report detailing:

   A. When it obtained the claim records of the insolvent insurer;

   B. The number of claim records it received from the insolvent insurer broken down by:

i. Active claims;

ii. Claims that are not active but still within the statute of limitations; and

iii. Claims that are beyond the statute of limitations;

C. A description of the condition of the claim records of the insolvent insurer; and

D. The steps MIGA has taken to ensure the claims are being adjusted in a timely manner.

3. During the meeting the Executive Director or the Executive Director's designee shall provide MIGA with a report detailing the number of claim records it has broken down by:

i. Active claims;

ii. Claims that are not active but still within the statute of limitations; and

iii. Claims that are beyond the statute of limitations.

4. At the conclusion of the meeting, the Board or its designee shall determine whether a follow-up report from MIGA or an additional meeting is required to ensure claims are being adjusted in a timely and accurate manner.

§ 1. Permanent Impairment Threshold

1. The permanent impairment threshold for cases with dates of injury on or after January 1, 1993 and before January 1, 2002 is in excess of 11.8%.

2. The permanent impairment threshold for cases with dates of injury on or after January 1, 2002 and before January 1, 2004 is in excess of 13.2%.

3. The permanent impairment threshold for cases with dates of injury on or after January 1, 2004 and before January 1, 2006 is in excess of 13.4%.

4. The permanent impairment threshold for cases with dates of injury on or after January 1, 2006 and before January 1, 2013 is in excess of 12%.

§ 2. Extension of 260-week limitation in § 213

The 260-week benefit limitation in § 213 was extended to:

1. 312 weeks on January 1, 1999;
2. 364 weeks on January 1, 2000;
3. 416 weeks on January 1, 2007;
4. 468 weeks on January 1, 2008; and
5. 520 weeks on January 1, 2009.

§ 3. Collection of permanent impairment data

1. 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.

2. Permanent impairment ratings 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.

3. 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. 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. 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.

§ 4. [*Reserved]*

§ 5. Requests for Extension of Benefits Pursuant to 39-A M.R.S.A. § 213(1)

1. Cessation of benefits pursuant to 39-A M.R.S.A. § 213(1) if no order or award of compensation or compensation scheme has been entered.

A. Prior to cessation of benefits pursuant to 39-A M.R.S.A. § 213(1), the employer 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.

B. 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.

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

1-A. Cessation of benefits pursuant to 39-A M.R.S.A. § 213(1) if an order or award of compensation or compensation scheme has been entered.

A. The employer must file a Petition to Terminate Benefit Entitlement which shall contain notice to the employee regarding the process for requesting an extension of benefits.

B. If the Petition to Terminate Benefit Entitlement is granted, the decree shall contain the following language:

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 of this decree or, if an appeal is filed, within 30 calendar days after the appeal is final.

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 30 days of the date the employee's petition is filed. The responses must be sent to the employer/insurer. Failure to provide the required responses may result in dismissal with prejudice of the petition, exclusion of evidence, or other sanction that the Board deems just.

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. Failure to provide the required evidence may result in exclusion of evidence or other sanction that the Board deems just.

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 responsible for payment of the additional benefits. The employer must establish a material change in circumstances since the previous order. Orders extending benefits beyond 520

weeks are not subject to review more often than every two years from the date of the board order allowing an extension.

Appendix I

(Employees must provide the following information to the employer/insurer within 30 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. Lost Time: Employer's First Report of Occupational Injury or Disease (WCB-1)

1. The definition of a day for purposes of filing a First Report of Occupational Injury or Illness (WCB-1) under § 303 is the wages in an employee's regular workday.

2. Except as provided in paragraph (4) of this section, a First Report of Occupational Injury or Illness (WCB-1) shall be filed within 7 days after an employee has actually lost wages in an amount equivalent to that sum which would have been earned in a regular workday.

3. For purposes of this section, "wages in an employee's regular workday" is the amount equivalent to a day's wages for those who earn the same amount each workday, regardless of the duration of such person's employment. For all others, "wages in an employee's regular workday" is determined by dividing the pre-tax wages earned by the employee during the four (4) full work week period immediately preceding the date of injury by the number of days worked during the same four (4) full work week period. In the event that an employee has worked for less than the four (4) full work week period preceding the date of injury, "wages in an employee's regular workday" is determined by dividing the pre-tax wages earned by the number of days worked.

   A. The employer/insurer shall record lost wages so that a First Report of Occupational Injury or Illness (WCB-1) can be timely filed pursuant to this rule and § 303.

   B. In cases involving lost wages from a concurrent employer, the employee shall report to the insurer lost wages from the concurrent employer so that a First Report of Occupational Injury or Illness (WCB-1) can be timely filed pursuant to this rule and § 303.

4. If the employee has physical limitations due to the injury and loses consecutive hours equal to a regular work day because the employer cannot accommodate those restrictions, a First Report of Occupational Injury or Illness (WCB-1) shall be filed within 7 days after an employee has actually lost hours equal to a regular work day regardless of actual wage loss.

§ 1-A. Medical Only: Employer's First Report of Occupational Injury or Disease (WCB-1)

An employer shall complete a First Report of Occupational Injury or Illness (WCB-1) within 7 days after the employer receives notice or has knowledge of an injury that has required the services of a health care provider but has not caused the employee to lose a day's work. A copy of the First Report of Occupational Injury or Illness (WCB-1) shall be sent to the employee and, unless the employer is self-insured, the employer's insurer within 24 hours after the First Report of Occupational Injury or Illness (WCB-1) has been completed.

§ 2. Filing Requirements

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. 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.

3. Duplicate paper copies of forms that are filed by fax or other form of electronic transfer will not be accepted.

§ 3. Formal Hearing Correspondence

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 an Administrative Law Judge, 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 regional office to which the case has been assigned.

2. Formal hearing correspondence on a proceeding in progress before an Administrative Law Judge shall be filed by mail, in-hand delivery, fax, or other form of electronic transfer, including e-mail, provided that signatures be included when required. Formal hearing correspondence is filed when the Board receives the correspondence in the regional office to which the case has been assigned.

§ 4. Electronic Data Interchange 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 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. Waivers

(1) **Waivers due to hardship.** 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. 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.

D. **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 January 1, 2010 Edition (Appendix V).

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 II) 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 II) 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 II) 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 III 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. **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) The required notice must be filed with the Board no later than 30 days after issuance, renewal or policy initiating 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.

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. (1) The provider must have an active, treating practice, or have had an active treating practice within the twenty-four (24) months period preceding appointment as an examiner in an individual case;

   (2) Be Board certified; and

   (3) Demonstrate experience in the treatment of work-related injuries.

   For purposes of this chapter, "active, treating practice" means the provider has direct involvement in evaluation, diagnosis and treatment of patients on a frequent and regular basis in their specific field of expertise.

   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 Executive Director or the Executive Director's designee 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. Examiner candidate applications are public information. The Board may request additional information from applicants.

4. The Executive Director or the Executive Director's designee 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. 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 Executive Director or the Executive Director's designee.

2. If the parties do not agree to the selection of a particular independent medical examiner, the requesting party shall file a Request for Independent Medical Examination (WCB M-2) with the Office of Medical/ Rehabilitation Services, Workers' Compensation Board, 27 State House Station, Augusta, Maine 04333 and follow the procedures contained in section 3 of this rule. The Executive Director or the Executive Director's designee shall assign an examiner from the list of qualified examiners. If the list does not contain a qualified examiner, the Executive Director or the Executive Director's designee may select a qualified medical examiner of his/her choice. An Administrative Law Judge 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 Executive Director or the Executive Director's designee from the list of Board approved independent medical examiners with possible input from the individual Administrative Law Judge. 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

   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 Administrative Law Judge 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 must be submitted by the requesting party at the same time the Request for Independent Medical Examination (WCB M-2) is filed. Opposing parties shall submit questions they wish to ask no later than fourteen (14) days after receipt of the requesting party's questions. Except as provided in subsection 3 of this section, additional questions are not permitted.

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 Administrative Law Judge. Any such communication must be received by the Board and copied to all opposing parties not later than fourteen (14) days prior to any examination and must clearly and conspicuously state that the communication has been agreed to by the parties or approved by an Administrative Law Judge. Communications that comply with this sub-section will be forwarded to the examiner through the Office of Medical/Rehabilitation Services. Communications received by the Board on or after the date of the examination will only be forwarded to the examiner with prior approval of an Administrative Law Judge.

4. The parties shall confer, prepare, and file 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. The joint medical stipulation shall be submitted by the party requesting the examination and shall include a representation either that all parties conferred and prepared the joint medical stipulation or that, despite due diligence, the requesting party was unable to confer with an opposing party or parties. 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 upon agreement of the parties or with permission of the Administrative Law Judge.

7. Pursuant to 39-A 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 Administrative Law Judge. If the examiner issues a supplemental report, a supplemental deposition may be permitted at the discretion of the Administrative Law Judge.

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

1. 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 Executive Director or the Executive Director's designee for good cause shown. The fee for the examination and report must be paid by the employer. In the event the exam is scheduled to determine apportionment of responsibility between employers, the employer/insurer that requested the exam shall pay for the examination and report, unless otherwise agreed to by the requesting employer/insurer and any other employer/insurer that is a party to the proceeding. If an employee requests the exam, all employers/insurers that are parties to the proceeding shall, unless they agree otherwise, split the cost equally.

2. 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.

3. 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. The independent medical examiner may also charge $200 per hour for up to three (3) hours of preparation time unless the examination is conducted at a later date. These charges shall be paid initially by the employer/insurer that requested the exam unless otherwise agreed to by the requesting employer/insurer and any other employer/insurer that is a party to the proceeding. If the employee requested the exam, all employers/insurers that are parties to the proceeding shall, unless they agree otherwise, split the cost equally. Payment of these charges is subject to the right of the employer(s)/insurer(s) 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 Administrative Law Judge.

4. 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.

§ 5. Application

These rules apply to all dates of injury. If any section, term, provision, or application of this Rule is adjudged invalid for any reason, such judgment shall not impair or invalidate any other section, term, provision, or application and the remainder of this Rule shall continue in full force and effect.

CHAPTER 5 MEDICAL FEES; REIMBURSEMENT LEVELS; REPORTING REQUIREMENTS

The Medical Fee Schedule is available online at http://www.maine.gov/wcb/Departments/omrs/medfeesched.html, or for purchase through Gossamer Press, 259 Main St., Old Town, ME 04468, Tel: (207) 827-9881, Fax: (207) 827-9861.

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.

SECTION 1. GENERAL PROVISIONS

1.01 APPLICATION

1. This chapter is promulgated pursuant to 39-A M.R.S.A. §§ 208 and 209-A. It applies to all medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided for treatment of a claimed work-related injury or disease on or after the effective date of this chapter, regardless of the employee's date of injury or illness. Treatment does not include expenses related to managed care services such as utilization review, case management, and bill review or to examinations performed pursuant to 39-A M.R.S.A. §§ 207 and 312.

1.02 PAYMENT CALCULATION

1. Pursuant to Title 39-A M.R.S.A. § 209-A, the Board has adopted this medical fee schedule which reflects the payment methodology developed by the federal Centers for Medicare and Medicaid Services. The Board has not adopted all components used by the federal Centers for Medicare and Medicaid Services. Therefore, the application of any fee schedule, payment system, claims processing rule, edit or other method of determining the reimbursement level for a service(s) not expressly adopted in this chapter is prohibited.

2. Payment is based on the fees in effect on the date of service.

1.03 DEFINITIONS

1. Acute Care Hospital: A health care facility with a General Acute Care Hospital Primary Taxonomy in the NPI Registry.

2. Ambulatory Payment Classification System (APC): Centers for Medicare & Medicaid Services' list of procedure codes, status indicators, ambulatory payment classifications, and relative weighting factors.

3. Ambulatory Surgical Center (ASC): A health care facility with an Ambulatory Surgical Clinic/Center Primary Taxonomy in the NPI Registry.
4. Bill: A request by a health care provider that is submitted to an employer/insurer for payment of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided for treatment of a work-related injury or disease.
5. Board: The Maine Workers' Compensation Board pursuant to 39-A M.R.S.A. § 151.
6. Critical Access Hospital: A health care facility with a Critical Access Hospital Primary Taxonomy in the NPI Registry.
7. Global Days: The number of days of care following a surgical procedure that are included in the procedure's maximum allowable payment but does not include care for complications, exacerbations, recurrence, or other diseases or injuries.
8. Health Care Provider: An individual, group of individuals, or facility licensed, registered, or certified and practicing within the scope of the health care provider's license, registration or certification. This paragraph shall not be construed as enlarging the scope and/or limitations of practice of any health care provider.
9. Health Care Records: includes office notes, surgical/operative notes, progress notes, diagnostic test results and any other information necessary to support the services rendered.
10. Implantable: An object or device that is made to replace and act as a missing biological structure that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to operate, program, and recharge the implantable.
11. Incidental Surgery: A surgery which is performed on the same patient, on the same day, by the same health care provider but is not related to the diagnosis.
12. Inpatient Services: Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours or is expected to have a length of stay exceeding 23 hours, even though it later develops that the patient dies, is discharged, or is transferred to another facility and does not actually stay in the institution for more than 23 hours.
13. Maximum Allowable Payment (MAP): The sum of all fees for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids established by the Board pursuant to this chapter.
14. Modifier: A code adopted by the Centers for Medicare & Medicaid Services that provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.
15. Outpatient Services: Services provided to a patient who is not admitted for inpatient or residential care (includes observation services).

16. Procedure Code: A code adopted by the Centers for Medicare & Medicaid Services that is divided into two principal subsystems, referred to as level I and level II of the Healthcare Common Procedure Coding System (HCPCS). Level I is comprised of Current Procedural Terminology (CPT®), a numeric coding system maintained by the American Medical Association (AMA). Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes. The CPT® manual is published by and may be purchased from the AMA, PO Box 930876, Atlanta, GA 31193-0876.

17. Resource-Based Relative Value Scale (RBRVS): Centers for Medicare & Medicaid Services' list of procedure codes, modifiers, relative weighting factors, global surgery days, and global surgery package percentages.

18. Severity-Diagnosis Related Group System (MS-DRG): Centers for Medicare & Medicaid Services' list of Medicare severity diagnosis-related groups, relative weighting factors, and geometric mean length of stay days.

19. Specialty Hospital: A health care facility with a Long-Term Care Hospital, Psychiatric Hospital, or Rehabilitation Hospital Primary Taxonomy in the NPI Registry. Specialty Hospital also includes those distinct parts of a health care facility that are certified by the Centers for Medicare & Medicaid Services as a Long-Term Care Hospital, Psychiatric Hospital, or Rehabilitation Hospital.

20. Usual and Customary Charge: The charge on the price list for the medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids that is maintained by the health care provider.

1.04 LEGAL DISCLAIMERS

1. This chapter includes data that is proprietary to the AMA, therefore, certain restrictions apply. These restrictions are established by the AMA and are set out below:

   A. The five character codes included in this chapter are obtained from the Current Procedural Terminology (CPT®), Copyright by the AMA. CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

   B. The responsibility for the content of this chapter is with the Board and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this chapter.

   C. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of CPT®. Any use of CPT® outside of this chapter should refer to the most current CPT® which contains the complete and most current listing of codes and descriptive terms.

1.05 AUTHORIZATION

1. Nothing in the Act or these rules requires the authorization of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206.

2. An employer/insurer is not permitted to require pre-authorization of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206 as a condition of payment.

1.06 BILLING PROCEDURES

1. Bills must specify the billing entity's tax identification number; the license number, registration number, certificate number, or National Provider Identifier of the health care provider; the employer; the employee; the date of injury/occurrence; the date of service; the work-related injury or disease treated; the appropriate procedure code(s) for the work-related injury or disease treated; and the charges for each procedure code. Bills properly submitted on standardized claim forms prescribed by the Centers for Medicare & Medicaid are sufficient to comply with this requirement. Uncoded bills may be returned for coding.

2. Bills for insured employers must be submitted directly to the insurer of record on the date of injury/illness. Health care providers shall attempt to verify the name of the insurer that wrote the workers' compensation policy for the specific employer on the date of injury/illness prior to the submission of a bill to an insurer.

3. In the event a patient fails to keep a scheduled appointment, health care providers are not to bill for any services that would have been provided nor will there be any reimbursement for such scheduled services.

4. A bill must be accompanied by health care records to substantiate the services rendered. Fees for copies of health care records are outlined below.

1.07 REIMBURSEMENT

1. The injured employee is not liable for payment of any medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206. Except as provided by 39-A M.R.S.A. § 206(2)(B), health care providers 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).

2. Changes to bills by employers/insurers are not allowed. The employer/insurer must pay the health care provider's usual and customary charge or the maximum allowable payment under this chapter, whichever is less, within 30 days of receipt of a properly coded bill unless the bill or previous bills from the same health care provider or the underlying injury has been controverted or denied.

A. When there is a dispute whether the provision of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids is reasonable and proper under § 206 of the Act, the employer/insurer shall pay the undisputed amounts, if any, and file a notice of controversy within 30 days of receipt. A copy of the notice of controversy must be sent to the health care provider from whom the bill originated in accordance with Chapter 3.

B. In cases where the underlying injury has been controverted or denied, a copy of the notice of controversy must be sent to each health care provider that submits or has submitted a request for payment within 30 days of receipt.

C. A health care provider, employee or other interested party is entitled to file a petition for payment of medical and related services for determination of any dispute regarding the provision of medical services.

3. When there is a dispute whether a request for future medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids is reasonable and proper under § 206 of the Act, the employer/insurer must file a notice of controversy within 30 days of receipt of the request. A copy of the notice of controversy must be sent to the originator of the request. A health care provider, employee, or other interested party is entitled to file a petition for payment of medical and related services for determination of any dispute regarding the request for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids.

4. Payment of a medical bill is not an admission by the employer/insurer as to the reasonableness of subsequent medical bills.

5. Nothing in this chapter precludes payment agreements to promote the quality of care and/or the reduction of health care costs.

A. A written payment agreement directly between a health care provider and an employer/insurer supersedes the maximum allowable payment otherwise available under this chapter.

B. A written payment agreement between a health care provider and an entity other than the employer/insurer seeking to invoke its terms supersedes the maximum allowable payment otherwise available under this chapter only if the employer/insurer is a contractual beneficiary of the payment agreement on the date of service.

C. An employee retains the right to select health care providers for the treatment of an injury or disease for which compensation is claimed regardless of any such payment agreement.

D. An employer/insurer that invokes a payment agreement to pay an amount that is different from the maximum allowable payment otherwise available under this chapter shall reference that payment agreement in the employer/insurer's explanation of payment or benefit.

E. In the event of a dispute as to whether there is a payment agreement that supersedes the maximum allowable payment otherwise payable, the burden is

on the party invoking the payment agreement to provide a written contract between the provider and the network within 30 days of a provider's request. This contract must establish the party's right to pay an amount different than provided in this chapter. Failure to produce the contract within 30 days of a request will result in the bill being subject to the maximum allowable payment established in this chapter.

6. Payment to out-of-state health care providers who treat injured employees pursuant to 39-A M.R.S.A. § 206 are subject to this chapter.

7. Modifiers which affect reimbursement are as follows:

-22 Increased Procedural Services: pay 150% of the maximum allowable payment under this chapter.

-50 Bilateral Procedure: pay 150% of the maximum allowable payment under this chapter for both procedures combined.

-51 Multiple Procedures: pay the highest weighted procedure at 100% of the maximum allowable payment under this chapter and all additional procedures at 50% of the maximum allowable payment under this chapter. Add-on codes are not subject to discounting.

-52 Reduced Services: pay 50% of the maximum allowable payment under this chapter if the procedure was discontinued after 1) the employee was prepared for the procedure and 2) the employee was taken to the room where the procedure was to be performed. Pay 100% of the maximum allowable payment if the procedure was discontinued after 1) the employee received anesthesia or 2) the procedure was started (e.g. scope inserted, intubation started, incision made).

-53 Discontinued Procedure: pay 25% of the maximum allowable payment under this chapter.

-54 Surgical Care Only: pay the intra-operative percentage of the maximum allowable payment under this chapter.

-55 Post-operative Management Only: pay the post-operative percentage of the maximum allowable payment under this chapter.

-56 Pre-operative Management Only: pay the pre-operative percentage of the maximum allowable payment under this chapter.

-59 Distinct Procedural Service: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-62 Two Surgeons: pay each surgeon 75% of the maximum allowable payment under this chapter.

-66 Surgical Team: pay 100% of the maximum allowable payment under this chapter for the surgical procedure and 25% of the maximum allowable payment under this chapter for the surgical procedure for each additional surgeon in the same specialty as the primary surgeon. If the surgeons are of two different specialties, each surgeon must be paid 100% of the maximum allowable payment under this chapter.

-73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia: pay 50% of the maximum allowable payment under this chapter.

-80 Assistant Surgeon: pay 25% of the maximum allowable payment under this chapter.

-81 Minimum Assistant Surgeon: pay 10% of the maximum allowable payment under this chapter.

-82 Assistant Surgeon (when qualified resident surgeon not available): pay 25% of the maximum allowable payment under this chapter.

-AS Assistant Surgeon (physician assistant, nurse practitioner, or clinical nurse specialist): pay 25% of the maximum allowable payment under this chapter.

-AD Surgical Anesthesia: Physician medically supervised more than 2 to 4 concurrent procedures: pay 50% of the maximum allowable payment under this chapter.

-QK Surgical Anesthesia: Physician medically directed 2, 3, or 4 concurrent procedures: pay 50% of the maximum allowable payment under this chapter.

-QX Surgical Anesthesia: CRNA was medically directed by a physician (2, 3, or 4 concurrent procedures): pay 50% of the maximum allowable payment under this chapter.

-QY Surgical Anesthesia: Physician medically directed a CRNA in a single case: pay 50% of the maximum allowable payment under this chapter.

-XE Separate Encounter: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-XP Separate Practitioner: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-XS Separate Structure: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-XU Unusual Non-Overlapping Service: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

1.08 FEES FOR REPORTS/COPIES

1. Health care providers may charge for completing an initial diagnostic medical report (Form M-1) or other supplemental report. The charge is to be identified by billing CPT® Code 99080.

2. The maximum fee for completing an initial M-1 form or other supplemental report is: Each 10 minutes: $30.00

3. Health care providers may charge for copies of the health care records required to accompany the bill. The charge is to be identified on the bill using CPT® Code S9981 (units equal total number of pages). The maximum fee for copies is $5 for the first page and 45¢ for each additional page, up to a maximum of $250.00.

4. For copies of health care records or other written information, including, but not limited to, billing records furnished in paper form, the maximum fee is $5 for the first page and 45¢ for each additional page, up to a maximum of $250.00. The copying charge must be paid by the requesting party. Health care providers shall not require payment prior to responding to the request unless the requesting party has an unpaid balance for previously requested information from the health care provider. In this event, a health care provider may require payment of the past due balance in addition to pre-payment of the current request prior to responding to the request. Health care providers shall not charge a fee for postage/shipping, sales tax, or a fee for researching a request that results in no records.

5. If the requested information exists in a digital or electronic format, the health care provider shall provide an electronic copy of the requested information, if an electronic copy is requested and it is reasonably possible to provide it. The health care provider may charge reasonable actual costs of staff time to create the electronic information and the costs of necessary supplies, up to a maximum of $150.00. The copying charge must be paid by the requesting party. Health care providers shall not require payment prior to responding to the request unless the requesting party has an unpaid balance for previously requested information from the health care provider. In this event, a health care provider may require payment of the past due balance in addition to pre-payment of the current request prior to responding to the request. Health care providers shall not charge a fee for postage/shipping, sales tax, or a fee for researching a request that results in no records.

1.09 FEES FOR MEDICAL TESTIMONY

1. Health care providers may charge for preparing to testify at depositions and hearings and for attendance at depositions and hearings for the purpose of giving testimony.

2. The maximum fee for preparing to testify at depositions and hearings is:

   First 30 minutes: $250.00

   Each additional 15 minutes: $125.00

3. The maximum fee for attendance at depositions and hearings for the purpose of giving testimony is:

   First hour or any fraction thereof: $500.00

   Each subsequent 15 minutes: $125.00

4. Travel time for attendance at depositions and hearings for the purpose of giving testimony is paid on a portal to portal basis when a deposition or hearing is more than ten miles from the health care provider's home base. The maximum fee for portal-to-portal travel for the purpose of giving testimony is:

   Each 60 minutes: $400.00

5. Health care providers may request advance payment of not more than $400.00 in order to schedule attendance at depositions and hearings. The advance payment will be applied against the total fees for medical testimony (preparation, travel, and attendance).

6. Health care providers will receive a maximum of $350.00 per canceled deposition when the cancellation occurs less than 24 hours prior to the scheduled start of the deposition. Health care providers will receive a maximum of $300.00 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 fee.

1.10 EXPENSES

1. The employer/insurer must pay the employee's travel-related expenses incurred for treatment (includes travel to the pharmacy) related to the claimed injury in accordance with Board Rules and Regulations Chapter 17.

2. The employer/insurer must pay the employee's travel-related expenses within 30 days of receipt of a request for reimbursement.

3. The employer/insurer must reimburse the employee's out-of-pocket costs for medicines and other non-travel-related expenses within 30 days of a request for reimbursement accompanied by receipts.

1.11 MEDICAL INFORMATION

1. A. Pursuant to 39-A M.R.S.A. § 208(1), authorization from the employee for release of medical information by health care providers to the employee or the employee's representative, employer or the employer's representative, or insurer or insurer's representative is not required if the information pertains to treatment of an injury or disease that is claimed to be compensable under this Act regardless

of whether the claimed injury or disease is denied by the employer/insurer.

B. Pursuant to 39-A M.R.S.A. § 208(1), health care providers must, at the written request of the employer/insurer representative, furnish copies of health care records or other written information, including, but not limited to, billing records to the employer/insurer representative and to the employee representative (if none, to the employee) pertaining to a claimed workers' compensation injury or disease, regardless of whether the claimed injury or disease is denied by the employer/insurer. Copies must be furnished within 10 business days from receipt of the written request. An itemized invoice must accompany the copies sent to the requestor.

C. Pursuant to 39-A M.R.S.A. § 208(1), health care providers must, at the written request of the employee or the employee's representative, furnish copies of health care records or other written information, including, but not limited to, billing records to the employee or the employee's representative pertaining to a claimed workers' compensation injury or disease, regardless of whether the claimed injury or disease is denied by the employer/insurer. Copies must be furnished within 10 business days from receipt of the written request. An itemized invoice must accompany the copies sent to the requestor.

2. A. Except as provided in subsection 3 of this section, if the employer/insurer or employee representative contends that medical information pre-existing and subsequent to the workplace injury for which claim is being made is relevant to issues in the workers' compensation case, it shall use Form WCB-220, set forth in Appendix V. Within 14 calendar days the employee or the employee's authorized representative, as defined in paragraph C of this section, shall sign the release and return it to the requesting party.

B. All parties, including health care providers, shall only use Form WCB-220 set forth in Appendix V. The use of forms other than the ones set forth in Appendix V and/or requiring additional forms is prohibited.

C. For purposes of this section, "authorized representative" has the same definition as set forth in 22 M.R.S.A § 1711-C(1)(A).

D. Health care providers must furnish copies of the health care records within 30 calendar days from receipt of a properly completed Form WCB-220.

E. Form WCB-220 may be revoked using Form WCB-220R.

3. A. In the event that the employer/insurer or employee representative contends that testing, treatment or counseling records related to psychological matters, HIV/AIDS, substance abuse, or sexually transmitted disease matters are relevant to issues in the workers' compensation case, it may obtain such specific information as agreed upon by the represented parties. If the represented parties agree, the parties shall use Form WCB-220A, WCB-220B, or WCB-220C, set

forth in Appendix V, as appropriate. Within 14 calendar days the employee or the employee's authorized representative, as defined in paragraph D of this section, shall sign the release and return it to the requesting party.

B. All parties, including health care providers, shall only use Form WCB-220A, WCB-220B, or WCB-220C set forth in Appendix V. The use of forms other than the ones set forth in Appendix V and/or requiring additional forms is prohibited.

C. In all other cases such information shall be requested on written motion to the Administrative Law Judge showing the need for the information. The Administrative Law Judge may authorize the release of this information subject to appropriate terms and conditions as to reasonable protection of confidentiality.

D. For purposes of this section, "authorized representative" has the same definition as set forth in 22 M.R.S.A § 1711-C(1)(A)E. Health care providers must furnish copies of the health care records within 30 calendar days from receipt of a properly completed Form WCB-220A, WCB-220B, or WCB-220C or within 30 calendar days from receipt of an order of an Administrative Law Judge.

F. Form WCB-220A, WCB-220B, or WCB-220C may be revoked using Form WCB-220R.

4. A. If an employee who is being paid pursuant to a compensation payment scheme revokes a medical release using Form WCB-220R, the employer/insurer may file a Motion to Compel with the Administrative Law Judge assigned to the case.

B. The Motion must include, at a minimum:

(i) A copy of the medical release form that was revoked;
(ii) The relevant Form WCB-220R;
(iii) Proof that the revocation was sent to the relevant health care provider(s);
(iv) An explanation of why continued receipt of the medial records is necessary to adjust the employee's claim; and
(v) Notice that the employee has 21 days to respond to the Motion.

C. The employee may reply within 21 days after receipt of the Motion. The reply must explain why continued receipt of the medical records is not necessary to adjust the employee's claim.

D. The Administrative Law Judge may grant the Motion to Compel if continued receipt of the medical records is necessary to adjust the employee's claim.

5. Nothing in the Act or these rules requires any personal or telephonic contact between any health care provider and a representative of the employer/insurer.

6. Health care providers must complete the M-1 form set forth in Appendix I in accordance with 39-A M.R.S.A. § 208. The use of a form other than the one set forth in Appendix I is prohibited and may subject the health care provider to penalty under 39-A M.R.S.A. § 360.

7. Pursuant to 39-A M.R.S.A. § 208, in the event that an employee changes or is referred to a different health care provider or facility, any health care provider or facility having health care records regarding the employee, including x rays, must forward all health care records relating to an injury or disease for which compensation is claimed to the next health care provider. When an employee is scheduled to be treated by a different health care provider or in a different facility, the employee must request to have the records transferred.

8. Fees for copies of medical information are as set forth in § 1.08 of this chapter.

1.12 PERMANENT IMPAIRMENT RATINGS

1. Permanent impairment will be determined by the use of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, copyright 1993.

2. Permanent impairment examinations performed by the employee's treating health care provider will have a maximum charge of $450.00.

SECTION 2. PROFESSIONAL SERVICES

2.01 PAYMENT CALCULATION

1. Pursuant to 39-A M.R.S.A. § 209-A, the medical fee schedule for services rendered by individual health care providers must reflect the methodology underlying the federal Centers for Medicare and Medicaid Services resource-based relative value scale.

2. Fees for anesthesia services are calculated for procedure codes by multiplying the applicable conversion factor times the sum of the base unit (relative value unit (RVU) of the procedure code plus any modifying units) and time unit. The definition of the unit components are as outlined below. The conversion factor for anesthesia services is $50.00.

3. Fees for all other professional services are calculated for procedure codes by multiplying the applicable conversion factor times the non-facility total RVU. The conversion factor for all other professional services is $60.00.

4. Fees for professional services (excluding anesthesia) are as outlined in Appendix II. In the event of a dispute regarding the fee listed in Appendix II, the listed relative weight times the base rate controls.

2.02 EVALUATION AND MANAGEMENT GUIDELINES

1. Definition of New Patient

   A. A new patient is one who has not received any professional services from the health care provider (or another health care provider of the exact same specialty and subspecialty who belongs to the same group practice) within the past three years, or

   B. A new patient is one who is being evaluated for a new injury/illness to determine work relatedness/causality, or

   C. A new patient is one who is being seen for a new episode of care for an existing injury/illness.

2. Payments for New Patient Visits

   Only one new patient visit is reimbursable to a health care provider (or another health care provider of the exact same specialty and subspecialty who belongs to the same group practice) for the same patient relating to the same episode of care.

3. For purposes of this section, “episode of care” includes all the professional services provided by the health care provider (or another health care provider of the exact same specialty and subspecialty who belongs to the same group practice) for the same patient for the same injury/illness from date of initial examination to date of discharge from care.

2.03 ANESTHESIA GUIDELINES

1. Definition of the Unit Components

A. Base Unit: RVU of the five digit anesthesia procedure code (00100-01999) listed in Appendix II plus the unit value of the physical status modifier plus the unit values for any qualifying circumstances.

Physical Status Modifiers. Physical Status modifiers are represented by the initial letter 'P' followed by a single digit from 1 to 6 as defined in the following list:

		UNIT VALUE
P1:	A normal healthy patient	0
P2:	A patient with mild systemic disease	0
P3:	A patient with severe systemic disease	1
P4:	A patient with severe systemic disease that is a constant threat to life	2
P5:	A moribund patient who is not expected to survive without the operation	3
P6:	A declared brain-dead patient whose organs are being Removed for donor purposes	0

Qualifying Circumstances. More than one qualifying circumstance may be selected. Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as the extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. This section includes a list of important qualifying circumstances that significantly affect the character of the anesthesia service provided. These procedures would not be reported alone, but would be reported as additional procedure numbers qualifying as an anesthesia procedure or service.

		UNIT VALUE
99100:	Anesthesia for patient of extreme age, under one year and over seventy	1
99116:	Anesthesia complicated by utilization of total body hypothermia	5
99135:	Anesthesia complicated by utilization of controlled hypotension	5
99140:	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

B. Time Unit: Health care providers must bill the number of minutes of anesthesia time. One time unit is allowed for each 15 minute time interval, or significant fraction thereof (7.5 minutes or more) of anesthesia time. If anesthesia time extends beyond three hours, one time unit for each 10 minute time interval, or significant fraction thereof (5 minutes or more) is allowed after the first three hours. Documentation of actual anesthesia time is required, such as a copy of the anesthesia record.

2. Calculation Examples

A. In a procedure with a RVU of 3 (no modifiers) requiring one hour of anesthesia time, the total units are determined as follows:

Base Unit	3.0 units
Time Unit	+ 4.0 units
Total Units	= 7.0 units

B. In a procedure with a RVU of 10, modifying units of 1 and qualifying circumstances of 2, requiring four hours and thirty minutes of anesthesia time, the total units are determined as follows:

Base Unit	13.0 units
Time Unit (First three hours)	+ 12.0 units
Time Unit (Subsequent 90 minutes)	+ 9.0 units
Total Units	= 34.0 units

C. In both cases, the maximum allowable payment is determined by multiplying the total units by the conversion factor.

Total Units X Conversion Factor = Maximum Allowable Payment

CONVERSION FACTOR = $50.00

2.04 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 under "Global Days" in Appendix II. The maximum allowable payment for a surgical procedure includes all of the following:

A. Any visit that has as its principal function the determination that the surgical procedure is needed.

B. All visits which occur after the need for surgery is determined and are related to or preparatory to the surgery.

C. Surgery.

D. All post-surgical care services, which are routinely performed by the surgeon or by members of the same group within the same specialty as the surgeon, including removal of sutures.

2. 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.

3. 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.

4. An incidental surgery will not be paid under the Workers' Compensation system.

5. When two or more surgical procedures are performed at the same session by the same individual, the highest weighted surgical code is paid at 100% of the fee listed in Appendix II and additional surgical procedures are paid at 50% of the fee listed in Appendix II. Add-on codes are not subject to discounting.

2.05 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

1. The employer/insurer must pay for all durable medical equipment, prosthetics, orthotics, and supplies that are ordered and approved by the treating health care provider.

2. Fees for durable medical equipment, prosthetics, orthotics, and supplies are as outlined in Appendix II. Invoices need not be requested by the employer/insurer.

SECTION 3. INPATIENT FACILITY FEES

3.01 BILLING

Bills for inpatient services must be submitted on a CMS Uniform Billing (UB-04) form. Health care providers are not required to provide the MS-DRG. Inpatient bills without the MS-DRG do not constitute uncoded bills.

3.02 ACUTE CARE HOSPITALS

The base rate for inpatient services at acute care hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $9,021.06.

2. On April 1, 2016, the base rate shall be $9,119.12.

3. On April 1, 2017, the base rate shall be $9,217.18.

3.03 CRITICAL ACCESS HOSPITALS

The base rate for inpatient services at critical access hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $10,525.95.

2. On April 1, 2016, the base rate shall be $10,144.90.

3. On April 1, 2017, the base rate shall be $9,763.86.

3.04 *[Reserved]*

3.05 PAYMENT CALCULATION

Pursuant to 39-A M.R.S.A. § 209-A, the medical fee schedule for services rendered by health care facilities must reflect the methodology and categories set forth in the federal Centers for Medicare and Medicaid Services severity-diagnosis related group system for inpatient services. Inpatient fees are calculated by multiplying the base rate times the MS-DRG weight. In the event of a dispute regarding the fee listed in Appendix III, the listed relative weight times the base rate controls. For inpatient services that take place during two different calendar years, payment is calculated based on the fees in effect on the discharge date.

3.06 OUTLIER PAYMENTS

The threshold for outlier payments is $75,000.00 plus the fee established in Appendix III. If the outlier threshold is met, the outlier payment is the charges above the threshold multiplied by 75%.

3.07 IMPLANTABLES

Where an implantable exceeds $10,000.00 in cost, an acute care or critical access hospital may seek additional reimbursement by submitting a copy of the invoice(s) along with the bill. Invoices need not be requested by the employer/insurer. Reimbursement is set at the actual amount paid plus $500.00. Handling and freight charges must be included in the hospital's invoiced cost and are not to be reimbursed separately. When a hospital seeks additional reimbursement pursuant to this chapter, the implantable charge is excluded from any calculation for an outlier payment.

3.08 SERVICES INCLUDED

All services provided during an uninterrupted patient encounter leading to an inpatient admission must be included in the inpatient stay. Services do not include costs related to transportation of a patient to obtain medical care. Costs related to transportation are payable separately.

3.09 FACILITY TRANSFERS

The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two hospitals:

1. A hospital transferring a patient is paid as follows: The MS-DRG reimbursement amount is divided by the number of days duration listed for the DRG; the resultant per diem amount is then multiplied by two for the first day of stay at the transferring hospital; the per diem amount is multiplied by one for each subsequent day of stay at the transferring hospital; and the amounts for each day of stay at the transferring hospital are totaled. If the result is greater than the MS-DRG reimbursement amount, the transferring hospital is paid the MS-DRG reimbursement amount. Associated outliers and add-ons are then added to the payment.
2. A hospital discharging a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons.
3. Facility transfers do not include costs related to transportation of a patient to obtain medical care. Costs related to transportation are payable separately.

3.10 OTHER INPATIENT FACILITY FEES

Inpatient services provided by institutional health care providers other than acute care or critical access hospitals must be paid at 75% of the provider's usual and customary charge.

3.11 PROFESSIONAL SERVICES

Individual health care providers who furnish professional services in an inpatient setting must be reimbursed using the fees set forth in Appendix II. The individual health care provider's charges are excluded from any calculation of outlier payments.

SECTION 4. OUTPATIENT FACILITY FEES

4.01 BILLING

Bills for hospital outpatient and ambulatory surgical services must be submitted on a UB-04 form. Outpatient hospital facility services performed on the same day for the same patient must be reported on a single UB-04 form.

4.02 ACUTE CARE HOSPITALS

The base rate for outpatient services at acute care hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $120.14.

2. On April 1, 2016, the base rate shall be $131.86.

3. On April 1, 2017, the base rate shall be $143.59.

4.03 CRITICAL ACCESS HOSPITALS

The base rate for outpatient services at critical access hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $143.85.

2. On April 1, 2016, the base rate shall be $155.17.

3. On April 1, 2017, the base rate shall be $166.50.

4.04 AMBULATORY SURGICAL CENTERS

The base rate for surgical services at ambulatory surgical centers shall be:

1. On the effective date of this chapter, the base rate shall be $80.39.

2. On April 1, 2016, the base rate shall be $79.46.

3. On April 1, 2017, the base rate shall be $78.53.

4.05 PAYMENT CALCULATION

Pursuant to 39-A M.R.S.A. § 209-A, the medical fee schedule for services rendered by health care facilities must reflect the methodology and categories set forth in the federal Centers for Medicare and Medicaid Services ambulatory payment classification system for outpatient services. Fees for procedure codes are calculated by multiplying the base rate times the APC weight. In the event of a dispute regarding the fee listed in Appendix IV, the listed relative weight times the base rate controls.

1. For procedure codes with no CPT®/HCPCS code or for procedure codes with a status indicator of N, there is no separate payment.

2. If the ACH Fee, CAH Fee or ASC Fee listed in Appendix IV is $0.00 for a procedure code with a status indicator other than N, then payment must be calculated at 75% of the health care provider's usual and customary charge.

3. When two or more procedure codes with a status indicator of T are billed on the same date of service, the highest weighted code is paid at 100% of the fee listed in Appendix IV and additional T status code procedures are paid at 50% of the fee listed in Appendix IV. Add-on codes are not subject to discounting.

4. When one or more procedure codes with a status indicator of N are billed without any other outpatient services (i.e. non-patient referred specimens or the facility collects the specimen and furnishes only the outpatient labs on a given date of service, etc.), payment must be calculated at 75% of the provider's usual and customary charge.

4.06 OUTLIER PAYMENTS

The threshold for outlier payments is $2,500.00 per procedure code plus the fee listed in Appendix IV. If the outlier threshold is met, the outlier payment is the charges above the threshold multiplied by 75%. If a bill has more than one surgical procedure with a status indicator of J, S or T and one or more of those procedures has less than a $1.01 charge, charges for all status J, S and T lines are summed and the charges are then divided across the J, S and T lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the outlier calculation.

4.07 IMPLANTABLES

Where an implantable exceeds $250.00 in cost, hospitals or ambulatory surgical centers may seek additional reimbursement (regardless of the status indicator) by submitting a copy of the invoice(s) along with the bill. Invoices need not be requested by the employer/insurer. Reimbursement is set at the actual amount paid plus 20% or the actual amount paid plus $500.00, whichever is less. Handling and freight charges must be included in the facility's invoiced cost and are not to be reimbursed separately.

4.08 SERVICES INCLUDED

Outpatient services include observation in an outpatient status.

4.09 TRANSFERS

The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two facilities:

1. A hospital or ambulatory surgical center transferring a patient is paid the maximum allowable payment established in this section.

2. A hospital discharging a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons per section 3.

3. Facility transfers do not include costs related to transportation of a patient to obtain medical care. Costs related to transportation are payable separately.

4.10 OTHER OUTPATIENT FACILITY FEES

Outpatient services provided by institutional health care providers other than acute care or critical access hospitals and ambulatory surgical centers (e.g. clinical medical laboratories, free standing outpatient facilities, etc.) must be paid at 75% of the provider's usual and customary charge.

4.11 PROFESSIONAL SERVICES

Individual health care providers who furnish professional services in an outpatient setting must be reimbursed using the maximum fees set forth in Appendix II. The individual health care provider's charges are excluded from any calculation of outlier payments.

CHAPTER 5

APPENDIX I

MEDICAL FEE SCHEDULE

PRACTITIONER'S REPORT (FORM M-1)

M-1 DIAGNOSTIC MEDICAL REPORT
MAINE WORKERS' COMPENSATION BOARD

EMPLOYEE NAME:	EMPLOYEE SSN (last 4 digits only): XXX-XX-	EMPLOYEE DOB:	EMPLOYEE PHONE:
EMPLOYER NAME:	EMPLOYER ADDRESS:		
DATE OF INJURY:	TIME OF INJURY: ☐ AM ☐ PM	DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO IF NO, LIST PLACE OF INJURY	
SUPERVISOR'S NAME	SUPERVISOR'S PHONE:	EMPLOYER FAX:	

NATURE/CAUSE OF INJURY:

DATE OF THIS EXAMINATION : _____ ☐ INITIAL ☐ PROGRESS ☐ FINAL

ICD-9/10 **DIAGNOSIS** CODES: _____

IN MY OPINION, THESE DIAGNOSES ARE ☐ WORK RELATED ☐ NOT WORK RELATED ☐ NOT YET IDENTIFIED AS TO CAUSE

HAVE DIAGNOSTIC TESTS BEEN PERFORMED? ☐ YES ☐ NO, IF YES, LIST: _____

IS TREATMENT TO CONTINUE? ☐**YES,** IF YES, DATE TO BE SEEN AGAIN: _____ ☐**NO,** IF NO, PATIENT AT MMI? ☐ YES ☐ NO

ESTIMATED LENGTH OF TREATMENT _____

TREATMENT PLAN: _____

_____

OFFICE PROCEDURES: _____

MEDICAL REFERRAL SPECIALTY: _____ CONSULTANT: _____

DOES TREATMENT INCLUDE MEDICATION THAT PREVENTS PATIENT FROM DRIVING OR PERFORMING SAFETY SENSITIVE WORK ? ☐ YES ☐ NO

IF YES, LIST ALL MEDICATIONS: _____

WORK CAPACITY: ☐ REGULAR DUTY ☐ NO WORK CAPACITY- IF CHECKED, ESTIMATED DATE OF RETURN : _____

☐ MODIFIED WORK (DESCRIBE RESTRICTIONS BELOW OR ON REVERSE)

IF CHECKED, ESTIMATED LENGTH OF RESTRICTIONS? _____

BODY REGION(S) THAT RESTRICTIONS APPLY TO: _____

RESTRICTIONS RECOMMENDED*: **List Below** **OR** ☐ **See side 2 of form for detailed restrictions**

*Restrictions are provided at the professional recommendation of the medical provider. Actual functional testing may not have been performed to validate employee's ability.

_____ _____

SIGNATURE OF HEALTH CARE PROVIDER DATE

PRINT NAME _____ ADDRESS _____ TELEPHONE _____

M-1 (Effective X/XX)

GUIDELINES FOR COMPLETING THE M1 FORM

ESTIMATED LENGTH OF TREATMENT: describe in days, weeks, or months
TREATMENT PLAN: INCLUDE items like REST, MEDICATION, EXERCISE, or other forms of treatment
OFFICE PROCEDURES: INCLUDE Items like CAST, SPLINT, STRAPPING, INJECTIONS, SUTURES, etc.
MEDICAL REFERRALS: INCLUDE items like THERAPY, SURGEON, CHIROPRACTIC, etc.
MODIFIED WORK: INDICATE RIGHT or LEFT as appropriate; FREQUENCY (Never, Occasional <33% use) and DURATION of activities allowed

	Never	Occ	Freq	SPINE/SHOULDER
NECK	☐	☐	☐	Over Shoulder Work
	☐	☐	☐	awkward neck positions
	☐	☐	☐	Reaching
	☐	☐	☐	Jerking/Tugging
	☐	☐	☐	Ladders
	☐	☐	☐	
	☐	☐	☐	
SHOULDER	☐	☐	☐	Use of ___Arm
	☐	☐	☐	Over Shoulder Reaching
	☐	☐	☐	Forward Reaching
	☐	☐	☐	Ladders
	☐	☐	☐	Jerking/Tugging
	☐	☐	☐	
	☐	☐	☐	
LUMBAR SPINE	☐	☐	☐	Sitting
	☐	☐	☐	Bending and Twisting
	☐	☐	☐	Prolonged seated position
	☐	☐	☐	Kneeling/Crouching/Crawling
	☐	☐	☐	Ladders
	☐	☐	☐	Stairs
	☐	☐	☐	Jerking/Tugging
	☐	☐	☐	
THORACIC SPINE	☐	☐	☐	Bending and Twisting
	☐	☐	☐	Prolonged seated position
	☐	☐	☐	Kneeling/Crouching/Crawling
	☐	☐	☐	Ladders
	☐	☐	☐	Stairs
	☐	☐	☐	Jerking/Tugging
	☐	☐	☐	
	☐	☐	☐	

	Never	Occ	Freq	UPPER EXTREMITY
ELBOW	☐	☐	☐	Use of ___Arm
	☐	☐	☐	Forceful/Repetitive Use of Arm
	☐	☐	☐	Forceful Gripping
	☐	☐	☐	Repetitive Gripping
	☐	☐	☐	Palm-Down Lifting
	☐	☐	☐	Pronation/supination
	☐	☐	☐	Reaching
	☐	☐	☐	Ladders
	☐	☐	☐	Jerking/Tugging
	☐	☐	☐	
	☐	☐		
WRIST	☐	☐	☐	Use of ____Hand
	☐	☐	☐	Forceful/Repetitive Gripping
	☐	☐	☐	Forceful/Repetitive Pinching
	☐	☐	☐	Use of Vibratory Tools
	☐	☐	☐	Awkward wrist positions
	☐	☐	☐	Pronation/supination
	☐	☐	☐	Ladders
	☐	☐	☐	Holds
	☐	☐	☐	Patient Transfers
	☐	☐	☐	Jerking/Tugging
HAND	☐	☐	☐	Use of ___Hand
	☐	☐	☐	Forceful/Repetitive Gripping
	☐	☐	☐	Forceful/Repetitive Pinching
	☐	☐	☐	Use of Vibratory Tools
	☐	☐	☐	Ladders
	☐	☐	☐	Jerking/Tugging
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

	Never	Occ	Freq	LOWER EXTREMITY
ANKLE	☐	☐	☐	Seated Work Only
	☐	☐	☐	Ladders
	☐	☐	☐	Stairs
	☐	☐	☐	Kneeling/Squatting/Crawling
	☐	☐	☐	Use of Foot Controls, affected foot
	☐	☐	☐	
	☐	☐	☐	
FOOT	☐	☐	☐	Seated Work Only
	☐	☐	☐	Ladders
	☐	☐	☐	Stairs
	☐	☐	☐	Kneeling/Squatting/Crawling
	☐	☐	☐	Use of Foot Controls, affected foot
	☐	☐	☐	
	☐	☐	☐	
HIP	☐	☐	☐	Seated Work Only
	☐	☐	☐	Ladders
	☐	☐	☐	Stairs
	☐	☐	☐	Kneeling/Squatting/Crawling
	☐	☐	☐	
	☐	☐	☐	
KNEE	☐	☐	☐	Seated Work Only
	☐	☐	☐	Kneeling/Squatting/Crawling
	☐	☐	☐	Ladders
	☐	☐	☐	Stairs
	☐	☐	☐	
	☐	☐	☐	
General	☐	☐	☐	Walking
	☐	☐	☐	Standing
	☐	☐	☐	Sitting
	☐	☐	☐	Push/Pull

Other Activity Restriction Suggestions

	Never	Occ	Occ	Lifting
LIFT / CARRY	☐	☐	☐	Lifting to 5 Lbs
	☐	☐	☐	Lifting to 10Lbs
	☐	☐	☐	Lifting to 15 Lbs
	☐	☐	☐	Lifting to 20 Lbs
	☐	☐	☐	Lifting to 25 Lbs
	☐	☐	☐	Lifting to 30 Lbs
	☐	☐	☐	Lifting to 35 Lbs
	☐	☐	☐	Lifting to 40 Lbs
	☐	☐	☐	Lifting to 50 Lbs
	Other			
	☐			Keep Load Close to Body
	☐			Keep Load in Knee-Chest Range
	☐			
	☐			

	Other
MISC	☐ No Driving
	☐ No Work at Unprotected Heights
	☐ No Work on Roof
	☐ Work as Splint Allows
	☐ Driving To and From Work Only
	☐ Tool Modification
	☐ Work Station Evaluation/Modification
	☐ Holds/Restraints
	☐ Patient Transfers
	☐
	☐
	☐

	Never	Occ	Occ	
PUSH / PULL	☐	☐	☐	No Push/Pull
	☐	☐	☐	Push/Pull to 25 Lbs
	☐	☐	☐	Push/Pull to 50 Lbs
	☐	☐	☐	Push/Pull to 75 Lbs
	☐	☐	☐	Push/Pull to 100 Lbs
	☐	☐	☐	Avoid Jerking/Tugging
HOURS	☐	☐	☐	May Work 4 Hrs/Day
	☐	☐	☐	May Work 6 Hrs/Day
	☐	☐	☐	May Work 8 Hrs/Day
	☐	☐	☐	May Work 10 Hrs/Day
	☐	☐	☐	No Overtime
	☐	☐	☐	No Double Shifts
	☐	☐	☐	Brief Rest/Stretch Break Every 1-2 Hrs
	☐	☐	☐	Rotate Job Tasks if Possible

DUTIES OF HEALTH CARE PROVIDERS

Pursuant to 39-A M.R.S.A. § 208(2), duties of health care providers are as follows:

- Except for claims for medical benefits only, within 5 business days from the completion of a medical examination or within 5 business days from the date notice of injury is given to the employer, whichever is later, the health care provider treating the employee shall forward to the employer and the employee a diagnostic medical report, on forms prescribed by the board, for the injury for which compensation is being claimed. The report must include the employee's work capacity, likely duration of incapacity, return to work suitability and treatment required. The board may assess penalties up to $500 per violation on health care providers who fail to comply with the 5-day requirement of this subsection.
- If ongoing medical treatment is being provided, every 30 days the employee's health care provider shall forward to the employer and the employee a diagnostic medical report on forms prescribed by the board. An employer may request, at any time, medical information concerning the condition of the employee for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request.
- A health care provider shall submit to the employer and the employee a final report of treatment within 5 working days of the termination of treatment, except that only an initial report must be submitted if the provider treated the employee on a single occasion.
- Upon the request of the employee and in the event that an employee changes or is referred to a different health care provider or facility, any health care provider or facility having medical records regarding the employee, including x rays, shall forward all medical records relating to an injury or disease for which compensation is claimed to the next health care provider. When an employee is scheduled to be treated by a different health care provider or in a different facility, the employee shall request to have the records transferred.
- A health care provider may not charge the insurer or self-insurer an amount in excess of the fees prescribed in §209-A for the submission of reports prescribed by this section and for the submission of any additional records.
- An insurer or self-insurer may withhold payment of fees for the submission of any required reports of treatment to any provider who fails to submit the reports on the forms prescribed by the board and within the time limits provided. The insurer or self-insurer is not required to file a notice of controversy under these circumstances, but must notify the provider that payment is being withheld due to the failure to use prescribed forms or to submit the reports in a timely fashion. In the case of dispute, any interested party may petition the board to resolve the dispute.

Other reminders:

- Except for the header information, the remainder of the M-1 form must be completed by the health care provider. This information is vital to the administration of the claim and the employee’s return to work.
- The M-1 form is not submitted to the board.
- Pursuant to Board Rules Chapter 5, a health care provider may charge a fee for completing the initial M-1.
- The attachment of narratives is optional; however, an employer/insurer may request, at any time (for a fee), medical information concerning the condition of the employee for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request. Pursuant to 39-A M.R.S.A. § 208(1) a medical release is not necessary if the information pertains to an injury claimed to be compensable under the Act (whether or not the claim is controverted/denied).

CHAPTER 5

APPENDICES II - IV

NOTE: For a complete copy of the Medical Fee Schedule, including the Appendices, please see the separate Publication entitled: "Medical Fee Schedule" located on the Board's website here: http://www.maine.gov/wcb/Departments/omrs/medfeesched.html

CHAPTER 5

APPENDIX V

MEDICAL RELEASE FORMS

(FORMS WCB-220, WCB-220A, WCB-220B, WCB-220C, AND WCB-220R

State of Maine Workers' Compensation Board
Limited Release of Medical/Health Care Information

Name: SSN (last 4 digits): XXX-XX-

Date Birth: Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information to an employer or its insurer. The Board's forms may NOT be altered. Abuses may result in penalties.

Notice to employee: The employer/insurer contends your health care provider's medical records, regardless of the date of injury, meaning all records relating to the diagnosis, treatment and care, including X-rays, related to the following body part(s) and/or condition(s):

_____

are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records, regardless of the date of injury, they have related to the diagnosis, treatment and care, including X-rays, of the body part(s) and/or condition(s) listed above. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

You have 14 days from receipt of this certificate to complete and return it to the employer/insurer. If you do not understand this form, talk with your legal representative. If you do not have a legal representative, a Workers' Compensation Board Claims Resolution Specialist can help you.

Voluntary: I understand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

Limited: I understand this form gives my health care providers permission to release only those health records related to the body part(s) and/or condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

This authorization does NOT authorize the release of information regarding testing, treatment or counseling related to: Psychological matters; substance abuse; HIV/Aids and sexually transmitted diseases.

I authorize release of my medical records to: _____
(Name of Recipient)

Address of Recipient:

_____

Format Requested (circle one): **Electronically (if available)**: _____ **Fax to**: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature_____ **Date**:_____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-220 (eff. XX/XX/XX)

State of Maine Workers' Compensation Board
Limited Release of Medical/Health Care Information Related to Psychological Matters

Name: SSN (last 4 digits): XXX-XX-

Date of Birth: Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information to an employer or its insurer. The Board's forms may NOT be altered. Abuses may result in penalties.

Notice to employee: The employer/insurer contends your health care provider's mental health records related to:

Mental health treatment and diagnosis/diagnoses

are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records, regardless of the date of injury, they have related to the condition(s) listed above. This release authorizes the release of records dating from _____ until twelve (12) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

Voluntary: I understand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

Limited: I understand this form gives my health care providers permission to release only those health records related to the condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

RIGHT TO REVIEW: You have the right to review your mental health records prior to the authorized release of the records. You may add material to your record in order to clarify information you believe is false, inaccurate or incomplete.

☐ Check this box if you want to review your records before they are released. By checking this box and signing below, I understand the review will be supervised and my review of the records prior to their release may delay the consideration of my claim.

I authorize release of my medical records to: _____
(Name of Recipient)

Address of Recipient:

_____

Format Requested (circle one): **Electronically (if available)**: _____ **Fax to**: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature_____ **Date**:_____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-220-A (eff. XX/XX/XX)

State of Maine Workers' Compensation Board
Limited Release of Medical/Health Care Information
Related to Substance Abuse

Name: SSN (last 4 digits): XXX-XX-

Date of Birth: Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information. The Board's forms may NOT be altered. Abuses may result in penalties.

Notice to employee: The employer/insurer/employee representative contends your health care providers' records related to the identity, diagnosis, prognosis, or treatment of substance abuse, regardless of the date of injury, are relevant to whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers, including Part 2 Program(s)_____ to
(name of facility/provider)
release the records they have related to the identity, diagnosis, prognosis, or treatment of substance abuse. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

Voluntary: I understand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

Limited: I understand this form gives my health care providers permission to release only those health records related to the condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: The information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

I authorize release of my medical records to: _____
(Name of Recipient)

Address of Recipient:

_____

Format Requested (circle one): **Electronically (if available):** _____ **Fax to:** _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature_____ **Date:**_____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-220-B (eff. XX/XX/XX)

State of Maine Workers' Compensation Board
Limited Release of Medical/Health Care Information
Related to HIV/AIDS and Sexually Transmitted Diseases

Name: SSN (last 4 digits): XXX-XX-

Date of Birth: Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information. The Board's forms may NOT be altered. Abuses may result in penalties.

Notice to employee: The employer/insurer/employee representative contends your health care providers' medical records related to:

☐ Your HIV infection status, including the results of an HIV test

☐ The diagnosis, treatment and care of sexually transmitted diseases

are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records they have related to the diagnosis, treatment and care of the condition(s) listed above, regardless of the date of injury. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care practitioner(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

Voluntary: I undersand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

Limited: I understand this form gives my health care providers permission to release only the medical records related to the condition(s) indicated above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: The information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

Potential Implications of Release: Releasing this information may have implications. Positive implications may include giving you more complete care. Negative implications may include discrimination if the data is misused.

IMPORTANT NOTICE: By signing this form I understand that I am authorizing the release of my medical records related to my HIV infection status and/or my medical records regarding diagnosis, treatment and care of sexually transmitted diseases.

I authorize release of my medical records to: _____
(Name of Recipient)

Address of Recipient:

_____

Format Requested (circle one): **Electronically (if available)**: _____ **Fax to**: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature_____ **Date**:_____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-220-C (eff. XX/XX/XX)

State of Maine Workers' Compensation Board
Revocation of Limited Release of Medical/Health Care Information

Name: **SSN (last 4 digits): XXX-XX-**

Date of Birth: **Date of Injury/Illness:**

Notice to employee: This revocation must be sent to the recipient who requested access to your records. You should keep a copy of the signed form for your records.

I _____ am revoking the limited release of medical/health care information
(Name)

signed by me on _____ and provided to _____. This release revokes authorization
(Date) (Employer/Insurer)

for all health care providers, unless specified below:

☐ Only the following health care providers: _____

_____

I understand this revocation may result in a loss of or reduction in entitlement to workers' compensation benefits. I also understand this release does not apply to medical records already provided pursuant to the release.

I have read and understood this form.

I hereby revoke the release of my medical records:

Employee or Authorized Representative Signature_____ **Date**:_____

For purposes of this revocation, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

Notice to employer/insurer/employee representative: Within 14 days after receipt of this form you must forward a copy to all health care providers to whom you provided the limited release signed by the employee on the date listed above.

Notice to employee: Your health care provider may not receive your revocation immediately and will continue to release your records until they receive a copy of this revocation. You should provide a copy of this revocation to your health care providers as soon as possible. You should also keep a copy of this revocation for your records.

WCB-220-R (eff. XX/XX/XX)

CHAPTER 6 REHABILITATION

SUBCHAPTER I
PROVIDER PROVISIONS

§ 1. Board-Approved Employment Rehabilitation Providers/Facilities

1. Minimum Qualifications

   An employment rehabilitation provider/facility ("provider") must have at least five years of experience in employment rehabilitation services, and:

   A. Certification as a Certified Rehabilitation Counselor (CRC);

   B. A Bachelor's degree in rehabilitation counseling or a closely related field; and/or

   C. A Master's degree in rehabilitation counseling or a closely related field.

2. Application

   To become board-approved, a provider must file an application with the Executive Director or the Executive Director's designee at the Office of Employment Rehabilitation Services. The provider must include the following with the application:

   A. An up-to-date résumé;

   B. Copies of any active certifications and degrees; and

   C. At least one rehabilitation report written by the provider. All confidential information must be redacted, or the entire application will be rejected and returned.

   The Executive Director or the Executive Director's designee may require applicants to provide additional information.

3. Approval

   Only the Board of Directors, in its sole discretion, may decide whether to add an applicant to the list of board-approved providers. The decision must be based upon the provider's application, location, and the Board's need for additional providers.

4. Appointment

Appointments are for two years. A provider may apply for reappointment at, or near, the end of the appointment.

A. The provider must finish work on any referral that was received prior to expiration of appointment.

B. A provider may be removed from the approved list by the Executive Director or the Executive Director's designee if the provider does not comply with the requirements of the Workers' Compensation Act and these rules.

§ 2. Provider Requirements

1. Evaluation and Plan

A. A provider must consider medical evidence and information received with a referral for evaluation.

B. If a provider finds the employee is not suitable for employment rehabilitation services, the provider must clearly articulate the reason(s) in the evaluation.

C. If a provider finds an employee is suitable for employment rehabilitation services, the provider must include in the evaluation, at a minimum, the following:

i. Clearly articulated reasons the provider believes employment rehabilitation services are warranted;

ii. A concise summary of medical records reviewed;

iii. The source, date, and description of the employee's current work capacity, including restrictions;

iv. Clearly defined vocational goals for the employee; and

v. A detailed employment rehabilitation plan, including a clear plan for workforce re-entry, an outline of expected costs, and the estimated length of the plan.

D. A provider must submit the evaluation of the employee to the Executive Director or the Executive Director's designee no later than sixty days after the referral from the Board, unless the provider has received an extension of time from the Executive Director or the Executive Director's designee.

2. Plan Implementation

A. If a plan is implemented, the provider shall submit monthly reports to the Executive Director or the Executive Director's designee and all interested parties.

B. The provider shall communicate in a timely and responsive manner with the Executive Director or the Executive Director's designee after selection and during plan implementation.

C. Except in cases that lump sum settle, no later than thirty days after the conclusion of the plan, the provider must submit a final report that indicates whether the employee has returned to work.

i. If the employee has returned to work, the report must indicate where the employee is working, and how the plan resulted in that particular employment.

ii. If the employee does not return to work, the report must indicate why the plan was unsuccessful.

D. The Employment Rehabilitation Fund is not responsible for costs incurred after a case is lump sum settled. If the provider was not notified of the date of the lump sum settlement, then any costs incurred after the settlement date shall be paid by the employer/insurer.

3. Extension and Modification Requests; Provider

The provider may request an extension or modification of a previously approved plan. A request must include the information required in §2(1)(C). The provider must submit a request for an extension of time or modification to the Executive Director or the Executive Director's designee within 30 days of the date the plan is scheduled to end.

4. Conflict of Interest

The provider must decline any referral to conduct an evaluation on a case for which the provider has a conflict of interest and must notify the Executive Director or the Executive Director's designee immediately of such conflict.

5. Billing

A. A provider must submit a completed Vendor Activation/Change form or other form approved by the State Controller to receive payment for services provided to the Board.

B. A provider must submit monthly invoices for payment of costs and services. Invoices must include, at a minimum, dates of service, invoice number, and provider name and address.

C. Payment for costs and services included in a plan must be made directly to providers, unless the payor and the provider agree otherwise.

SUBCHAPTER II
APPLICATION AND PLAN

§ 3. Evaluation for Suitability

1. A party seeking rehabilitation services must file an Application for Evaluation for Employment Rehabilitation Services (WCB- 320) pursuant to 39-A M.R.S.A. § 217(1) with the Executive Director or the Executive Director's designee.

   A. The application must be complete, include copies of relevant medical records, and indicate whether the employee is receiving benefits or has received benefits;

   B. The applicant must provide a copy of the application and an attachment index to the parties; and

   C. Proposed rehabilitation plans will not be accepted with the application.

2. A party opposing the application shall file an objection no later than 10 business days after receipt of the application.

3. If a timely objection is not received, the Executive Director or the Executive Director's designee, after review of the application, may refer the employee to an approved provider.

4. If a timely objection is received, the matter will be forwarded to a Hearing Officer or Administrative Law Judge (ALJ) for review.

   A. The Hearing Officer or ALJ shall require all interested parties to submit written evidence and arguments pursuant to a schedule established by the Hearing Officer or ALJ. At the discretion of the Hearing Officer or ALJ, a testimonial hearing may be scheduled for the parties to present relevant testimony; and

   B. The Hearing Officer or ALJ's decision will be limited to whether employment rehabilitation services have been voluntarily offered and accepted.

   C. The Hearing Officer or ALJ's decision is final, but without prejudice to a future application, and is not subject to any appeal.

5. The Employment Rehabilitation Fund is responsible for the costs associated with the evaluation.

§ 4. Proposed Employment Rehabilitation Plan

1. Upon receipt of a proposed plan, the Executive Director or the Executive Director's designee shall forward the plan to all interested parties.

2. No later than 10 business days after receipt of the plan:

A. The Executive Director or the Executive Director's designee, or an interested party may request clarification of the plan.

i. Requests for clarification must include specific, written questions to the provider, with copies provided to the Executive Director or the Executive Director's designee, and interested parties; and

ii. The provider shall respond to the request in writing and amend the report as needed, or request a conference, with copies provided to the Executive Director or the Executive Director's designee, and interested parties, no later than 10 business days after receipt of the request for clarification.

B. The employer/insurer must notify the Board if the employer/insurer intends to voluntarily pay for the plan. If clarification has been requested, the employer/insurer must notify the Board if it intends to voluntarily pay for the plan no later than 10 days after receipt of clarification; and

C. The employer/insurer may file a written objection to the plan. If clarification has been requested, the employer/insurer may object to the plan no later than 10 days after receipt of the clarification.

3. If a timely objection is received, the matter will be forwarded to a Hearing Officer or ALJ for review.

A. The Hearing Officer or ALJ shall require all interested parties to submit written evidence and arguments pursuant to a schedule established by the Hearing Officer or ALJ. At the discretion of the Hearing Officer or ALJ, a testimonial hearing may be scheduled for the parties to present relevant testimony; and

B. The Hearing Officer or ALJ's decision will be limited to whether the proposed plan is likely to return the injured employee to suitable employment at a reasonable cost.

C. The Hearing Officer or ALJ's decision is final and not subject to any appeal unless the request to implement the plan is denied.

4. If a timely objection is not received, the Executive Director or the Executive Director's designee:

A. Shall order implementation of the proposed plan if the employer/insurer has agreed to voluntarily pay for the plan; or

B. May, after review of the plan, order implementation of the proposed plan, with costs to be paid from the Employment Rehabilitation Fund, if the employer/insurer has not agreed to voluntarily pay for the plan.

§ 5. Extension and Modification Requests; Parties

1. If a provider requests an extension or modification of a previously approved plan, the provisions of §4 subsections 1 through 4 apply.

§ 6. Plan Termination

An employment rehabilitation plan may end in the following ways:

1. The provider notifies the parties and the Executive Director or the Executive Director's designee, through a closure report, that services outlined in the plan have been completed.

2. The duration allowed under § 217(5) has expired.

3. A provider's request for an extension of time is denied by the Executive Director or the Executive Director's designee, or, if there is an objection to the request, by the Hearing Officer or ALJ.

4. The provider terminates the plan because the applicant is unwilling or unable to continue, or is otherwise uncooperative.

5. The parties enter into an agreement to end the plan.

6. A Hearing Officer or ALJ orders the plan to end.

7. The applicant's workers' compensation claim lump sum settles. The Employment Rehabilitation Fund is not responsible for costs incurred after a case is lump sum settled. If the provider was not notified of the date of the lump sum settlement, then any costs incurred after the settlement date shall be paid by the employer/insurer.

§ 7. Recovery of Costs

1. If an injured employee returns to suitable employment after completing a rehabilitation plan to which the employer/insurer did not agree to pay, the Executive Director or the Executive Director's designee shall order the employer/insurer to pay an amount equal to 180% of the costs paid, except the cost of the evaluation, from the Employment Rehabilitation Fund.

2. The employer/insurer shall, no later than 14 days after receipt of the Board's order, either pay the amount ordered by the Board or file a petition in the Central Office of the Workers' Compensation Board objecting to the order.

3. If a timely petition is received, the Board shall refer the matter to mediation.

4. If the matter is not resolved during mediation, the matter will be forwarded to a Hearing Officer or ALJ for hearing.

    A. The provisions of Chapter 12, §§ 3- 6, 9, and 12-19 apply to hearings conducted under this section.

B. The employer/insurer may raise all issues and defenses that were, or could have been raised, in any prior proceeding conducted under this chapter or § 217.

C. The Hearing Officer or ALJ's decision is subject to appeal as set forth in 39-A M.R.S.A. § 321-B.

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, the entity shall 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 Certificate of Accreditation and any other documents/information as requested by the Board; 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 Board.

      (1) 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 proof that URAC certification has been renewed and the new expiration date is provided.

5. The Board 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. § 210 or Workers' Compensation Board Rule Chapter 7.

6. The Board may at any time request case records for purposes of investigating Insurers/Utilization Review Agents compliance with 39-A M.R.S.A. § 210 and Board Rules.

7. The Board shall make available the list of entities certified by the Board to perform utilization review activities.

§ 2. *[Reserved]*

§ 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. § 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.

CHAPTER 8 PROCEDURES FOR PAYMENT

SUMMARY**:** 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, 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. If the employee's date of injury is on or after January 1, 2013, the employee's incapacity benefits must be calculated by multiplying the employee's gross average weekly wage by two (2) and then dividing that amount by three (3).

§ 6. The employer is obligated to make all payments of benefits ordered by an Administrative Law Judge 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 Administrative Law Judge ordering such payment. Interest must be calculated using the formulae and table contained in Appendix I.

§ 8.

A. If the injured employee's date of injury is prior to January 1, 2013, 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, but not more than the maximum benefit under section 211. 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.

B. If the injured employee's date of injury is on or after January 1, 2013, partial benefits are equal to 2/3 of the difference due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the average gross weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum benefits under section 211. To calculate partial benefits:

1. Determine 2/3 of the employee's gross average weekly wages, earnings or salary in effect at the time of the employee's injury.

2. Determine 2/3 of the employee's post-injury weekly earnings.

3. The difference between the post-injury rate and the pre-injury rate is the partial benefit amount.

§ 9. For dates of injury prior to January 1, 2013, 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. If an employee is released to return to work without restrictions or limitations due to the injury before exhausting the seven day waiting period, a Notice of Controversy is not required to be filed regarding incapacity benefits unless the employee makes a specific claim for benefits.

§ 11. Reductions or discontinuances pursuant to 39-A M.R.S.A. § 205(9)(A) are governed by this section.

1. Except as provided in paragraph (2) of this sub-section, reductions and discontinuances pursuant to 39-A M.R.S.A. § 205(9)(A) must be based on the employee's actual earnings.

2. An employer may discontinue benefits regardless of the employee's actual earnings if:

   A. The employee returns to work without restrictions or limitations, due to the injury for which benefits are being paid, according to the employee's treating health care providers; and

   B. There are no conflicting medical records with respect to the lack of restrictions or limitations due to the injury for which benefits are being paid.

   C. For purposes of this subsection, return to work includes periods where:

      (1) The employee is released to return to work without restrictions or limitations due to the injury for which benefits are being paid by the employee's treating health care providers;

      (2) There are no conflicting medical records with respect to the lack of restrictions or limitations due to the injury for which benefits are being paid; and

      (3) The employee, instead of returning to work, receives vacation pay, "paid time off" or its equivalent, or holiday pay instead of regular wages.

3. The Discontinuance or Modification of Compensation (WCB-4) shall be filed by the employer or insurer within 14 days after the employee returns to work or receives an increase in pay discontinuance or reduction 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. Pursuant to P.L. 2009, c. 280, reductions and/or discontinuances based on earnings when an employee returns to work with a different employer and an employer/insurer has filed a 21-day certificate of discontinuance or a Petition for Review are governed by this section.

1. Actual documented earnings must be provided by the employee or the employee's representative to the employer/insurer within 7 days of the employee's return to work as required by 39-A M.R.S.A. § 308(1). Actual documented earnings must be received by the employer/insurer from the employee or the employee's representative in writing. The documentation may be pay stubs or other suitable written evidence to substantiate the discontinuance or reduction.

2. Reduction or discontinuance pursuant to § 205(9)(B)(1).

    A. When benefits are discontinued or reduced pursuant to § 205(9)(B)(1), actual documented earnings means the written documentation relied upon by the employer/insurer to justify the reduction or discontinuance indicated in the 21-day certificate of discontinuance.

    B. The employer/insurer must include, with the 21-day certificate of discontinuance, form WCB-231A (Employee's Return to Work Report) along with the following statement:

NOTICE

Your weekly benefits will be reduced or discontinued each week to the amount shown on the 21-day certificate of discontinuance. You are required to provide documentation to the insurer of your weekly earnings for the 21-day period by completing the enclosed "Employee's Return to Work Report." If you fail to provide documentation, the reduction or discontinuance shown on the 21-day certificate of discontinuance shall remain in effect and your benefits will not be adjusted.

C. Within 14 calendar days after the expiration of the 21-day period, or within 14 days after receipt of documentation from the employee if the documentation is received after the expiration of the 21-day period, the employer/insurer shall file with the Board the documentation it has received along with an amended form WCB-8 which shall also include any necessary adjustments based on the documentation received by the employer/insurer.

3. Reduction or discontinuance pursuant to § 205(9)(B)(2)

A. When benefits are discontinued or reduced pursuant to § 205(9)(B)(2), actual documented earnings means the written documentation relied upon by the employer/insurer to justify the reduction or discontinuance requested in the Petition for Review.

B. In addition to the Petition for Review, the employer/insurer shall send to the employee form WCB-231A (Employee's Return to Work Report) along with the following statement:

NOTICE

Your weekly benefits will be reduced or discontinued each week to the amount shown on the Petition for Review. You are required to provide documentation to the insurer of your weekly earnings while the Petition for Review is pending before the Workers' Compensation Board by completing the enclosed form "Employee's Return to Work Report." If you fail to provide documentation, the reduction or discontinuance shown on the Petition for Review shall remain in effect and your benefits will not be adjusted.

C. The employer/insurer shall file the actual documented earnings referenced in sub-§ (1) of this section and form WCB-4 showing the adjustment that was made with the Board at the same time it files the Petition for Review.

Thereafter, the employer/insurer shall, within 30 days after receipt of actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4 showing the adjustment that was made.

§ 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 an 02 First Report using the IAIABC Claims Release 3 format. The employee's return to work date shall be filed within seven (7) days of the employee's return to work.

§ 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. The Consent Between Employer and Employee (WCB-4A) may be used when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification, reduction or discontinuance in ongoing weekly incapacity benefits. The Consent Between Employer and Employee (WCB-4A) may be used when the parties agree to discontinue or reduce benefits during the 21-day period following the filing of a Certificate of Discontinuance or Reduction of Compensation (WCB-8). The Consent Between Employer and Employee (WCB-4A) cannot be used to reduce or discontinue benefits on a date that is subsequent to the date the parties sign the WCB-4A.

2. The WCB-4A shall be signed by the employee or a representative of the employee, and a representative of the insurer.

3. The parties may agree to the pre-injury average weekly wage or may agree to pay benefits based upon a provisional wage and reserve the issue of the pre-injury average weekly wage for later determination by the Board. In either event, the form shall also indicate whether the employee is receiving 100% of the benefits at issue for the designated period. If the employee is receiving less than 100% of the benefits at issue for the designated period, the form shall indicate the percentage of benefits that the employee is receiving.

4. The employer or insurance carrier shall make compensation payments within 10 calendar days after the WCB-4A is signed by the parties.

5. Signing the WCB-4A does not by itself create a compensation payment scheme.

6. The WCB-4A shall be distributed as follows: (1) Workers' Compensation Board; (2) Employee; (3) Insurer; (4) Employer.

7. 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.

8. 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).

9. 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.

10. 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.

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 x 83) x 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 =

$$\frac{((\text{Weekly compensation x weeks of benefits}) + \text{Interest due}) \text{ x days x } 10\%}{365}$$

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 x 25) x 0.022328 = $167.46 (The interest due through July 26, 1997.)

Then, calculate the interest due between the date the last payment was due and the payment date:

$$\frac{((\$300.00 \times 25) + \$167.46) \times 405 \times 10\%}{365} = \$850.77$$

(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.A. § 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). 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)

1. Calculation of reduction to employee's weekly benefits.

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.

2. Coordination of benefits paid pursuant to "paid time off" or equivalent plans.

A. Paid time off or equivalent plan means an employer-paid benefit that covers both sick leave and vacation leave.

B. If a paid time off or equivalent plan designates a specific portion of the benefit as sick leave, an employer/insurer may reduce benefits, as set forth in 39-A M.R.S.A. § 221(3)(A)(2).

C. If a paid time off or equivalent plan does not designate a specific portion of the benefit as sick leave, an employer/insurer may reduce benefits, as set forth in 39-A M.R.S.A. § 221(3)(A)(2), when the benefit taken is used for the equivalent of sick leave rather than vacation leave.

§ 3. Notification and Release of Social Security Benefit Information Pursuant to § 221(4).

A. (1) When an employee is receiving either weekly or lump sum payments pursuant to § 212 or § 213 the employer/insurer shall mail a notice, in a form prescribed by the Board, to the employee of possible eligibility for Social Security benefits and the requirements for establishing proof of those benefits.

(2) Notice must be promptly mailed to the employee after the date the employee reaches his or her full retirement age as defined by the Social Security Administration.

(3) The notice must be mailed to the Workers' Compensation Board at the same time it is sent to the employee.

B. The notice shall include the following language:

NOTICE

(1) Because you have reached your full retirement age as defined by the Social Security Administration, you must, within 30 days after receipt of this notice:

- Apply for Social Security old-age insurance benefits. (You cannot be compelled to apply for early federal old-age insurance benefits.)

  - You may apply at a local Social Security office; or
  - Online at: http://www.ssa.gov/pgm/retirement.htm.

- To understand your rights and responsibilities with respect to your application for and receipt of Social Security benefits, and the Workers' Compensation Act, you should consider seeking advice from an attorney or other expert in Social Security and Workers' Compensation laws.

- You must provide proof to us that you have applied for benefits.

  - Proof of application must be mailed to us within 14 days after you submit your application to the Social Security Administration at the following address:

    [INSERT EMPLOYER/INSURER ADDRESS]

  - Proof of application includes:

    A letter from you, or your attorney or advocate establishing you filed the required application;

- You must complete, sign and return the enclosed authorization form, approved by the Social Security Administration, to release benefit information. Please note, your employer/insurer can only use this form to determine if you are entitled to receive Social Security benefits and, if so, the amount of the benefit you are receiving and the period of time you are or have been receiving Social Security benefits.

(2) Pursuant to 39-A M.R.S.A. § 221 your benefits will be reduced by up to 50% of the amount of old-age insurance benefits your employer is entitled to offset and you receive under the Social Security Act.

(3) If you fail to provide proof of application or sign and return the enclosed form, we may, with the approval of the Workers' Compensation Board, discontinue your compensation benefits until the proof of application and/or the authority for release of information is provided. Compensation benefits withheld must be reimbursed to you when the required proof of application, or the authority for release of information, or both, has been provided.

C. If a new authority for release of benefit information is required, the employer/insurer must send the following notice along with the appropriate Social Security form.

NOTICE

The enclosed release previously signed by you has expired. Pursuant to 39-A M.R.S.A. § 221(6), you are required to sign and return the enclosed release within 30 days after receipt of this notice.

If you fail to provide proof of application or sign and return the enclosed form we may, with the approval of the Workers' Compensation Board, discontinue your compensation benefits until the proof of application and/or the authority for release of information is provided. Compensation benefits withheld must be reimbursed to you when the required proof of application, or the authority for release of information, or both, has been provided.

D. The employer/insurer may notify an employee receiving incapacity benefits, who is near the age of 62, of his or her obligation to inform the employer/insurer of application for and receipt of old age Social Security benefits, the date those benefits begin and the amount of those benefits, so that the appropriate offset can be taken.

CHAPTER 12 FORMAL HEARINGS

§ 1. Filings

1. Petitions and other notifications of disputes shall be filed with the Board's Central Office in Augusta, Maine.

2. Except as specifically provided in the Maine Workers' Compensation Act of 1992 or in these rules, any party opposing a motion or wishing to respond to another party's submission must file a response not later than 21 days after the filing of the motion.

§ 2. Medical Bills

Itemized bills, liens, co-pays, and out of pocket expenses must be filed with petitions for payment of medical and related expenses. This rule does not prohibit a party from seeking a prospective order for payment of medical treatment if payment for that treatment or treatments, or related expenses, has been denied by the opposing party.

Petitions for payment of medical and related expenses can be amended up to the date of the last scheduled hearing.

Payment of medical and related expenses must be made within 10 days after a decree is issued or the date the information required in Chapter 5 is received, whichever is later.

§ 3. Dismissals

1. Parties shall be prepared and ready for hearing. If the petitioning party is unprepared or fails to appear, the Administrative Law Judge shall dismiss the matter unless good cause is shown within 30 days.

2. The Board, by its own motion, after notice to the parties and in the absence of a showing of good cause to the contrary, may dismiss an action for want of prosecution at any time more than two years after the last docket entry showing any action taken by the petitioning party. That dismissal operates as an adjudication upon the merits.

3. Unless otherwise indicated, the dismissal of any petition is without prejudice.

§ 4. Interpreters

An Administrative Law Judge may appoint an interpreter, including an interpreter for the deaf. Interpreters must be appropriately sworn.

§ 5. Continuances

1. A request for a continuance must:

   A. Be in writing and can be submitted by mail, fax, or other form of electronic transfer;

   B. Be filed no later than 7 days before the hearing or conference;

   C. Indicate the reason(s) for the request;

   D. Indicate whether there is any objection to the request;

   E. Indicate whether the employee is working;

   F. Indicate whether weekly benefits are being paid; and,

   G. Indicate whether medical treatment is being denied.

2. Parties should not assume that a continuance has been granted. A continuance requires the Administrative Law Judge's approval. An Administrative Law Judge shall deny a request for continuance that does not comply with the requirements in subsection 1, absent a showing of good cause.

3. If a party who has already requested one continuance requests an additional continuance for the same proceeding, that party must affirm that the party's client approves the request.

§ 6. Conferences

1. When one or more parties is unrepresented, the Board shall schedule a conference before a hearing is set. The parties are not required to fill out the Joint Scheduling Memo as provided in § 9 before the conference. The Joint Scheduling Memo may be filled out at the conference with the Administrative Law Judge.

2. Except as provided in this section, when all parties are represented, the Board will not schedule a conference. The parties shall complete a Joint Scheduling Memo as provided in § 9.

3. The Administrative Law Judge may set a case for conference if one or more parties requests a conference or at the Administrative Law Judge's initiative. If the petitioning party objects to the request, the Administrative Law Judge shall consider the impact of further delay on the petitioning party.

§ 7. *[Reserved]*

§ 8. Exchange of Information; Discovery

1. The parties shall complete the exchange of information form found in Appendix II, and provide it to the opposing party or parties no later than 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 the party. If a party is represented by counsel, the signature of counsel constitutes that party's representation that after due inquiry, that party 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 up to three additional, non-complex questions of reasonable length, subject to objection by the opposing party or parties and review by the Administrative Law Judge. Subject to the limitations set forth in this rule, other information may be exchanged by agreement.

   The employee shall provide to the employer any report generated by a physician, surgeon, or chiropractor who attended an examination under 39-A M.R.S.A. § 207.

2. Discovery motions must be filed in the appropriate regional office. Objections to discovery motions must be filed within 21 days of their receipt. The Administrative Law Judge may decide the motion without a hearing or conference, but may schedule a hearing or conference, at the judge's discretion or upon request of one or more parties.

3. Witnesses may only be deposed by agreement of the parties or by order of the Administrative Law Judge pursuant to subsection 2. Unrepresented employees may not be deposed.

4. Except as provided in section 10, depositions of experts must be scheduled before the testimonial hearing and completed no later than 45 days after the hearing. Additional time may be allowed upon motion to the Administrative Law Judge. At the hearing, the parties shall provide the Administrative Law Judge with the dates of depositions that have been scheduled but are not yet completed.

§ 9. Joint Scheduling Memorandum

1. The parties or their representatives shall confer and complete fully and accurately a Joint Scheduling Memorandum. The petitioning party shall file the Joint Scheduling Memo with the appropriate regional office no later than 45 days after mediation or the filing of a petition, whichever is later. If the Joint Scheduling Memo is not received in a timely fashion, the Administrative Law Judge may dismiss the pending petitions if the Joint Scheduling Memo is not filed within 21 days after notice from the Board that the petitions will be dismissed. An objection to the Joint Scheduling Memo must be filed no later than 21 days after its submission.

2. A hearing will not be scheduled on a petition until the parties file a Joint Scheduling Memo as provided in this section.

3. The Administrative Law Judge may deem waived legal issues not raised in the Joint Scheduling Memo.

4. A Joint Scheduling Memo template is included in Appendix I.

§ 10. Independent Medical Examination

1. Requests

A. (1) If a § 312 examination has been requested prior to the filing of the Joint Scheduling Memo, the parties shall state on the memo the date of the request, whether the request has been approved by the Board's Office of Medical and Rehabilitation Services, and, if approved, the name of the examiner and the date of the examination.

(2) If a § 207 examination has been requested prior to the filing of the Joint Scheduling Memo, the parties shall state on the memo the date of the request, the name of the examiner, and the date of the examination.

B. (1) If a § 312 examination has not been requested prior to the filing of the Joint Scheduling Memo, a request must be made no later than 30 days from the date of filing.

(2) If a § 207 examination has not been requested prior to the filing of the Joint Scheduling Memo, a request must be made no later than 30 days from the date of filing.

C. A request for an extension of the 30-day period must be made in writing to the Administrative Law Judge no later than 30 days after a party receives significant medical evidence. The 30-day period may be extended by order of the Administrative Law Judge if the moving party demonstrates

good cause. Good cause includes, but is not limited to, generation of significant medical evidence since the filing of the Joint Scheduling Memo. Good cause does not include failure to have exchanged relevant medical information in a timely manner pursuant to Board Rule Chapter 4, section 3.

2. Depositions

An independent medical examiner may be deposed only by agreement of the parties or order of the Administrative Law Judge. If the Administrative Law Judge orders a deposition, it must be scheduled within 45 days after entry of the order permitting the deposition.

§ 11. Work Search, Labor Market, and Surveillance Evidence

The following rules apply to cases involving work search, labor market or surveillance evidence.

1. No later than 30 days after mediation or the filing of a petition, whichever is later, the employee shall provide the employer with the work search or labor market evidence that the employee intends to introduce into evidence. It is recommended the employee use a standardized Workers' Compensation Board work search log and shall include, at a minimum, names of prospective employers, dates of application, responses to the application, if any, and whether the application was submitted in person, by mail, electronically, or by some other means.

2. No later than 21 days after receipt of information provided pursuant to subsection 1, the employer shall provide the employee with the labor market evidence that the employer intends to introduce into evidence.

3. Work search and labor market evidence developed or obtained after the deadlines set forth in subsections 1 and 2 of this section shall be exchanged no later than 7 days before the hearing.

4. Except as provided in subsection 5 of this section, regardless of whether the employer intends to offer the surveillance information into evidence, the employer shall provide the surveillance information to the employee as follows:

   A. The employer shall provide all surveillance information to the employee developed since the date of injury, or since the last decree, whichever period is shorter, in connection with the claim and provide an affirmation that all surveillance information has been provided. The employer shall provide the surveillance to the employee within 14 days after the employer receives the information from the employee under subsection 8(1) of this

chapter or Appendix II, and in no event later than 7 days before the hearing.

B. For surveillance information obtained by the employer before the submission of the Joint Scheduling Memo, the employer shall provide that information to the employee within 14 days after the employer receives information from the employee under subsection 8(1) of this chapter or Appendix II.

C. For surveillance information obtained by the employer after the submission of the Joint Scheduling Memo, the employer shall provide surveillance information to the employee no later than 14 days after the employer receives that information, and, in no event, later than 7 days before the hearing.

5. The employer may file a motion to stay production of surveillance information with the Executive Director prior to the production deadlines established in subsection 3 of this section. The motion must include all surveillance information. The employer shall file a cover letter with the motion, a copy of which the employer shall timely provide to the employee and the Administrative Law Judge. The employer is not required to provide a copy of the motion or the surveillance information to the employee or the Administrative Law Judge. The Executive Director, or the Executive Director's designee, may, if there are significant inconsistencies with information provided by the employee pursuant to these Rules, allow the employer to defer providing the surveillance information to the employee until immediately after the employee's sworn testimony. The Executive Director, or the Executive Director's designee, shall act upon motions filed under this subsection no later than 14 days after their receipt.

§ 12. Exhibits

1. The parties may mark exhibits submitted into the evidentiary record by number and submission date. Absent agreement of the parties to the contrary, the Administrative Law Judge may exclude an exhibit offered at hearing that was not exchanged by the parties at least 7 days before the final hearing in the matter.

2. The parties may jointly submit relevant medical records and reports as a single, indexed, and tabbed exhibit. The reports and records must be in chronological order and grouped together by health care provider, unless otherwise specified. Exhibits to which there is an objection must be marked separately. The Administrative Law Judge may exclude an exhibit that does not comply with this subsection.

§ 13. Formal Hearings

1. The Board shall schedule a case for a formal hearing as soon as practicable for the duration identified in the Joint Scheduling Memo or otherwise requested. If the parties do not indicate a duration, the case will be set for 60 minutes for receipt of all testimony and evidence. The Administrative Law Judge, at the judge's discretion, may adjust the length of a hearing or strictly enforce the time allotted.

2. An Administrative Law Judge may allow an additional hearing if necessary. When determining whether to schedule an additional hearing, the Administrative Law Judge shall consider whether weekly benefits are being paid. If weekly benefits are not being paid, the Administrative Law Judge may order payment of benefits without prejudice if an additional hearing is ordered.

§ 14. Position Papers

The Administrative Law Judge shall establish a due date for position papers. A request for additional time to file position papers must be made in writing and must indicate whether the opposing party objects to the request. In lieu of position papers, the parties may request oral argument at the close of the final hearing.

§ 15. Proposed Findings of Fact

Proposed findings of fact and conclusions of law shall be filed no later than 15 days after the filing of a motion for additional findings filed pursuant to 39-A M.R.S.A. § 318. If the moving party fails to timely file proposed findings and conclusions, the Administrative Law Judge may dismiss the motion.

§ 16. Alternative Procedures or Timeframes

Upon notice to the parties and for good cause, an Administrative Law Judge may alter the requirements and timeframes in this chapter. In determining whether there is good cause to order alternative procedures or time frames, the Administrative Law Judge may consider the relative efficiency of alternative procedures, fairness to the parties, and the needs of unrepresented parties.

§ 17. Sanctions

An Administrative Law Judge may impose sanctions on a party who violates these rules, following reasonable opportunity to be heard. The Administrative Law Judge may dismiss pending petitions; grant relief requested in the petitions; exclude evidence; award payment of attorney's fees; or order other temporary relief, including payment or discontinuance of weekly benefits without prejudice until the violating party complies or a final decision is issued.

§ 18. Lump Sum Settlements; Record of Proceedings

1. The Board shall record hearings on proposed settlements pursuant to 39-A M.R.S.A. § 352 and include those recordings in the official record of the case.

2. A. An Administrative Law Judge may conduct hearings and issue decisions on 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, an Administrative Law Judge shall determine expected future medical costs related to the injury.

§ 19. Disposition of Evidence

1. If a decision of an Administrative Law Judge, the Appellate Division, or the Board has not been timely appealed, all evidence submitted by the parties and transcripts of proceedings in the matter may be destroyed by the Board after 60 days from the expiration of the time for appeal set forth in 39-A M.R.S.A. § 321-B or § 322. Prior to that time, parties may file a written request for return of evidence or transcripts and either enclose a postage pre-paid envelope or schedule a time to pick up the file materials. Evidence and transcripts in cases that are appealed to the Law Court may be destroyed no earlier than 60 days after the Law Court denies appellate review or issues an opinion. This rule must be executed in accordance with 5 M.R.S.A. § 95(9).

2. The Board shall clearly note the anticipated time of file destruction on all decrees, findings of fact and conclusions of law, and Appellate Division decisions issued after the effective date of this rule.

3. The Board shall preserve audio tapes and electronic recordings of hearings for 6 years from the date on which the testimony was presented, except that the Board shall preserve audio tapes and electronic recordings of lump sum settlement conferences for 10 years from the date the lump sum settlement was approved.

§ 20. Title of "Administrative Law Judge"

Pursuant to PL 2015 c. 297, the title of "Hearing Officer" was changed to "Administrative Law Judge." The Board's amendments to its rules concerning these titles are intended to adopt this change.

Appendix I: Joint Scheduling Memorandum

Appendix II: Exchange of Information Form

Chapter 12
APPENDIX I

_____
Administrative Law Judge

STATE OF MAINE
WORKERS' COMPENSATION BOARD

_____ _____
DOI

v.

_____
WCB#

_____

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: _____.

3. Relief requested, including nature and period of incapacity:

4. Issues, including affirmative defenses:

5. Section 312 examination requested?: Yes No When:_____

   With whom:_____

6. Section 207 examination requested?: Yes No When:_____

   With whom:_____

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:

I affirm that the parties have exchanged information as provided in this chapter.

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. Your full name, age, and level of education/training.

2. Describe the injury: the nature of the injury, how and when it happened, when you realized that the injury resulted from your work, who at work you told about the injury, and when you told that person.

3. Have you worked since the injury? If so, when, where, and how much did you earn? Have you received unemployment benefits since the injury? If so, state the period of time you received benefits, state whether the benefits are ongoing, and state how much is or was the weekly amount received.

4. What medical treatment have you received as a result of your work injury? Include the names and addresses of doctors, hospitals, and other health care providers you have seen because of this injury.

5. Have you ever injured the same body part before?

   Do you have any pre-existing medical conditions related to that body part? If so, describe any medical treatment you have received for those injuries or conditions and include the names of doctors, hospitals, and other health care providers that treated you for those injuries or conditions.

6. Please indicate with a yes or no whether your employer pays for all or part of any fringe benefits such as health, life, disability, dental insurance, or contributions to a 401(k) or pension plan.

7. Please state whether you are asking to be reinstated to the job you were working in when you were injured or to another job for the same employer.

8. List all the jobs you have had over the past 10 years, when you had each job, and what your duties were in each job.

9. List all of your witnesses, other than yourself and your medical providers, and give a short summary of their testimony.

10. Have you suffered any other injuries since you were injured at work? If you have, describe when and how each injury happened and provide the names and addresses of doctors, hospitals, and any other health care providers that you saw because of those injuries.

11. Please provide a description of your current daily activities.

12. Please tell whether you have engaged in any sports, recreational, or home maintenance activities after your date of injury.

13. Are there activities you can no longer do as a result of your injury? If so, describe those activities.

14. Please state whether you have received Old Age Social Security benefits since the date of your injury.

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. If the employee has requested reinstatement, please list all positions available from the date of that request through the present that are 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. If so, describe the position.

2. Supply all relevant wage information including a wage statement and complete fringe benefits 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 six months.

3. Except as provided in section 11, subsections 3 and 4 of this chapter, state whether the employer has any evidence that the employee's reports of limitations or other history given to any person in this case are inaccurate and state the basis for that contention. Provide relevant documentary and written information.

4. Supply a copy of the employee's personnel file consistent with *Harding v. Walmart Stores, Inc.*, 2001 ME 13, 765 A.2d 73.

5. State the legal name of your business, the number of employees it employs, and the nature of your operation.

6. List your witnesses and give a summary of their testimony.

7. Give the name(s) and the position(s) of the person(s) supplying this information.

CHAPTER 13 RULES OF APPELLATE DIVISION

§ 1. Scope of Rules

This chapter governs the procedure of the Maine Workers' Compensation Board Appellate Division ("the division"). It is promulgated pursuant to 39-A M.R.S.A. § 321-A (3) and must be construed to secure the prompt and inexpensive review of board decisions.

§ 1-A. Submissions to Appellate Division

Submissions to the Appellate Division are filed when received at the Appellate Division or at any of the Board's regional offices. A party filing a submission at a regional office is responsible for the cost of transferring the submission to the division.

§ 2. Composition of Appellate Panels; Sessions

1. Composition of Panels.

   A. Pursuant to 39-A M.R.S.A. § 321-A, the Executive Director of the Workers' Compensation Board or, upon designation by the Executive Director, the clerk of the division, shall appoint a panel of at least three full-time Administrative Law Judges from those then serving as Administrative Law Judges of the Workers' Compensation Board. An Administrative Law Judge may not be a member of a panel that reviews that Administrative Law Judge's decision. An Administrative Law Judge may be a member of more than one panel at the Executive Director's discretion.

   B. The Executive Director or, upon designation by the Executive Director, the clerk of the division, shall select a presiding judge for each panel.

   C. The Executive Director may expand the panel if the Executive Director determines that the issue(s) presented on appeal warrant consideration by more than three Administrative Law Judges or by the division *en banc*.

2. Sessions.

   The Executive Director shall determine when and where the division holds sessions.

3. Notice.

After an appeal is assigned to a panel and a session, the clerk of the division shall notify the parties of the composition of the panel and the date the session will occur.

§ 3. Appeal to the Appellate Division

1. Time for Filing.

A party shall file a Notice of Intent to Appeal (WCB-240) an Administrative Law Judge's decision with the clerk of the division within 20 days after the latest of:

A. Receipt of notice of the Administrative Law Judge decision;

B. If an Administrative Law Judge amends a decision and that amendment materially affects the issue(s) on appeal, receipt of notice of an amended Administrative Law Judge decision; or

C. If a motion for findings of fact and conclusions of law has been filed pursuant to 39-A M.R.S.A. § 318, receipt of notice of the Administrative Law Judge's ruling on the motion.

If, after a party files a Notice of Intent to Appeal under this section, a different party seeks review of a different issue than the issue(s) identified for appeal in the first notice, that party may file a Notice of Intent to Appeal within the 20-day period provided in paragraphs A-C, or within 14 days after the date the first notice was filed, whichever is later.

If both a Notice of Intent to Appeal and a motion for findings of fact and conclusions of law are filed within 20 days after receipt of notice of a decision by an Administrative Law Judge pursuant to 39-A M.R.S.A. § 318, the division shall stay action on the Notice of Intent to Appeal until the Administrative Law Judge rules on the motion. The appellant shall notify the division no later than 10 days after receipt of notice of the ruling on the motion whether the appellant will pursue the appeal.

For purposes of this chapter, "decision" means a final decision issued by an Administrative Law Judge that fully disposes of the matters pending before the Administrative Law Judge. "Decision" does not include interlocutory or non-final decisions including, but not limited to, provisional orders.

2. Filing.

A party shall file a Notice of Intent to Appeal with the division and identify the issue(s) being appealed. The filing date is the date the Notice of Intent to Appeal

is received at the appellate division or at any of the Board's Regional Offices. Receipt may include receipt by e-mail, provided the original is sent by U.S. mail or other carrier on or before the due date. The appealing party shall include a copy of the decision being appealed, and shall indicate on form WCB-240 that the transcript of the relevant hearing(s) will be ordered or has already been prepared.

3. Service.

A party that files a Notice of Intent to Appeal shall serve a copy of the notice to the attorney or advocate of record of each party, or if a party is unrepresented, to the party at that party's last known address.

4. Multiple Appeals.

Unless otherwise agreed upon by the parties, when more than one party has appealed, the party who appeals first is deemed the appellant for the purposes of this chapter.

5. Dismissal of Appeals.

A. Withdrawal of appeal.

Upon receipt of a written stipulation of the parties withdrawing an appeal, the clerk of the division shall dismiss the appeal. If the parties do not agree to withdraw an appeal, an appeal may be withdrawn only by permission of the panel acting through the presiding judge.

B. Failure to perfect appeal.

Dismissals for failure to perfect appeal are as follows:

i. Upon a motion of a party and a showing of substantial prejudice, the panel acting through the presiding judge may dismiss a timely filed appeal if the appellant fails to:

a. Provide a copy of the decision; or

b. Serve the parties as provided in § 3.3;

ii. Upon a motion of a party or at the initiative of the panel acting through the presiding judge, the division may dismiss an appeal if an appellant fails to comply with § 4.1; or

iii. Upon a motion of a party or at the initiative of the panel acting through the presiding judge, the division may dismiss an appeal if an appellant fails to comply with § 5.

C. Settlement.

If the parties agree to settle a case pending before the division, the appellant shall notify the division, which shall stay action on the appeal. The appellant shall notify the division within 10 days after the board approves the settlement and the clerk of the division shall dismiss the appeal.

D. Failure to guarantee payment.

If, after 60 days' notice to the appellant that a guarantee of payment for preparation of the transcript is required, the appellant fails to guarantee payment or request a waiver of payment of costs pursuant to § 4(1-A), the panel acting through the presiding judge may dismiss the appeal.

§ 4. The Record on Appeal

1. Preparation.

The appellant shall prepare the record on appeal. Upon filing the Notice of Intent to Appeal, the appellant shall request the appropriate regional office to order necessary transcripts for the appeal. The appellant shall pay the cost of producing the record, including the transcript(s). Within 45 days after the filing date of the Notice of Intent to Appeal, the appellant shall deliver one copy of the record to the clerk of the division and one copy of the record to each party involved in the appeal. The clerk may grant an extension of time if there is a delay in the preparation of the transcript.

1-A. Waiver of Payment of Costs.

An appellant seeking to appeal to the division may file an application for leave to proceed without payment of costs. The application should be filed within ten days of the Notice of Intent to Appeal, and in no event later than the date the record is due.

The application shall be accompanied by an affidavit of the appellant stating (i) the person's monthly income and necessary monthly expenses; (ii) whether the person is receiving public assistance income and, if so, identifying the government program and the nature and the duration of the assistance; (iii) that

the appeal is filed in good faith; and (iv) the appellant agrees to repay the Board for any costs that have been waived or paid, if at any time during the pendency of the appeal, the appellant becomes or is discovered to be financially able to repay those costs.

The affidavit shall be kept separate from the other papers in the case and kept confidential.

The panel acting through the presiding judge may enter such orders, including but not limited to limiting the record on appeal, as it deems appropriate.

2. Contents.

The record on appeal consists of copies of the pleadings; transcripts of proceedings; exhibits; exhibit list; position papers; the Administrative Law Judge decision(s) being appealed; the Notice of Intent to Appeal; proposed findings submitted to the board; further findings of fact and conclusions of law issued by the Administrative Law Judge; and petitions, decisions or other matters of which the Administrative Law Judge took administrative notice. The parties may agree to exclude from the record any items that are unnecessary for deciding the appeal.

3. Format.

The pages of the record must be clearly numbered and be printed on both sides. Each volume of the record on appeal may contain no more than 150 double-sided sheets of paper and must be securely bound. The cover of the record on appeal must be of heavy grade paper and indicate the case name, the date of injury/injuries, the board file number, the Appellate Division case number, and names of the attorneys or advocates representing each of the parties and the names of the parties they represent. The panel may request an electronic copy of the record, but the parties may not otherwise submit an electronic copy without the panel's permission.

4. Correction or Modification of the Record.

If a party claims that the transcript does not accurately reflect what occurred before the board or that something material is missing from the record on appeal, the party may file a motion to modify the record with the appellate division. The clerk of the appellate division may refer the motion to the Administrative Law Judge who issued the decision. The Administrative Law Judge may, in response to that motion, or by request of the panel acting through the presiding judge, order

preparation of a supplemental record to be filed with the clerk of the division and made part of the record on appeal.

§ 5. Time for Briefs

1. Time for Filing Briefs.

When the record on appeal has been prepared pursuant to §4 and filed with the clerk of the division, the clerk of the division shall notify each party in writing of the briefing schedule. The appellant has 30 days after the date the record is filed to file a brief. The appellee has until the date designated by the division in the briefing schedule, or 20 days after receipt of the appellant's brief, whichever is later, to file a brief. The appellant has 15 days after the due date for the appellee's brief to file a reply brief. A brief is considered filed when received by the division. Receipt may include receipt by e-mail, provided the original and all required copies are sent by U.S. mail or other carrier on or before the due date.

1-A. Cross-Appeals.

When a cross-appeal has been filed, the briefing schedule is as follows:

The appellant has 30 days after the record is filed to file a brief. The appellee/cross-appellant shall consolidate the appellee's brief and the cross-appellant's brief in a single brief to be filed on or before the date designated by the division in the briefing schedule, or 20 days after receipt of the appellant's brief, whichever is later. The cross-appellee has 20 days after the due date of the appellee/cross/appellant's brief to file a response. The appellant/cross-appellee shall consolidate the reply brief and response to the cross-appellant's brief in a single brief. The appellee/cross-appellant has 15 days after the due date for the cross-appellee's brief to file a reply brief. A brief is considered filed when received by the division.

2. Extensions.

A party may file a written motion to extend the time to file a brief before the date the brief is due. The clerk shall grant motions for extensions of 14 or fewer days if the moving party represents that there is no objection to the motion. Additional unopposed requests for extensions may be granted for good cause. The panel acting through the presiding judge may grant motions for extensions to which a party objects, after reviewing the circumstances of the appeal. The clerk or the

panel acting through the presiding judge may not grant a motion to extend filed after the due date of the brief for which the motion is filed.

3. Number of Copies to be Filed and Served.

Unless otherwise ordered by the panel acting through the presiding judge, five copies of each brief must be filed with the clerk of the division and one copy of each brief must be served on the counsel or advocate for each of the other parties separately represented. If a party is unrepresented, a copy of each brief must be sent to that party at the party's last-known address. The panel acting through the presiding judge may reject a brief that is not accompanied by acknowledgement or certificate of service that shows compliance with this subsection.

4. Failure to File Briefs.

If an appellant fails to comply with this rule, the appeal may be dismissed under §3.5. If an appellee fails to comply with this rule, the panel may decide the appeal without considering submissions of the appellee, including oral argument in an appeal in which oral argument is otherwise allowed.

§ 6. Contents of Briefs

1. Appellant's Brief.

The appellant's brief must include the following, under appropriate headings and in the order provided:

A. A table of contents with page references;

B. A table of cases, statutes, and other authorities cited;

C. A statement of the facts of the case;

D. A statement of the issues presented for review; and

E. The appellant's argument(s), which may include a summary. This section must include the appellant's contentions regarding the issue(s) presented and the legal analysis of those issue(s), with citations to authorities and page references from the appendix or the record, only if the referenced document is not in the appendix. Except for good reason, all documents referenced in the briefs should be included in the appendix.

2. Appellee's Brief.

The appellee shall comply with the requirements of subsection 1, except that the appellee may exclude a statement of the facts or the issues if the appellee is satisfied with the appellant's statements.

3. Reply Brief.

The appellant/cross-appellee may file a reply brief only on new matters raised in the appellee/cross-appellant's brief. If a cross-appeal is filed, the appellant/cross-appellee shall include the appellant/cross-appellee's answer to the cross-appellant's issues within any reply brief that is filed. The cross-appellant may file a reply to the cross-appellee's brief. Further briefs may only be filed with the permission of the panel acting through the presiding judge.

4. Cross-appellant's Briefs.

If a cross-appeal is filed, the cross-appellant shall include the cross-appellant's issues and arguments within the appellee's brief.

5. Amicus Curiae's Brief.

An amicus curiae may file a brief only with the written consent of all parties or with the permission of the panel acting through the presiding judge. A motion for permission to file must identify the interest of the applicant and state the reasons an amicus curiae brief is warranted. Except by agreement of the parties, any amicus curiae proceeding under this subsection shall file its brief no later than 14 days after the date the appellee's brief is filed, unless the panel acting through the presiding judge allows later filing for good cause shown. A party may file a brief in reply to the amicus brief only with the permission of the panel acting through the presiding judge.

6. Brief Format.

Without prior approval of the panel acting through the presiding judge, briefs may not exceed 20 single-sided printed pages. Briefs may be reproduced by standard printing or by any duplicating process capable of producing a clear black image on white paper. All printed material must appear in at least 12 point font on white, opaque, unglazed paper. The cover of the appellant's brief must be blue; the appellee's, red; an amicus curiae's, green; and any reply brief, gray.

Briefs must be bound in volumes with pages 8½ x 11 inches and type matter not exceeding 6½ x 9½ inches, double-spaced, except quotations. The front cover of the brief must include:

A. The name of the Workers' Compensation Board Appellate Division;

B. The Appellate Division case docket number;

C. The title of the case;

D. The nature of the proceeding before the division (e.g., Appeal);

E. The title of the document (e.g. Brief for Appellant); and

F. The name and address of the attorney or advocate filing the document and the name of the party on whose behalf the document is filed; or if a party is unrepresented, the name and address of the party.

The panel or the clerk may request electronic copies of briefs.

7. Historical Appendices.

If the appeal involves provisions of the current or former Act or rules no longer in effect, the parties shall include copies of applicable statutory sections or rules as an appendix to their briefs.

§ 7. Appendices to Briefs

1. Filing.

The appellant shall file five copies of an appendix to the appellant's brief with the clerk of the division no later than the date the appellant's brief is due. The panel acting through the presiding judge may require the appellant to file additional copies as needed. The appellant shall serve a copy of the appendix on each party on the same date the appellant files the appendix with the division.

2. Contents.

The appendix must contain those documents from the record necessary for the review of the issue(s) on appeal, and must contain a table of contents. The parties shall confer and attempt to agree on the contents of the appendix. If the parties do not agree, no later than 14 days before the appendix is due under §7.1, the appellant shall provide the appellee with a list of the documents the appellant proposes to include in the appendix. If the appellee wishes to add documents to the appendix, within seven days the appellee shall designate the additional documents to include, and the appellant shall include those documents unless otherwise ordered by the panel acting through the presiding judge. The appendix may not include any documents that are

not part of the board file or the record on appeal other than a supplement of legal authorities. The parties shall not include a document in the appendix more than once. Except for good reason, all documents referenced in the briefs should be included in the appendix.

3. Cost.

Unless the parties otherwise agree or leave to proceed without payment of costs has been granted pursuant to §4(1-A) of this rule, the appellant shall pay the costs of producing the appendix. If the appellee includes documents the appellant believes are unnecessary for the review of the issue(s) on appeal, the appellee shall advance the additional cost of producing the documents. At the conclusion of proceedings, the panel's presiding judge may assign responsibility for disputed costs to either or both parties.

4. Format.

Without prior approval of the clerk, the appendix may not exceed 150 double-sided sheets of paper that are clearly paginated. The appendix must be reproduced by standard printing or by a duplicating process capable of producing a clear black image on white paper. To the extent possible, pages must be printed on both sides, on 8 1/2" x 11" white, opaque, unglazed paper. The appendix must have a white cover that conforms with cover requirements for a brief as provided in §6.6(A)-(F).

§ 8. Decision on Record

The division shall decide appeals based exclusively on the written submissions of the parties as provided in this chapter, except as provided in §9.

§ 9. Oral Argument

1. Request for Oral Argument.

A panel may schedule a case for oral argument or a party may request in writing the opportunity to present oral argument. The writing must be under separate cover from any other board filing. The requesting party shall indicate the reason oral argument is necessary for the understanding and disposition of the appeal. The panel acting through the presiding judge may grant a motion of an amicus curiae to participate in an oral argument only for extraordinary reasons. If a party fails to request oral argument within 7 days after the later of the due date of the appellant's reply brief or the cross-appellant's reply brief, if a cross appeal is filed, oral argument is waived.

2. Scheduling.

If the panel schedules oral argument, the clerk of the division shall notify the parties in writing at least 21 days in advance of the time and place the oral argument will be held.

3. Postponement.

A written motion for postponement of oral argument must be filed with the clerk of the division at least 14 days before the scheduled hearing date. The panel acting through the presiding judge may allow shorter notice for emergencies or other exceptional circumstances, but the motion for postponement must be made as soon as reasonably possible.

4. Time Allowed for Argument.

The appellant and appellee have 20 minutes each for presentation of oral argument. If an employee and one or more employers/insurers are appellees, the employee shall have 20 minutes for presentation or oral argument and the employers/insurers may allocate a total of 20 minutes for oral argument. The panel may allow additional time for oral argument if a party files a motion showing good cause on or before the date appellant's reply brief is due under §5.1.

5. Order of Argument.

The appellant may open and conclude the argument. The panel may allow the appellant to reserve up to five minutes for concluding remarks and rebuttal if the appellant requests the reservation before beginning the appellant's presentation.

6. Cross and Separate Appeals.

A cross or related separate appeal must be argued with the initial appeal at a single hearing unless the division directs otherwise. If separate parties support the same argument, the parties shall avoid duplication of argument.

7. Failure to Appear.

If the attorney or advocate for a party, or an unrepresented party, fails to appear to present argument, the panel may hear argument from any attorney, advocate, or unrepresented party present, and the panel shall decide the case on the record of appeal, the briefs, and the argument. If no one appears to present argument, the panel shall decide the case on the record of appeal and briefs, unless the panel directs otherwise.

§ 10. Action

Pursuant to 39-A M.R.S.A. § 321-B(3), the panel, after due consideration, shall issue a written decision affirming, modifying, vacating, or remanding an Administrative Law Judge's decision. The written decision of the panel must be filed with the board and mailed to the attorney or advocate for each party, or if a party is unrepresented, to that party at the party's last known address.

§ 11. Disposition of Evidence

1. Disposition of Evidence.

   Workers' Compensation Board Rule Chapter 12, §19 applies to the disposition of evidence when no party appeals from a division decision to the Supreme Judicial Court.

2. Recordings.

   The board shall preserve recordings of division oral arguments for six years from the date of the argument.

§ 12. Application

This chapter applies to all appeals filed on or after the original effective date of this chapter.

CHAPTER 14 REVIEW BY FULL BOARD

SUMMARY: The rules of this chapter shall govern the procedures for obtaining a review of an Administrative Law Judge's decision by the Board pursuant to 39-A M.R.S.A. § 320.

§ 1. Request for Board Review

1. An Administrative Law Judge may request the Board to review a decision of that Administrative Law Judge pursuant to 39-A M.R.S.A. § 320 by filing with the Board form WCB-300 and a copy of the decision for which review is sought. Except when a motion is filed to find the facts specially and state separately the conclusions of law, the request must be made within 25 days of the issuance of a decision. If a motion is filed to find the facts specially and state separately the conclusions of law, the request must be made within 5 days of the issuance of a decision on the motion. The Board will distribute copies of the decision attached to form WCB-300 to all Board members within 5 working days of receipt of form WCB-300. The Board shall also distribute notice of the request for review to the Law Court.

2. If a request for review is filed prior to a timely motion to find the facts specially and state separately the conclusions of law, the Administrative Law Judge shall, within 5 days of the issuance of a decision on the motion, notify the Board whether or not the request for review is valid or should be withdrawn.

§ 2. Board Action

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 60 days after receipt of form WCB-300.

2. If a Motion for Findings of Fact and Conclusions of Law is filed after an Administrative Law Judge 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 60 days after receipt of the Administrative Law Judge'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 consider only 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 § 320 shall be accomplished as follows: The name of the case, along with an indication that the case is being reviewed pursuant to § 320, shall be placed on the Board's agenda under the heading "General Counsel's report."

5. The Board shall notify the Administrative Law Judge, 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. Record

Responsibility for preparing the record shall be with the Board. The record shall consist of all evidence considered by the Administrative Law Judge 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 Administrative Law Judge 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.

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 §§ 205(3) and 205(4). Complaints under § 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 § 205(4).

2. For complaints involving § 205(3), the Abuse Investigation Unit will obtain documentation of payments made pursuant to §§ 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 § 205(3). The order will specify the factual findings upon which the penalty is based.

4. For complaints involving § 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 § 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 the authority to assess sanctions and forfeitures pursuant to § 313.

2. The mediators will refer all recommendations for sanctions and forfeitures under § 313 to the Executive Director or the Executive Director's designee. 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 Executive Director or the Executive Director's designee will process all requests for penalties under § 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 § 313(4) for failure to attend a scheduled mediation.

4. All other § 313(4) sanctions and any other forfeiture or sanction referral not falling within these prescribed categories will be referred for action by 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 § 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 warrant it, a hearing will be held prior to imposition of sanctions under § 313(4).

6. Sanctions and forfeitures under both §§ 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 § 324(2).

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 § 324(2)(A)(1).

   F. Upon completion of its investigation, the Abuse Investigation Unit will provide the Executive Director or the Executive Director's designee with a recommended disposition of the case, which may include a suggested

forfeiture amount. The Executive Director or the Executive Director's designee will review the recommendation as well as the parties' contentions and will issue an order either granting, denying or dismissing the petition.

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, the employer or insurance carrier shall pay reasonable costs and attorney's fees related to the fine as determined by the Executive Director or the Executive Director's designee.

§ 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 § 324(3) and delegates to the Executive Director or the Executive Director's designee the authority to assess civil penalties, after hearing, pursuant to § 324(3).

2. The Deputy Director of Benefits Administration will report all instances of noncompliance with §§ 401 and 403 of the Act to the Abuse Investigation Unit, which 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 § 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 § 359(2). The Board designates the Executive Director, or the Executive Director's designee, 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 § 359(2).

2. Any party in interest may file a § 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 § 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 during, or as a result of 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 § 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 39-A M.R.S.A. § 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 § 360(1).

2. Any party in interest, including the Deputy Director of Benefits Administration or other interested party, may file a complaint under § 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 39-A M.R.S.A. § 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 § 360(2) and delegates to the Executive Director, or the Executive Director's designee, 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 § 360(2).

2. Any party in interest, including any deputy director or assistant director of the Workers' Compensation Board, may file a § 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 § 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 during, or as a result of 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.

CHAPTER 16 CONFIDENTIALITY OF FILES

Pursuant to 39-A M.R.S.A. § 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 number 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. An Administrative Law Judge, mediator, arbitrator, an appointed or agreed upon § 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. An Administrative Law Judge, 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;

2. Medical records including but not limited to medical records admitted into evidence; and

3. Information sealed during the dispute resolution process by an Administrative Law Judge 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 or sensitive pursuant to § 5 of this chapter are public records. Public records include, but are not limited to, Board decisions, transcripts of testimony, and exhibits admitted into evidence.

CHAPTER 18 EXAMINATIONS BY IMPARTIAL PHYSICIAN(S) PURSUANT TO 39-A M.R.S.A. § 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 § 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 Administrative Law Judges, 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 § 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 organized 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 of the 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 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.