**90-351 WORKERS' COMPENSATION BOARD**

**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.

STATUTORY AUTHORITY: 39-A M.R.S. §§ 101 *et seq.*

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EFFECTIVE DATE (ELECTRONIC CONVERSION):

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NON-SUBSTANTIVE CORRECTIONS:

 September 12 and October 9, 1996 -- addition of header, changed “Sec.” to §, minor spelling.

REPEALED AND REPLACED:

 July 4, 2001

NON-SUBSTANTIVE CORRECTIONS:

 January 8, 2003 - character spacing only.

 March 17, 2004 - apostrophe in title only.

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