Commonwealth of Massachusetts

Executive Office of Administration and Finance

Human Resources Division

Human Resources Division

Workers’ Compensation Unit

Best Practices Manual

Internal Quality Assurance Measures Guide

January 1, 2020



Workers’ Compensation Team,

The purpose of the HRD/WC Best Practices Manual – Internal Quality Assurance Measures Guide is to provide employees of the Commonwealth of Massachusetts with a reference manual containing policies and procedures for administering workers’ compensation cases. Although the manual has been authored to touch upon many complex and challenging subjects, it is recommended that the appropriate workers’ compensation experts be contacted when questions arise that are not addressed in the manual.

The subjects in this manual include document filings, decision making, claims management, benefit payments, return to work, third party subrogation, interaction with legal counsel, fraud, escalation process and risk management. In addition, as the document is a work in progress, HRD will revise the manual bi-annually and upload it to the eServices website for user access at: <https://www.eservices.hrd.state.ma.us>.

Please contact the Director of Workers’ Compensation, Russell Gilfus at (617) 878-9778 with any questions or suggestions regarding workers’ compensation issues and the HRD/WC Best Practices Manual.

Thank you for your continued support of HR Transformation Workers’ Compensation as we continue to focus on better case management and improved service delivery to our injured employees and partner agencies.

Regards,

Jeff McCue

Assistant Secretary

Chief Human Resources Officer

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# INTRODUCTION TO HRD/WC UNIT’S SCOPE:

The Human Resources Division/Workers’ Compensation Unit (HRD/WC) is the legislatively authorized administrator of the Commonwealth’s self-insured workers’ compensation program. The Unit issues both wage-replacement and medical coverage benefits to injured Commonwealth employees pursuant to G.L. c. 152. The Unit is funded each fiscal year in the General Appropriations Act, 1750-0105. Subsequently, each agency is charged back the workers’ compensation costs that are expended on behalf of their agency. In addition, an administrative fee is added for case management.

HRD/WC follows an aggressive medical management strategy to restore the employee’s health, which leads to a timely return to work. It is the goal of HRD/WC to return the injured employee to gainful employment in an expedient, economic and proficient manner. To that end, HRD/WC strives to involve the partner agency in the full claims process while following a centralized, non-biased decision making approach.

All claims activity is documented by the Claims Adjuster in the eCompManager notes, which are downloaded to eServices for viewing by partner agencies. The partner agency designee documents claims activity in eServices, which is viewable by the adjuster.

**eCompManager:** Internal HRD/WC application used to manage and process workers’ compensation cases.  The data includes the injured employee’s personal and employment information, and workers’ compensation medical and indemnity payments. Documents/images including medical records and bills, investigations, independent medical examinations, DIA Forms, correspondence and any other information on the case are uploaded to eCompManager. The HRD/WC Unit is a paperless process.

**eServices**:  To maintain HRD/WC’s dependable case handling and customer service approach, HRD/WC provides the following services through its portal eServices to its partner agencies. The eServices external application provides authorized partner agency users with the ability to report work related injuries to HRD/WC and review workers’ compensation data for their agency.  In addition, agencies have access to the following information:

* Timely Claims Activity Summaries;
* Medical and Indemnity Warrant Payout Reports;
* Ability to print and manipulate Risk Management Reports;
* Ability to request, file and view Notice of Injury and First Report of Injury;
* Ability to request file copies;
* Ability to schedule and review investigation reports;
* Ability to schedule and review Independent Medical Exam (IME);
* Ability to file a Return to Work / Change of Status Form;
* Ability to monitor claims activity including adjuster and UR notes;
* Ability to review payments issued for indemnity and medical;
* Ability to view workers’ compensation financial data with the ability to compare different years through the Dashboard; and,
* Report and review Occupational Safety and Health Act (OSHA) data as required by the Bureau of Labor Statistics (BLS).

# COMPENSABLE WORKERS’ COMPENSATION INJURIES:

A workers’ compensation case is filed when an employee suffers a personal injury arising out of and in the course of employment. The condition or illness is only compensable to the extent that the injury or disease is causally related to the industrial incident.

Personal injuries may be acute and affect any body part, such as the back, neck, knee or shoulder, but may also result from a repetitive injury such as carpal tunnel syndrome, or even a heart attack that arises out of and in the course of employment. In addition, a psychiatric disability may be compensable if the predominant contributing cause of the injury is an event or series of events occurring within the employment. Psychiatric disabilities are not compensable when the event or series of events is a bona fide personnel action. There are various standards for causation for both physical and mental injuries, depending on the circumstances.

# PARTNER AGENCY RESPONSIBILITY:

## RESPONSIBILITY FOR FILING A NOTICE OF INJURY / INITIAL CLAIMS REPORTING:

The Notice of Injury (NOI) packet must be filed by the partner agency within 48 hours of being notified that an injury occurred. The packet is submitted via eServices, which is available 24 hours per day, 7 days per week. A NOI packet should be filed even if the reporting partner agency does not believe that the injury occurred as claimed, or if they do not have the injured employee’s signature on the NOI. The following five documents make up NOI packet, which should be compiled by the HR representative at the Partner Agency and can be uploaded via eServices.

1. FILING OF NOTICE OF INJURY (48 Hour Rule):
2. **Notice of Injury Report**:
	1. Completed NOI report prepared and signed by the employee, when possible;
	2. Witness statements can be attached to the NOI, or forwarded to HRD/WC within 10 days of the NOI filing, and,
	3. Manager/Supervisor comments must also be included.
3. **Authorization for Release of Medical Records**:
	* Signed by the employee; and,
	* Filed electronically to HRD/WC through eServices portal as an attachment, or emailed directly to the HRD/WC adjuster for uploading into eServices. (Emailed documents will only be accepted by HRD/WC if the partner agency does not have access to eServices or the internet.)
4. **Injured Workers’ Guide to Medical Treatment and First Fill Form**:
	* Partner agency must provide the employee with the Injured Workers’ Guide to Medical Treatment and First Fill Form ;
	* First Fill form enables the injured worker to fill prescriptions, even before the NOI is filed, at no cost to the employee. The first fill is NOT charged to the file if the adjuster ultimately denies the claim.
		1. Express Scripts will later provide a card for the employee to provide to the pharmacy for ongoing prescriptions once the adjuster indicates that the case is eligible for prescriptions.
	* Commonwealth pays medical cost at DIA Rates;[[1]](#footnote-1)
5. **Physician’s Report**:
	* The physician’s report must be given to the employee by the partner agency at the time the injury is reported. The employee is then instructed by the partner agency to give the physician’s report to their treating physician at their initial evaluation. Upon completion, the physician’s report must be forwarded to HRD/WC by fax # (617) 727-8331 by the treating physician.

 e. **Concurrent Employment Review Form:**

1. The partner agency must also provide the employee with a Concurrent Employment Review Form, which notes whether the employee was concurrently employed at a different employer.
2. The workers’ compensation coordinator will send the signed form to the concurrent employer.

If the employee loses five or more calendar days of work, the partner agency must file a FORM 101 First Report of Injury and supporting documentation;

**PARTNER AGENCY RESPONSIBILITY:**

1. **FILING FIRST REPORT OF INJURY (5 Lost Days):**
	1. **FORM 101 First Report of Injury:**
		1. When an employee alleges they are unable to earn full wages for 5 or more calendar days of work, the partner agency must file a Form 101 First Report of Injury via eServices. Forms that are entered prior to 4:00pm will be sent electronically to the Department of Industrial Accidents (DIA) by HRD/WC that day. Forms entered after 4:00pm are sent electronically to the DIA by HRD/WC the following business day. The FORM 101 First Report of Injury must be received by the DIA before 4:00PM on the 7th day.
		2. Once received, a copy of the FORM 101 First Report of Injury is mailed by HRD/WC to the injured employee per DIA guidelines.
	2. **Average Weekly Wage (AWW) Computation Schedule:**
2. In addition to the FORM 101, the partner agency must forward a completed AWW Computation Schedule to HRD/WC via eServices attached to the FORM 101.
3. The AWW is calculated by dividing the total gross earnings for the 52 weeks prior to the date of injury by 52, but if the employee lost more than two weeks’ time during the 52 week period, the earnings are divided by the number of weeks worked and not by 52.[[2]](#footnote-2)
4. The AWW includes salary, overtime, shift differential, tips and commissions. The figure does not include fringe benefits such as group life insurance, health and accident programs and pension plans when paid by the employer.
5. If the injured worker has been employed for less than 52 weeks, the AWW is calculated by dividing the gross earnings by the number of weeks worked.
6. The earnings of employees who were hired on a strictly seasonal basis are divided by 52 weeks, even though they may have only worked a limited time during the year.
	1. **Concurrent Employment Review Form:**
		1. If the employee was concurrently employed, the concurrent employer’s wages may be added to the average weekly wage calculation.
		2. The adjuster will confirm with the concurrent employer whether the wages are accurate, whether the employer was required to be covered by G.L c.152 and whether the concurrent employer should have had workers’ compensation insurance.

# DECISION MAKING / THREE POINT CONTACT / INVESTIGATION OF CLAIM:

Within 24 hours of receipt of the Notice of Injury Packet, HRD/WC will review the documents. The Claims Supervisor will enter a note into eCompManager[[3]](#footnote-3) if the injury category for severity is 3 or above,[[4]](#footnote-4) or when there is unusual case circumstances involved. The note will contain an action plan, which may include the Three Point Contact to determine compensability, a referral to the Nurse Case Manager if the injury is moderate or higher and an Early Intervention Program for catastrophic claims. In addition, the adjuster will notify the HRD/WC Third Party Coordinator of any potential claims for subrogation.

The assigned adjuster will perform a Three Point Contact Investigative Review within 48 hours of receipt of the First Report of Injury packet by contacting/interviewing the following parties:

1. Partner Agency
2. Employee
3. Treating physician, when available

In their conversation with the partner agency, the adjuster will ask the following questions and document eCompManager with the answers:

* Does the partner agency have any issues with the case?
* Were there witnesses to the injury?
* Did the agency receive medical documentation from the claimant or treatment provider?
* How did the loss occur?
* Has the injured worker returned to work?
* If the injured employee has not returned to work, is there a potential for modified duty available?
* Has the injured worker produced medical documentation indicating ongoing disability?

The adjuster will also contact the employee within 48 hours of receipt of the First Report of Injury Packet with the following questions and will document eCompManager with the answers:

* How did the injury take place?
* What body part(s) were injured?
* Were there any witnesses?
* Who is treating the employee?
* What is his/her diagnosis?
* Has the employee injured this body part previously and how did that injury occur? (Adjuster will answer this question via review of eCompManager history and ISO Report.)
* What is the treatment plan?
* When is the follow up visit?
* Has the employee contacted the employer about modified duty?
* Are there any co-morbid issues which may delay the return to work?
* Are there any prior workers’ compensation claims?
* Are there any potential third party claims?

In addition, the adjuster contacts the treating physician within 48 hours of receipt of the First Report of Injury Packet, if applicable. The adjuster will request all related treatment notes to date, along with a statement of ongoing disability.

Through the interview process of the Employee, Employer and Treating Physician, the adjuster will determine compensability. Although the adjuster will not ask the following questions, the adjuster will consider the following indicators of fraud set out by the National Insurance Crime Bureau:

* Alleged injury relates to a pre-existing claim.
* Is the employee claiming medical only.
* Injuries are all subjective.
* Diagnosis is inconsistent with treatment.
* Employee is disgruntled, soon-to-retire or facing imminent firing or layoff.
* Employee is involved in seasonal work that is about to end.
* Employee took unexplained or excessive time off prior to claimed injury.
* Employee is a drifter and has a history of short-term employment.
* Employee is new on the job.
* Employee is experiencing financial difficulties and or domestic problems prior to submission of the claim.
* Employee recently purchased private disability policies.
* Employee has a history of reporting subjective injuries.
* Employee was recently terminated or laid off.
* Has several other family members also receiving workers’ compensation benefits or other social insurance benefits such as unemployment.
* Employee is unusually familiar with workers’ compensation claim handling procedures and law.
* Employee is uncooperative.
* Surveillance or tip indicates that the injury may be fraudulent.
* Employee has submitted substantial material misrepresentation on the employment applications.
* Employee is never home or spouse/relative answering phone states the employee just stepped out, during initial three point contact.
* Return calls to residence have strange or unexpected background noises which indicate that it may not be a residence.
* The adjuster has received medical documentation from different doctors containing several different diagnoses and/or disability dates.
* Accident occurs late Friday afternoon or shortly after the employee reports to work on Monday.
* Accident is not witnessed or witness to the accident conflicts with the applicant’s version.
* Accident occurs in an area where injured employee would not normally be.
* Details of accident are vague or contradictory, have inconsistencies, and are not credible.
* Incident is not promptly reported by employee to supervisor.
* Attorney lien/notice of representation letter filed the same date as the claim.
* The first notice to HRD/WC is by employee counsel.

The adjuster will thoroughly document all conversations and information received in eCompManager. In addition, upon receipt of medical documentation, the adjuster will upload the documents to eCompManager.

Although the above mentioned indicators will be considered throughout the life of a workers’ compensation case, the importance of the pay without prejudice period at the initial stages of the case cannot be underestimated. The 180-day period allows for an extended investigatory period, without accepting liability, and may be used to effectively control the claim and the narrative of the case before it is presented to an administrative judge at the Department of Industrial Accidents.

# DETERMINATION OF TYPE OF CASE:

If an employee is injured and misses 0 – 5 days of work, the case is designated a “no lost time / medical only case” and HRD/WC may be responsible for payment of reasonable, necessary and related medical treatment. Upon receipt of the no-lost-time claim, a medical only adjuster will be assigned to the case.

Following the investigation review by the adjuster, which includes a conversation and input from the partner agency, if the decision is made to approve payment of medical, the adjuster will monitor the case as follows:

* Monitor medical documentation to determine whether there may be a pre-existing/non work related injury to that same body part and monitor medical treatment to ensure that it is not excessive;
* Process all reasonable, necessary and related medical bills;
* Monitor for possible lost time and report changes in status to the Claims Supervisor for reassignment to a Lost Time Adjuster;
* For the first 12 weeks of treatment, the adjuster should review requests for treatment and make the appropriate approvals/denials. However, HRD/WC is mandated to undertake utilization review before denying any request for medical services during this initial 12 week period. Extensive care such as injections and/or surgeries should be forwarded to Utilization Review, even if it falls in the first 12 weeks;
* Forward appropriate requests for medical treatment to Utilization Review (UR) to determine if treatment is reasonable and necessary;
* Treatment that extends beyond 120 days may be substantiated, by ordering an Independent Medical Examination, Record/Peer Review or reviewed by the Medical Case Manager, depending on the injury; and,
* If a medical bill is deemed unrelated, or the case is found not compensable, the Adjuster will file the appropriate UR and bill denial letters.

#  APPROVAL / DENIAL OF CASE:

Once HRD/WC files the FORM 101 First Report of Injury, HRD/WC has 14 calendar days to either approve and pay benefits, or notify the employee and the DIA that it is denying the case and the reasons therefore. Pursuant to §8 of Chapter 152, HRD/WC can pay a case without prejudice for up to 180 days from the first date of disability, without accepting liability for the case/admitting the injury occurred.[[5]](#footnote-5)

Following the HRD/WC adjuster’s investigation of the case and determination on compensability, which includes consultation with the partner agency and their legal counsel if a legal issue is in question, the adjuster, will issue the appropriate response forms to the DIA. If the claim for benefits is approved, the adjuster will file a FORM 103 Notification of Payment with the DIA. If the claim is to be denied, the adjuster will file a FORM 104 Notification of Denial with the DIA, ensuring that all grounds for denial of the claim are clearly stated. In each instance the adjuster uploads the filings into eCompManager and notes the action.

A claims supervisor reviews all questionable claims with the adjuster, partner agency and their legal counsel and notes their findings in eCompManager and notifies the agency. If weekly workers’ compensation benefits are being paid, the employee must miss 21 days in order to be paid for the first 5 days.[[6]](#footnote-6)

The first check issued by the adjuster is made payable to the employee in care of the agency for sick time buy back.[[7]](#footnote-7)

Cases accepted within the pay without prejudice period must have a plan of action at the outset, although that plan may change as additional medical documentation is received. Upon receipt of the case, the adjuster will review for the severity of the injury. If the injury is significant, surgical intervention is required, or there is a significant pre-existing history of injury to the affected body part, the case will be assigned to the Medical Case Manager.

# CASE MANAGEMENT BY DATE REQUIREMENTS

## ADJUSTER REQUIREMENTS: 0 – 14 DAYS:

* Confirm the Notice of Injury is signed by the employee and the supervisor, when possible;
* Confirm the Release of Medical Records is signed by the employee, when possible;
* Confirm that the Average Weekly Wage Schedule was received and notes whether the employee is full-time or a seasonal employee;
* Confirm with employee the timeframe for which they actually worked;
* Within 48 hours of the receipt of the First Report of Injury, or notice that the employee will miss more than 5 days, the three point contact must take place;
* Adjuster creates a plan of action at the outset, although that plan may change as additional medical/nonmedical information is received;[[8]](#footnote-8)
* Confirm who the employee is treating with, the diagnosis and whether a disability note is on file;[[9]](#footnote-9)
* Follow up to secure medical notes and records;
* Review eCompManager and ISO Claims Search to determine whether the employee injured this body part before and whether it was work-related;
* Are there any co-morbid issues that that may delay a return to work;
* Contact legal counsel if legal issues exists;[[10]](#footnote-10)
* Discuss with partner agency whether a modified duty program exists and is available to the employee within the restrictions of the medical;[[11]](#footnote-11)
* Determine whether a potential for subrogation exists and notify the HRD/WC Third Party Coordinator;
* Request a copy of the police report if the injury was a motor vehicle accident;
* Once determination to approve is made, contact partner agency to confirm employee has not returned to work;
* Process approval/denial within 14 days of filing the FORM 101; and,
* Confirm with partner agency that Family Medical Leave Act (FMLA) paperwork is in process because FMLA runs concurrently with Workers’ Compensation.

## ADJUSTER REQUIREMENTS: 15 – 90 DAYS:

* Follow up with a phone conversation to the employee after each medical appointment, or if there has been no medical appointment within 30 days;
* Forward a work capacity form to the medical provider following each visit;
* Upon receipt of a release to modified duty, contact partner agency on whether modified duty is available, and recommend the partner agency issue a modified duty job offer within the restrictions set out in the medical if available;
* Review file for termination;
* Review each medical for inconsistencies and pre-existing conditions;
* During the first 12-week period, review treatment requests and process approvals;
* If a significant treatment request is made in the first 12-week period, forward the request to Utilization Review to determine whether the treatment is reasonable and necessary;
* Monitor employee prescriptions for potential overuse of opioids (MED level exceeds 90);
* Refer the case to nurse case management if there is a complicated medical condition, a serious or catastrophic injury, anticipated disability exceeds 8 weeks, or the adjuster/partner agency deems the referral appropriate; and,
* Dependent on case circumstances, the following tools may be useful when determining the nature of injury and the extent of disability in consultation with the partner agency :

* + Independent Medical Examinations (IME)
	+ Investigations,
	+ ISO Claims Searches[[12]](#footnote-12)
	+ Employee Earnings Statements
	+ DOR Wage Matches
	+ Registry of Motor Vehicle Searches
	+ Adjuster performs and Internal Social Media Review

## ADJUSTER REQUIREMENTS: 91 – 120 DAYS:

* Follow up with a phone conversation to the employee after each medical appointment, or if there has been no medical appointment within 30 days;
* Forward a work capacity form to the medical provider following each visit;
* Upon receipt of a release to modified duty, contact partner agency on whether modified duty is available, and recommend the partner agency issue a modified duty job offer within the restrictions set out in the medical if available;
* Review file for termination if the employee rejects the modified duty job offer;
* Review each medical for inconsistencies and pre-existing conditions;
* Forward medical requests that are deemed compensable to Utilization Review to determine whether the treatment is reasonable and necessary;
* Monitor employee prescriptions for potential overuse of opioids (MED level exceeds 90);
* Refer the case to nurse case management if there is a complicated medical condition, a serious or catastrophic injury, anticipated disability exceeds 8 weeks, or the adjuster/partner agency deems the referral appropriate;
* Adjuster calculates the end of compensation date and enters it on eCompManager;
* Consider resolution to close out the case; and,
* Dependent on case circumstances, the following tools may be useful when determining the nature of injury and the extent of disability in consultation with the partner agency:
	+ Independent Medical Examinations (IME)
	+ Investigations,
	+ ISO Claims Searches
	+ Employee Earnings Statements
	+ DOR Wage Matches
	+ Registry of Motor Vehicle Searches
	+ Adjuster performs an Internal Social Media Review

## ADJUSTER REQUIREMENTS: 121 – 170 DAYS:

* Follow up with a phone conversation to the employee after each medical appointment, or if there has been no medical appointment within 30 days;
* Forward a work capacity form to the medical provider following each visit;
* Upon receipt of a release to modified duty, contact partner agency on whether modified duty is available, and recommend the partner agency issue a modified duty job offer within the restriction set out in the medical;
* Review file for termination by day 170;
* Review each medical for inconsistencies and pre-existing conditions;
* Monitor employee prescriptions for potential overuse of opioids (MED level exceeds 90);
* Refer the case to nurse case management if the adjuster/partner agency deems the referral appropriate;
* Forward medical requests that are deemed compensable to Utilization Review to determine whether the treatment is reasonable and necessary;
* Unless the employee recently underwent surgery, a request for an IME should be considered no later than day 121;
* Upon receipt of the IME, review for termination of benefits or securing a modified duty job offer from the partner agency;
* Consider resolution to close out the claim;
* No later than day 150, a FORM 105 is forwarded to the employee to extend the Pay Without Prejudice Period, if appropriate;
* Follow up after the signed receipt of the FORM 105 and forward to the DIA with the FORM 101 and FORM 103 attached, within the 160th day;
* Forward an Earnings Report to the employee. If not completed by the employee and returned to HRD/WC, consider suspension of benefits (Earnings Statements are forwarded to employees every 6-months);
* Confirm with partner agency that Catastrophic Illness Leave paperwork is in process, if applicable;[[13]](#footnote-13) and,
* Dependent on case circumstances, the following tools may be useful when determining the nature of injury and the extent of disability in consultation with the partner agency:
	+ Independent Medical Examinations
	+ Investigations,
	+ ISO Claims Searches
	+ Employee Earnings Statements
	+ DOR Wage Matches
	+ Registry of Motor Vehicle Searches
	+ Adjuster performs an Internal Social Media Review

## ADJUSTER REQUIREMENTS: 171 DAYS AND BEYOND:

* Follow up with a phone conversation to the employee after each medical appointment, or if there has been no medical appointment within 30 days;
* Forward a work capacity form to the medical provider following each visit;
* Upon receipt of a release to modified duty, contact partner agency on whether modified duty is available, and recommend the partner agency issue a modified duty job offer within the restriction set out in the medical;
* Review file for termination if the employee rejects the modified duty job offer and the pay without prejudice period was extended; otherwise, file a request to modify or discontinue the employee’s benefits;
* Review each medical for inconsistencies and pre-existing conditions;
* Monitor employee prescriptions for potential overuse of opioids (MED level exceeds 90);
* Refer the case to nurse case management if the adjuster/partner agency deems the referral appropriate;
* Forward medical requests that are deemed compensable to Utilization Review to determine whether the treatment is reasonable and necessary;
* If employee has lost 180 days and the adjuster is in receipt of a medical that notes the employee is permanently disabled from performing the essential functions of their position, discuss with partner agency whether a voluntary or involuntary Accidental Disability Retirement is warranted;[[14]](#footnote-14)
* Consider resolution to close out the claim;
* Forward an Earnings Report to the employee. If not completed by the employee and returned to HRD/WC, consider suspension of benefits (Earnings Statements are forwarded to the employee every 6-months); and,
* Dependent on case circumstances, the following tools may be useful when determining the nature of injury and the extent of disability in consultation with the partner agency:
	+ Independent Medical Examinations - considered every 6-months depending on medical condition
	+ Investigations – considered once per year unless circumstances require more frequent investigations
	+ ISO Claims Searches – consider once per year unless circumstances require more frequent searches
	+ Employee Earnings Statements – forward every 6 - months
	+ DOR Wage Matches – complete every 6 - months
	+ Registry of Motor Vehicle Searches – if required
	+ Labor Market Survey – as requested by legal counsel
	+ Adjuster performs an Internal Social Media Review

NOTE: The adjuster will thoroughly document all findings in eCompManager.

# SUPERVISOR CLAIMS REVIEW AUDIT BY DATE REQUIREMENTS

## AUDIT REQUIREMENTS:  0 – 14 DAYS:

* Review NOI submissions for Early Intervention Program;
* Confirm adjuster reviewed claim for subrogation;
* Confirm adjuster referred appropriate claims for Medical Case Management; and,
* Enter a note into eCompManager providing guidance, advice, strategies, specific assignments and target dates to guide the claim toward closure.

## AUDIT REQUIREMENTS:  15 – 90 DAYS:

* Review adjuster decision to approve / deny claim;
* Review adjuster decision to approve / deny medical;
* Review current treatment status and whether termination / modification of benefits is advisable;
* Review case for modified duty medical and potential modified duty job offer;
* Review for proper use of an IME, Investigation, ISO, DOR Wage Match, Earnings Statement, referral to the HRD/WC Nurse Case Manager, Internal Social Media Review, etc.;
* Ensure that work capacity forms are being submitted and reviewed;
* Ensure employee contacts are meeting adjuster requirements;
* Review subrogation claim;
* Review / develop legal strategy if appropriate;[[15]](#footnote-15) and,
* Enter a note into eCompManager providing guidance, advice, strategies, specific assignments and target dates to guide the claim toward closure.

## AUDIT REQUIREMENTS:  91 – 120 DAYS:

* Review current treatment status and whether termination / modification of benefits is advisable;
* Review claim for modified duty medical and potential modified duty job offer;
* Review for proper use of an IME, Investigation, ISO, DOR Wage Match, Earnings Statement, referral to HRD/WC Nurse Case Manager, Internal Social Media Review, etc.;
* Ensure that work capacity forms are being submitted and reviewed;
* Ensure employee contacts are meeting adjuster requirements;
* Ensure FORM 105 is sent to the claimant to extend PWP if appropriate;
* Review subrogation claim;
* Review / develop legal strategy if appropriate; and,
* Enter a note into eCompManager providing guidance, advice, strategies, specific assignments and target dates to guide the claim toward closure.

## AUDIT REQUIREMENTS:  121 – RESOLUTION: (Quarterly Review)

* Review current treatment status and whether termination / modification of benefits is advisable;
* Review claim for modified duty medical and potential modified duty job offer;
* Review for proper use of an IME, Investigation, ISO, DOR Wage Match, Earnings Statement, referral to HRD/WC Nurse Case Manager, Internal Social Media Review, etc.;
* Ensure that work capacity forms are being submitted and reviewed;
* Ensure employee contacts are meeting adjuster requirements;
* Review for receipt and processing of the form 105;
* Review subrogation claim;
* Monitor employee prescriptions for potential overuse of opioids (MED level exceeds 90);
* Review whether FMLA has expired;
* Review whether Catastrophic Leave applies or has expired;
* Review / develop legal strategy if appropriate; and,
* Enter a note into eCompManager providing guidance, advice, strategies, specific assignments and target dates to guide the claim toward closure.

# CASE MANAGEMENT TOOLS

The adjuster has many tools available to them when administrating workers’ compensation claims at HRD/WC. Dependent on the case circumstances, the following tools may be useful when determining the nature of injury and extent of disability: Independent Medical Examinations (IME), Investigations, ISO Claims Searches, Labor Market Surveys, Employee Earnings Statements, DOR Wage Matches, Registry of Motor Vehicle Searches and Nurse Case Management.

## A. INDEPENDENT MEDICAL EXAMINATIONS (IME)

When an adjuster, the litigating attorney or the partner agency designee believes that a clarification of the injured employee’s work capacity, causation for treatment, ongoing care, treatment plan, or work capacity is required may schedule an Independent Medical Exam.[[16]](#footnote-16) An IME may clarify the history of an injury; determine whether there is a disability and whether any disability that might exist is related to the work incident.[[17]](#footnote-17) An IME can also address restrictions on the employee’s ability to perform their position from which a job offer can be made.[[18]](#footnote-18)

An IME may be needed to request a discontinuance or modification, or following a conciliation in the below mentioned instances:

1. Clarification of causation;
2. Restriction to activity;
3. Make additional treatment suggestions or to comment on the appropriateness of a treatment request;
4. Medication review;
5. Loss of function or scarring;
6. To determine if the injury or disease remains a major but not necessarily predominant cause of the disability or the need for ongoing medical treatment; and,
7. Whether the injured worker has reached a medical endpoint or maximum medical improvement.

A request for an IME exam is made via eServices or eCompManager. Each request must specify the type of specialist needed, or request assignment to a specific physician. If the claim is in litigation, legal counsel must be notified before scheduling. A standard request form is provided in eServices; however, additional questions may be asked of the physician in the notes section of the request. The IME physician generally focuses on the questions addressed in the IME request.

Once a request has been made, the claim will appear in the adjusters IME inbox for approval. The adjuster has 72-hours to approve the request and prepare the medical file for scheduling. The adjuster will provide pertinent medical records which may include diagnostic tests, treating physician reports, emergency room records, previous IME exams, correspondence, video, or other reports to the HRD/WC IME Vendor Coordinator to be forwarded to the IME Vendor who schedules the appointment. An additional attachment detailing the claims summary may also be prepared and forwarded at that time.

The HRD/WC IME Vendor Coordinator will schedule the exam in accordance with the information on the request form. Once a date is scheduled, the HRD/WC Vendor Coordinator will enter the information into eCompManager for upload and notify the partner agency. The HRD/WC Vendor Coordinator will set a diary for 1 week before the exam to confirm with the Vendor that all records were received and forwarded to the physician, and 2 weeks after the IME appointment to follow up on whether the IME is completed. A diary notation will also appear in the adjuster’s diary indicating that the IME has been scheduled.

The HRD/WC Vendor Coordinator will forward copies of the prepared file to the IME vendor. The IME vendor will send appointment letters to all parties. The appointment letter is uploaded to eCompManager by the HRD/WC Vendor Coordinator. The HRD/WC Vendor Coordinator will follow up to ensure that the report is received from the IME vendor within 2 weeks of the IME appointment, or by a date that was previously agreed upon.

The adjuster, partner agency and legal counsel will review the IME report within 72 hours of its receipt. It is the responsibility of the adjuster to review the quality of the report and to confirm that all questions posed to the physician have been sufficiently answered.

If the report is satisfactory, the adjuster will close the report on eCompManager, causing it to be uploaded to e-Services. If the report is not satisfactory, the adjuster will enter a note in eCompManager for a clarification or a rewrite is required. The adjuster will request that the HRD/WC Vendor Coordinator return the report for re-write if all questions posed to the IME Physician were not answered, or if it is clear that the IME physician did not review the medical records received by the vendor.[[19]](#footnote-19) An addendum will be requested if additional information is forwarded to the IME physician following the completion of the original IME report.[[20]](#footnote-20)

The vendor must complete the clarification/rewrite in 5 to 7 business days. The final report will then be emailed to the HRD/WC Vendor Coordinator to be uploaded. Upon receipt of the rewritten report, the HRD/WC Vendor Coordinator will also delete the previously submitted report.

In the alternative, if an addendum is needed, the adjuster will update eCompManager by clicking on the addendum button and forward the new information or additional questions to the HRD/WC Vendor Coordinator who will forward to the IME vendor. The IME vendor will then submit the physician’s addendum within 5 to 7 days of the addendum request.

The HRD/WC Vendor Coordinator will keep track of instances of unsatisfactory performance and timeliness of the IME reports. Too many issues may result in the removal of the IME Vendor or the IME doctor from the useable list. HRD/WC Vendor Coordinator will update the banned IME doctor list quarterly and a copy of this list will also be disseminated to the adjusters and legal counsel. If there are any particular problems with an IME vendor or medical doctor, the adjuster will notify HRD/WC management immediately.

## B. INVESTIGATIONS

Investigations are ordered if the adjuster, partner agency or a medical provider questions the employee’s disability, or wants to secure additional information regarding the employee’s daily activities. Investigations should be considered in many circumstances including the following examples:

* There is indication of fraud or malingering.
* There are indications from medical reports and continuing contacts that the employee’s improved condition will support termination or reduction of benefits.
* There is indication that the employee may be earning wages that they are not reporting.

Requests for investigation are made through eServices or eCompManager by either the HRD/WC adjuster, the Partner Agency or Legal Counsel. The specific reasons for the investigation must be entered into the notes section of the eServices investigation request. The adjuster will receive the request in eCompManager and order/process the request. The adjuster and partner agency will then enter additional notes or directions if warranted for the HRD/WC Vendor Coordinator to be included in the referral to the investigation vendor. Relevant information to be forwarded to the Investigation vendor may include photo identification if available or time and place of an upcoming medical / nonmedical appointment for the vendor to easily locate the employee.

The HRD/WC Vendor Coordinator will assign the claim to an investigation vendor in accordance with the instructions on the referral. Upon receipt of the report, the HRD/WC Vendor Coordinator will upload the report into eCompManager. The report will then be forwarded to the adjuster via their Investigation Inbox and a diary will notify the adjuster that the report has been received.

The adjuster will review the video and the written investigatory report. The adjuster will then note the results in eCompManager and determine whether additional surveillance is necessary. Results should be discussed with the Partner Agency who will also be able to review the report in eServices.

## C. ISO CLAIMS SEARCHES

An ISO Claim Search should be conducted at the inception of every lost time claim and in medical only cases where treatment continues for more than 30-days. ISO is a property/casualty insurance industry's warehouse database where participating insurers and other organizations submit reports on individual insurance claim filings. The information available through ISO includes prior claim filings for motor vehicle accidents, workers’ compensation and general liability claims.

The adjuster conducts an on-line search through ISO by submitting HRD/WC claims information to seek a “match” for prior claims submitted by other insurers.If prior claims were reported by an insurer on behalf of an employee, the adjuster must closely review the previous bodily injury claims that affected the same or similar body parts involved in the current workers’ compensation claim. If there is a match, the adjuster will place a phone call to the listed adjuster and send an Index Request, located in the “W” or shared drive to the other insurance company with a release of medical records attached, requesting medical evidence or settlement/litigation information on that prior claim.

An ISO is automatically run for all accepted active claims once per year to determine if an injured employee collecting workers’ compensation benefits may be deceased. If any open claims appear on the list, the adjuster will verify that status by contacting the representing attorney, searching obituaries, or by performing an alive and well check via surveillance. Benefits will cease upon confirmation of the passing of the injured worker and the partner agency shall be notified.

D. DEPARTMENT OF REVENUE (DOR) WAGE MATCH

In anticipation of litigation, or when there is an indication that the claimant may be working elsewhere, the adjuster can request a DOR Wage Match.

* The request is made by emailing the Business Analysis Unit to run the report on the employee, indicating the quarters for which the wage match should be run.
* The Business Analysis Unit will contact the DOR and request wage records for the time period specified by the adjuster.
* The adjuster will receive an Excel spreadsheet indicating whether wages were earned during the quarters requested. If there are no wages, an email will be sent to the adjuster indicating the same.

DOR Wage Match reports are run by the Business Analysis Unit on a quarterly basis. The reports are run for any injured worker receiving indemnity benefits. These spreadsheets are forwarded to the assigned adjuster for review. If income is reported and confirmed, the adjuster contacts legal counsel to discuss a plan of action, which may include:

* Unilateral modification of benefits;[[21]](#footnote-21)
* Filing a request for a modification of benefits;
* Assignment of additional surveillance;
* Termination of benefits; or,
* Reporting the injured worker to the Attorney General’s Office for prosecution of fraud.

The DOR Wage Match data can only be shared with a DOR authorized user unless permission is specifically granted by DOR.

## E. REGISTRY OF MOTOR VEHICLE (RMV) SEARCHES

When an adjuster or partner agency designee questions the location of an injured worker, or requires confirmation of a residential address, the adjuster will have a RMV Search conducted. HRD/WC has access to the RMV website to confirm the current residential address of the injured worker.

* If a RMV request is required, the adjuster or partner agency designee will notify the HRD/WC Vendor Coordinator via email.
* The HRD/WC Vendor Coordinator will run a search through the RMV database. The Vendor Coordinator will then email the results to the adjuster who will note the address in eCompManager.

## F. EMPLOYEE EARNINGS STATEMENTS

Employee’s receiving workers’ compensation benefits must provide information regarding any other sources of earnings that they may be receiving. One tool to obtain such information is a FORM 126 Employee Earnings Report. The Earnings Report requests information regarding any wages received during the preceding six (6) months. The claimant has 30-days to complete, sign and return the Earnings Report. Failure to do so results in a suspension of benefits.[[22]](#footnote-22)

HRD/WC issues Employee Earnings Reports twice per year, in January and July, to those employees receiving weekly workers’ compensation benefits.[[23]](#footnote-23) The Employee Earnings Report must be completed by the employee and received back by HRD/WC within 30-days of the mailing.

Upon receipt of the Earnings Report, it is uploaded into eCompManager and the adjuster will enter a note in the claims section on whether the employee reported earnings.

When earnings are reported, the adjuster will review the file to determine which benefits the employee is collecting. If the employee is being paid total disability benefits, the adjuster will contact the legal department about filing a termination, discontinuance or modification request. The adjuster will then review the payments to determine if an overpayment was made. If it is determined that an overpayment was issued, the adjuster will recoup the overpayment pursuant to G.L. c. 152, §§8(2)(d) and 11D(2).

In addition, if the employee is collecting partial disability benefits, the adjuster will calculate the benefits being paid and if an overpayment was issued, the adjuster will recoup the overpayment as noted above.

If the form is not received within 30-days, the adjuster will review the file and notify the partner agency the employee’s benefits are being suspended.[[24]](#footnote-24) If the benefits are being suspended, the adjuster will file a Form 107 indicating that benefits are being suspended due to the failure to return the Earnings Report pursuant to §11D. The signed Forms will be sent certified mail to the employee, their legal counsel and via regular mail to the DIA and the partner agency. The adjuster will update the claim status tab with the date of the suspension.

Upon receipt of the earnings report, the adjuster will reinstate benefits and calculate the retro payment, if necessary.

## G. VOCATIONAL REHABILITATION

Vocational Rehabilitation is a process by which it is determined whether an injured employee may be qualified for retraining, and then working with the employee to develop the retraining program. Determinations for suitability are typically made because the injured employee cannot return to their pre-injury position, or has reached medical maximum improvement and has permanent physical limitations. Department of Industrial Accidents / Office of Education and Vocational Rehabilitation (DIA/OEVR) is the Commonwealth agency assigned to oversee the rehabilitation process.

There are 4 ways an injured worker may be referred for Vocational Rehabilitation:

* 1. HRD/WC can file a request for an employee to be seen by DIA/OEVR.
	2. The injured worker may contact DIA/OEVR and request vocational rehabilitation services.
	3. DIA/OEVR may initiate the process once liability is established, the injured employee has permanent work restrictions as a result of the injury, and the restrictions render them incapable of returning to their pre-injury occupation.
	4. HRD/WC can file a request with OEVR, 6-months after an adverse determination was previously made.

DIA/OEVR will send a letter notifying the injured worker and the adjuster that a mandatory meeting has been scheduled. The notification will include a request to have recent medical documentation sent to their office for review during the suitability determination process.Upon receipt of this notification, and review of the file by the adjuster, within 10-days the adjuster will forward to the DIA all medical reports, IME’s, surveillance reports, conference orders, hearing decisions – if appropriate - and enter a note in eCompManager.[[25]](#footnote-25)

A mandatory meeting is then scheduled and will include the DIA/OEVR Review Officer, the injured employee and their legal representative. During this meeting, the employee is interviewed by the DIA/OEVR Officer who will also review the file forwarded from HRD/WC. Following the meeting, the DIA/OVER Officer will prepare a determination of suitability and forward it to the appropriate parties. Upon receipt of the determination, the adjuster must review immediately for accuracy, thoroughness, appropriateness, etc. to determine if the case needs to be appealed to the Commissioner/Director of the DIA.

The injured worker may be deemed not suitable for services by DIA/OEVR. If this occurs, the adjuster will upload the DIA/OEVR letter in eCompManager to document the suitability determination.

If the injured worker is determined suitable for Vocational Rehabilitation, the adjuster will forward the determination and claim file to the HRD/WC Vocational Rehabilitation Coordinator for assignment to a Vocational Counselor. HRD/WC has 30-days to assign the counselor. The Vocational Counselor will prepare an Individual Written Rehabilitation Plan (IWRP) which may include assisting the injured worker with job placement, job research or job retraining.

The Vocational Counselor contacts the injured worker to set a time to meet in person and discuss the employee's education, interests, transferable skills and re-employment goals.[[26]](#footnote-26) Once this is complete, an IWRP is drafted. HRD/WC in consultation with the agency may or may not agree to the plan and additional changes or negotiations may take place. Once agreed upon, the vocational plan will begin.

An injured employee may refuse to attend the meeting or participate in the plan. The consequences for doing so may result in a reduction of the indemnity benefits. In order to reduce benefits, the adjuster must first provide the DIA/OEVR Review Officer with documentation outlining the attempts to work with the injured worker and their refusal to participate.If the Review Officer determines that the documentation is sufficient, they will notify HRD/WC to reduce the employee’s indemnity benefits by 15%. In order to have the benefits fully reinstated, the injured worker must comply with the Vocational Rehabilitation process.

## H. LABOR MARKET SURVEY

A labor market survey is a document that is prepared by a vocational rehabilitation counselor to be used in litigation. The survey documents the employee’s skills and educational level. It also clarifies for the judge the employee’s transferable skills to other types of employment in the open labor market when a modified duty position is not available at the partner agency.

The Labor Market Survey provides evidence for insurer counsel to submit to the DIA Administrative Judge that the injured employee may have an earning capacity.

To request the report, the adjuster will send a referral to the HRD/WC Vocational Vendor Coordinator indicating that the Labor Market Survey is needed, and whenever possible, the date and location of when testimony will be required. An electronic referral will be forwarded to the HRD/WC Vocational Vendor Coordinator’s inbox in eCompManager.

The adjuster will require a copy of the injured worker’s resume or job application, a copy of the FORM 101 and a copy of the most recent §11A Impartial Exam, or Independent Medical Exam if the §11A Exam will not be used at the hearing and any relevant surveillance or medical reports. This information is necessary for the Vocational Rehabilitation Counselor to determine the claimant’s physical limitations and to determine the transferrable skills the employee possesses. This information can be forwarded to the HRD/WC Vendor Coordinator in eCompManager.

The Vocational Rehabilitation Counselor will generally require 2-4 weeks to review the file and prepare the Labor Market Survey. The Survey will report potential positions or careers to which the employee may be qualified and the salary and or wages for the positions.

The Labor Market Survey must be available on the date of the hearing.

The defense attorney will present the report at Conference/Hearing, and the Vocational Rehabilitation Counselor who prepared the report may be required to testify at hearing.

# EXTENSIONS/TERMINATIONS/DENIALS/RESUMPTIONS

## EXTENSION OF PAY WITHOUT PREJUDICE PERIOD

The Pay without Prejudice period is the 180-day period following an injury during which weekly benefits can be unilaterally modified / terminated if the claim was paid within the first 14-days of notice from the employing agency. This 180-day period can be extended by agreement between the insurer and the injured employee, but must be approved by the DIA.[[27]](#footnote-27)

The process to extend the pay without prejudice period is that after consulting with the partner agency the adjuster sends the employee and their attorney (no later than the 140th day) the FORM 105 Pay without Prejudice Extension Form with a letter attached, which is available in eCompManager. A copy of the letter and FORM 105 is automatically uploaded into the Documents tab of eCompManager and uploaded into eServices for viewing by the agency.

A 10-day diary is scheduled by the adjuster to ensure receipt of the approved FORM 105 from the DIA. If the FORM is not returned, the adjuster will consider termination of benefits following a discussion with the partner agency and legal counsel. If the FORM 105 is returned, it is scanned into eCompManager and forwarded to the adjuster via the eCompManager mailbox. A copy of the signed FORM 105, along with the completed Form 101 and 103 must be sent to the DIA for approval. If the FORM 105 is not back on the 170th day, consideration may be given for a termination of benefits, or at least a discussion held with the partner agency.[[28]](#footnote-28)

A diary entry will then be entered into eCompManager so the adjuster is reminded to secure receipt of the approval letter from the DIA. If the approval letter is not received within this period of time, the adjuster will contact the DIA for verbal approval and request a copy of the approved FORM 101. A status notation will be entered into the claims notes. The adjuster will set another 160-day diary entry to review the file prior to the end of the extended pay without prejudice period.

## TERMINATION OF BENEFITS:

During the first 180 days of a claim, otherwise known as the pay without prejudice period, benefits can be unilaterally terminated by HRD/WC. HRD/WC must provide the employee with 7-days written notice prior to terminating the benefits and the reason for the termination.[[29]](#footnote-29) Normally, HRD/WC gives 10-day notice of termination to guarantee the 7-day notice requirement is met.

Benefits may be terminated for a variety of reasons including the following:

* No personal injury;
* No injury arising out of and in the course of employment;
* No disability;
* No causal relationship between the personal injury and any disability;
* No updated medical documentation or disability information provided by the claimant or treating physician; and,
* A modified duty job offer was made consistent with restrictions outlined in a medical report and the offer was rejected by the employee.

The decision to terminate is made in consultation with the partner agency and legal counsel. In that instance, the adjuster will update eCompManager notes screen indicating the termination, the reason why and the date through which the employee will be paid.[[30]](#footnote-30)

The adjuster will mail to the DIA the FORM 106 and attach exhibits outlining the reason for the termination. The FORM 106 with attached exhibits will be sent by certified mail to the claimant and his counsel, if applicable. A copy of the documents are automatically stored in eCompManager and uploaded to eServices for partner agency review. If the case is on a pay without prejudice extension, a copy of the approval letter must be attached to the FORM 106.

The adjuster updates eCompManager, indicating the last day through which payment will be made. This ensures that no further payments will be issued to the employee.

DENIALS:

Within 14 days of the receipt of either a FORM 101 or a FORM 110, the adjuster reviews the facts of the claim with the partner agency. If there are questions regarding liability, compensability or disability of the claim, the adjuster in consultation with the partner agency will issue a Denial FORM 104 via certified mail to the injured employee, the employee’s attorney, the DIA and the partner agency. A copy of the form will be uploaded to eCompManager.[[31]](#footnote-31)

Once HRD/WC receives the FORM 101First Report of Injury from the partner agency, HRD/WC has 14 calendar days to either, approve and pay benefits, or notify the employee and the DIA that it is denying the case and the reasons therefore.[[32]](#footnote-32) Prior to making the decision to deny, the adjuster must review the claim with the partner agency. If the denial is based on a legal issue, the denial must also be reviewed by their legal counsel.

Reasons for denials most commonly used include the following:

1. No personal injury;
2. No injury arising out of the course of employment;
3. No Disability;
4. No Causal Relationship between the personal injury and disability;
5. G.L. c. 152 §1(7A) Pre-existing condition; or,
6. Statute of Limitations.

## RESUMPTIONS:

If an injured employee who collected workers’ compensation benefits returned to work and then went back out, the employee may seek a resumption of ongoing workers’ compensation benefits. The length of time the employee returned to work will determine the required course of action.

If the employee returned to work and liability is accepted; HRD/WC must resume payments if within twenty-eight calendar days of return to employment, the employee leaves employment and, within twenty-one calendar days thereafter, informs the partner agency and HRD/WC by certified letter that the disability resulting from the injury renders them incapable of performing such work; provided further that if due, compensation shall be paid under section thirty five. [[33]](#footnote-33)

In that instance, the adjuster will reinstate benefits, make the appropriate adjustment in the claim status tab and fully document the action in eCompManager.

If the employee returns to work for more than 28 days and then goes back out of work, the partner agency must complete a resumption form, which can be downloaded from eServices and faxed to the HRD/WC adjuster. Upon receipt of the Form, the adjuster forwards the fax to the HRD/WC Vendor Coordinator to update the status of the claim and add to the adjuster’s 14-day review tab.

Upon receipt of either Form, the adjuster notes in eCompManager that the claimant has gone back out of work and will discuss resumption with the partner agency and legal counsel if applicable. If payments are to resume, the adjuster will complete a FORM 107 and send copies to the claimant, the DIA and to employee counsel. A copy of the FORM 107 will automatically upload to the Document tab in eServices for viewing by the partner agency. The adjuster will also place a note in the eCompManager file as to the determination.

If the resumption is questioned, the adjuster will issue a denial. Please see Denial section above.

# IMPORTANCE OF RETURNING THE EMPLOYEE TO WORK

The goal of HRD/WC is to return injured employees to work. Although there is much focus and time spent on the payment of medical and indemnity benefits, all actions that take place in the administration of the claim are focused on returning the employee to work. The return to work process starts during the initial contacts with the injured employee, the partner agency and the employee’s medical providers. The adjuster should ask each of these contacts about the employee’s ability to return to work. Every conversation that takes place by the adjuster with the employee, medical provider or partner agency should consider a return to work, and the conversation documented in eCompManager.

There are many types of return to work options that may include the following:

* Full duty with partner agency;
* Temporary modified or light duty with the partner agency;
* Regular job at the partner agency with a reasonable accommodation under the ADA; or,
* Employment with another employer.

The adjuster must be in constant contact with the partner agency to ensure that when a medical is received that notes a potential for the employee to return to modified work, the partner agency is given ample notice to produce a modified duty job offer within the restrictions set out in the medical, if able. The adjuster should work with the treating physicians and the partner agency to obtain medical clearance for modified duty positions that are available, even if the initial medical note was not adequate to clear the employee to return to that position.

In addition, there are many benefits to the employee returning to work including:

* Employees remain active during their recovery helping to prevent loss of physical fitness;
* Employees can earn additional wages, rather than the reduced workers’ compensation rates; and
* Getting employee’s back to work avoids disruption in their life and gives the employee a sense of purpose.

These advantages offset the idea that the longer an employee is out of work, the less likely the employee will return to work.

# COMPENSABLE WORKERS’ COMPENSATION BENEFITS

## G.L. c. 152, §34 TEMPORARY AND TOTAL DISABILITY BENEFITS:

While the incapacity for work resulting from the injury is total, during each week of incapacity HRD/WC shall pay the injured employee compensation equal to sixty percent of his or her average weekly wage before the injury, but not more than the maximum weekly compensation rate, unless the average weekly wage of the employee is less than the minimum weekly compensation rate, in which case said weekly compensation shall be equal to his average weekly wage.  The total number of weeks of compensation due the employee under this section shall not exceed one hundred fifty-six or 3 years. [[34]](#footnote-34)

## G.L. c. 152, §35 PARTIAL DISABILITY BENEFITS:

While the incapacity for work resulting from the injury is partial, during each week of incapacity the HRD/WC shall pay the injured employee a weekly compensation equal to sixty percent of the difference between his or her average weekly wage before the injury and the weekly wage he or she is capable of earning after the injury, but not more than seventy-five percent of what the employee would receive if he or she were eligible for total incapacity benefits under section thirty-four. An insurer may reduce the amount paid to an employee under this section to the amount at which the employee's combined weekly earnings and benefits are equal to two times the average weekly wage in the Commonwealth at the time of such reduction.

The total number of weeks of compensation due the employee under this section shall not exceed two hundred sixty or 5 years, except in very specific cases which would be litigated at the DIA.[[35]](#footnote-35) Combined payment under §34 and §35 cannot exceed three hundred and sixty four weeks, or 7 years.

## G.L. c. 152, §34A PERMANENT AND TOTAL DISABILITY BENEFITS:

While the incapacity for work resulting from the injury is both permanent and total, HRD/WC shall pay to the injured employee, following payment of compensation provided in sections thirty four and thirty-five, a weekly compensation equal to two-thirds of his average weekly wage before the injury, but not more than the maximum weekly compensation rate nor less than the minimum weekly compensation rate.[[36]](#footnote-36)

## G.L. c. 152, §§31/32 DEATH; COMPENSATION FOR DEPENDENTS:

If death results from the injury, HRD/WC shall pay the widow or widower, so long as he or she remains unmarried, a weekly compensation equal to two-thirds of the average weekly wages of the deceased employee but not more than the average weekly wage in the Commonwealth; provided, however, that in no instance shall the widow or widower, receive less than one hundred and ten dollars per week…provided that in case any child of the deceased employee is a child by a former wife or husband, the death benefit shall be divided between the surviving wife or husband and all dependent children of the deceased employee in equal shares, the surviving wife or husband taking the same share as a child. Death benefits should never be paid without consultation with the partner agency.

Under certain circumstances, if the widow or widower dies or if there is no surviving wife or husband of the deceased employee, such amount or amounts as would have been payable to or for his or her own use and for the benefit of all children of the employee shall be paid in equal shares to all the surviving children or other dependents of the employee.[[37]](#footnote-37)

## G.L. c. 152, §36 SCARRING AND LOSS OF FUNCTION BENEFITS:

The employee may have the right to a one-time payment if a work-related injury or illness results in a permanent loss of certain specific bodily functions or for scarring located on the face, neck or hands, or suffers from a disfigurement such as a limp, atrophy or swelling.[[38]](#footnote-38)

# MEDICAL BENEFITS

## MEDICAL BILLS:

When an injured employee is treated by a medical provider, all reasonable, necessary and related medical bills will be submitted to HRD/WC for payment and processing. (Medical bills are paid at Industrial Accident Board Rates.)

Upon receipt of a medical bill, the adjuster reviews the bill and medical note to ensure compensability and that the bill is reasonable, necessary and related to the industrial injury. Medical bills cannot be paid without accompanying office note from the provider.[[39]](#footnote-39) If the bill warrants payment, the adjuster approves and forwards the bill to the bill payer via eCompManager to be rated and paid.

If the bill is denied, the adjuster notifies the provider in writing of the denial and the reason for it. The correspondence is automatically uploaded to the document tab of eCompManager and the denial is documented on the bill denial screen. When treatment provided is out of the ordinary, or has not been previously reviewed by Utilization Review (UR), the adjuster forwards the bill through eCompManager to UR for retro review. Pursuant to G.L. c. 152, the adjuster has 30-days from the date of receipt of the bill to make payment or deny.[[40]](#footnote-40)

Hospital bills in excess of $10,000 may require an audit by an external vendor. In this instance, once the adjuster determines compensability in consultation with the agency and forwards the bill to the billing unit via eCompManager, the billing unit will determine if the audit is needed based on the service rendered. If the audit is necessary, the billing unit will forward the bill to the adjuster supervisor for review and referral to an external audit company. The referral packet needs to include the UB-92, the itemized bill and all corresponding notes. The bill-auditing vendor[[41]](#footnote-41) will then have 72 hours to perform a pre-screen and contact the claims supervisor with a determination of whether or not an additional audit is required.

If an audit is deemed necessary, it should be completed within 2 weeks by the vendor, provided additional medical documentation is not required. If additional information is required, the vendor will forward a request to HRD/WC for additional documentation, which will be recorded in eCompManager Claims Notes. Once the completed audit report is received, the claims supervisor forwards the approved bill to the bill payer to remit payment to the provider in accordance with the audit results.

When possible, the adjuster should strive to limit their outstanding bills in eCompManager to 50.

## UTILIZATION REVIEW:

Utilization Review is a system for reviewing the appropriate and efficient allocation of health care services given to a patient or group of patients as to necessity, for the purpose of recommending or determining whether such services should be covered or provided by an insurer, provider, nonprofit service organization, third-party administrator or employer based on a particular diagnosis.[[42]](#footnote-42)

Requests for medical treatment are received via fax by the UR operations staff or through electronic data transfer from our vendor.[[43]](#footnote-43) The request is then scanned into the UR Tab of eCompManager and assigned to the appropriate claim. The adjuster reviews the UR Tab throughout the day to address new requests.

Upon receipt of a request for medical treatment, the adjuster has 24 hours to review the claim/medical request with the partner agency for causation and compensability. If after the review, the determination cannot be made without obtaining additional information, the adjuster will place a note of explanation in the UR comment box of eCompManager and seek the additional information.

If the adjuster in consultation with the agency determines that the treatment request is not causally related, or the claim is not compensable, the appropriate denial of treatment letters will be sent via eCompManager. The denial will be faxed to the requesting provider with the determination uploading into the Documents Tab of eCompManager.

If the medical request is received within the first 12 weeks of the injury, the adjuster shall review the request with the partner agency and if it appears reasonable, necessary and causally related, approve that request without first seeking approval from Utilization Review. The determination letter will be faxed by the adjuster to the requesting provider and the letter will be uploaded to eCompManager Documents Tab.

Following the first 12-weeks, or if a medically complicated request such as surgery is made, the adjuster will forward the request to the UR vendor for review and determination. The request is sent to the UR vendor via a secured/encrypted electronic data transfer. UR will review the request within the established guidelines and determine whether the treatment requested is reasonable and necessary. The determination letter including rational is sent by the UR provider to the treatment requestor and the employee and is returned to HRD/WC via electronic transfer. The results of the review are documented in the UR notes screen and the determination letter is uploaded into eCompManager Documents Tab.[[44]](#footnote-44)

An adjuster may approve requests for treatment in consultation with the partner agency even after the first 12 weeks, without first obtaining UR review, when orders and agreements require approval, or for initial evaluations and diagnostic tests.

## PHARMACY BENEFIT MANAGER:

HRD/WC has a contract with a Pharmacy Benefits Manager to manage its pharmacy program. Included in this program is issuance of prescription cards to our employees, a set drug formulary, a suite of reports to be used by HRD/WC for medication management that details the utilization of medications by employee, and a letter campaign to educate our injured employees, prescribing physicians and attorneys.

First Fill Program - the partner agency designee provides a copy of the First Fill Form to injured employees when they complete the Notice of Injury. This form may be used by the injured employee to fill prescriptions written prior to a claim being entered into eServices. The First Fill Program enables the employee to pick up their first prescription at no expense to the employee. If the claim is later denied, HRD/WC is not billed for the prescription filled under the First Fill program.

The HRD/WC IT team sends Pharmacy Benefits Manager an electronic eligibility file daily at 5:00pm. This file provides claim information for all newly reported claims and makes any changes to eligibility status due to resumptions, orders or termination of pharmacy benefits. The Pharmacy Benefits Manager mails the injured employee a prescription card upon receipt of the eligibility file for ongoing presentation to the pharmacy.

Drug Formulary - HRD/WC has a standard workers’ compensation drug formulary that includes anti-viral medications for our patient and prisoner care providers. The formulary provides common workers’ compensation medications such as Non-Steroidal Anti-Inflammatory Drugs (NSAID), opioids and the anti-virials to be automatically approved for a specified period of time, without prior authorization by the adjuster.

Medication requests that are NOT on the formulary or have exceeded the time covered under the formulary will require prior authorization by the adjuster in consultation with the partner agency. The adjuster will receive an email indicating that prior authorization is pending. The adjuster will sign into the Pharmacy Benefits Manager system and review for approval.

* An approval can be made for a one time fill, but for no more than a 6 month period.
* Denial of the medication can be made by the adjuster for lack of medical documentation or that the medication is not related to the industrial injury.
* The Adjuster may request a Letter of Medical Necessity from the Oasis system.
* Requests for Compound Medications and opioids with a combined Morphine Milligram Equivalent (MME) value over 120 are forwarded to the Claims Supervisor for review and approval. Such requests should not be approved for more than two months without a plan in plan in place to reduce opioid use.
* Questions related to the use of opioids should be addressed to the Medical Director, i.e. the length of time opioids should be prescribed following a surgical intervention.

Letter Campaigns – the Pharmacy Benefits Manager provides education letters to the employees and the prescribers with topics such as taking opioids, the dangers of high MME levels and high acetaminophen values.

The Pharmacy Benefits Manager provides reports that detail utilization of medications under our plan and red flag claims with a high MME so that HRD/WC can assign Medical Case Management to address this issue with prescribing providers.[[45]](#footnote-45)

## INTERNAL TELEPHONIC MEDICAL CASE MANAGEMENT / MEDICAL DIRECTOR:

If the injured worker has suffered a severe injury, has a significant history of a pre-existing condition, is taking a high level of opioids, or a significant surgical intervention is required, an HRD/WC Medical Case Manager (MCM)/Medical Director (a Contract physician with HRD) will be assigned for telephonic medical management. This nurse will have ongoing contact with the medical treatment provider, the injured worker, the adjuster and the partner agency when appropriate to ensure ongoing and appropriate treatment. (Denied claims are not referred for MCM.)

Best practices value the importance of engaging nurse case managers and clinical staff proactively on a claim versus after the fact. Often the correct clinic review can identify issues, concerns about durations and or treatment, compliance issues with the injured individual not following recommended recovery steps or other items that directly impact cost and duration but may not be apparent to a non- medical adjuster.

To assign the claim for MCM the adjuster completes a referral form in eCompManager. In addition, the adjuster copies the file and refers it to the nurse for review. The MCM works with the partner agency, the medical provider, the injured worker, the Medical Director and the adjuster to monitor the treatment plan and facilitate a safe return to work.

For medically complicated cases, or where there is a question on causation, the MCM may assign the case to the Medical Director to review and prepare a report. The MCM will prepare a referral sheet documenting the question for the doctor to review and print out the medical records. The Medical Director will prepare his/her response and email it to the adjuster. The adjuster will upload this report as a medical to the Document tab.

The MCM may also request the Medical Director for intervention in cases where there is a high Morphine Milligram Equivalent for opioid medications.

Following a review of the medical file, the Medical Director may prepare a letter to the treating physician, advising the adjuster and the partner agency, expressing concerns over the dosage of opioids and discuss options for weaning and/or alternative treatment. If there is no response to the letter, the Medical Director may reach out to the prescribing physician for a peer to peer consultation.

The Medical Director will work with the MCM to monitor compliance with post-surgical treatment and therapy and a weaning or detox program, in cases involving opioid use.

Instances where claims may be referred for MCM:[[46]](#footnote-46)

* + Serious or catastrophic injuries;
	+ Claims where surgical intervention is required;
	+ The injured worker has a pre-existing or degenerative condition;
	+ The injured worker is of an advanced age;
	+ Partner agency requests an MCM be assigned;
	+ Adjuster’s supervisor requests that a MCM be assigned; or,
	+ When the adjuster deems the claim appropriate.

Case closure will take place within 30 days of the claimant being rated at maximum medical improvement, the employee has returned to work or the claimed benefits are terminated.

## EXTERNAL MEDICAL CASE MANAGEMENT:

In cases where an employee is seriously injured, telephonic case management may not be sufficient. In these cases, the adjuster should consider assigning the claim to an outside nurse case management company to perform in person visits with the employee, attend their medical appointments and manage medical treatment.

An adjuster must first review the file for compensability. Once the claim has been determined compensable and liability has been established or accepted, the adjuster can review the file with his/her supervisor, the partner agency where appropriate, and the Telephonic Medical Case Manager. If the decision is made that an outside nurse case manager should be assigned to case, the adjuster will complete a referral form via eCompManager. The completed referral will be forwarded to the HRD/WC Vendor Coordinator for assignment to the appropriate vendor.

Examples of injuries where external Medical Case Management may be considered are as follows:

* Amputations;
* 2nd & 3rd degree burns that cover a considerable amount of skin;
* Spinal cord injuries;
* Head/brain injuries;
* Injuries that require hospitalization over 3 days;
* Serious injuries to multiple body parts; or,
* If an injured worker is not compliant with their treatment plan.

The assigned external medical case manager will attend medical appointments with the injured worker and manage their medical treatment plans. Status reports will be provided to the HRD/WC Vendor Coordinator who will upload the note to eCompManager every 30 days. When the report is uploaded, the Vendor Coordinator will set a diary for the adjuster to review the report.

The vendor will close the file within 30-days of a successful return to work, or when so instructed by the adjuster.

## NARCOTIC AGREEMENT

While treating an injury, use of narcotic substances may be required. A nurse case manager monitors the use of narcotics - their effectiveness, the patient response to the narcotics – and confirming that the course of treatment is not harming the patient or creating an addiction issue. This must be done in collaboration with the prescribing physician, the pharmacy provider and the partner agency.

In the event that an injured worker is on multiple narcotic medications, or has been prescribed narcotics for a 3 - 6 month period or more, the adjuster should first refer the case to the medical director for review. If the medical director deems the use of opioid medication to be reasonable, necessary and causally related to the work injury, the adjuster should consider forwarding a Narcotic Agreement to the employee’s prescribing physician. The Narcotic Agreement requires the treating physician to comment on the appropriateness of ongoing prescriptions.

Once the adjuster forwards the Narcotic Agreement to the prescribing physician, the adjuster will schedule a two (2) week diary entry to determine whether the completed forms have been received from the treatment provider. In the prescribing physician’s response, they must describe the plan of treatment and reason for the prescribed narcotics.

If the forms have not been returned, the adjuster will call the prescribing physician’s office to determine the status of the forms. If the Medical Director does not find 1) the opioid treatment is reasonable, necessary and causally related to the work injury, 2) a sufficient plan of treatment is not provided, or 3) the prescribing physician does not return the forms, the adjuster, in consultation with the partner agency, may consider scheduling an Independent Medical Exam to address the prescription concerns and the reasonableness of the treatment plan. The adjuster may also, in consultation with the agency, suspend approval for such treatment unless and until the treating physician resolves the prescription concerns.

## SURGICAL FEE NEGOTIATIONS:

As of April 2009, HRD/WC does not negotiate surgical fees unless agreed to in consultation with the partner agency. HRD/WC pays medical bills pursuant to the Mass. Rates set out in Title 1141 CMR § 4100.

# BENEFITS ADJUSTMENTS

## CHILD SUPPORT DEDUCTIONS:

Individuals receiving workers’ compensation benefits may also be required to pay child support in accordance with a Child Support Order. The Order may be forwarded from the Partner Agency or come directly from the Department of Revenue/Child Support Division. Once received, HRD/WC must forward payments in the ordered amount to the Department of Revenue/Child Support Division.

When the adjuster receives the uploaded copy of a child support order signed by a judge, or a DOR Deduction Form from the agency, the adjuster will place a note in eCompManager and submit the child support documentation to the claims supervisor for processing the payment.

The supervisor will enter the weekly deduction amount into the Deductions Tab of eCompManager. The system will automatically make the deduction from any indemnity benefit payment. The deduction will be processed first, and then any remaining funds forwarded to the employee.

If child support obligations are modified while the injured worker is receiving workers’ compensation, a copy of the modification order will be submitted by the employee to the adjuster. The adjuster will note the change in eCompManager and forward the forms to the claims supervisor who will make the adjustment in the eCompManager Deductions Tab.

## OVERPAYMENT RECOVERY:

If a claimant is overpaid benefits, those monies will be recouped.[[47]](#footnote-47) For example, recoupment may occur in the following instances:

* Where an employee is receiving partial disability benefits based on actual wages earned, and they earn more than the disability payment was based on;
* If the employee receives an adjustment in their wages while receiving partial disability benefits;
* If the completed earnings report indicates that the employee is receiving additional income not factored into their workers’ compensation benefits; or,
* A retroactive modification in benefits is issued based on a judge’s determination.[[48]](#footnote-48)

In any situation where an individual has been overpaid, the adjuster will take the following steps to recoup the overpaid monies:

Upon receipt of an Employee Earnings Report that indicates employee is receiving earnings in addition to the workers’ compensation indemnity payments, the adjuster will calculate the overpayment and notify the agency immediately.[[49]](#footnote-49) The adjuster should calculate the average earnings from the earnings report and adjust the compensation rate paid during that period to calculate the overpayment. The partner agency must be notified immediately and legal counsel should also be notified. In most cases where the employee reports earnings that are higher than the assigned or agreed upon earning capacity, a request for modification or discontinuance should be seriously considered.

The adjuster will reduce the current indemnity amount by no more than 30% to recoup the overpayment amount.

The adjuster will enter a note in eCompManager indicating that the overpayment amount was deducted and will apply towards the overpayment. The time frame for recovery will be noted. The adjuster will update the indemnity screen with the reduced figure and place a diary entry to increase the indemnity amount once the overpayment has been recouped.

In the event that the employee is no longer receiving benefits and an overpayment exists, the adjuster will review the file with the employee, the partner agency and agency counsel. A letter will then be forwarded by the adjuster to the employee advising them of the overpayment and how to pay.

If no repayment plan can be arranged, the adjuster will review the issue with agency counsel and the partner agency and contact that Attorney General’s Office regarding filing an action for recoupment. If the Attorney General’s office refuses to file a claim for recoupment, the adjuster, in consultation with the agency may file for recoupment with the DIA. This can be done by filing a FORM 108 requesting recoupment and providing documentation of the overpayment. These FORMS are sent via certified mail to the injured worker and their attorney. The FORMS will also be forwarded to the DIA and uploaded into eCompManager. A note indicating this action will be entered into ECompManager and a copy of the packet placed into the file.

The adjuster will enter a diary note for 30 days to follow-up to determine the results of the conciliation and whether the employee agreed to repay the overpayment.

## RETURNED CHECKS:

In the event that a claimant moves, the bi-weekly indemnity check will not be forwarded to the new address by the postal service because there is language printed on the indemnity check mailing indicating that checks may not be forwarded to a new address. Instead, the check is returned to HRD/WC. The following process will be performed on returned checks:

* Upon receipt of the returned check, the adjuster will investigate whether the mailing address is correct. If not, the new address will be updated in eCompManager on the employee demographic screen and placed on the next scheduled check.
* The adjuster will contact the employee or their legal representative and confirm the updated mailing address. The claimant will be advised that the check was returned, and that the adjuster will correct the address and forward the check to the updated mailing address.
* If the adjuster is unable to speak to the employee, the adjuster will contact their legal counsel or the agency to obtain current mailing address.

## CHECK REPLACEMENTS:

Indemnity payments are warranted and forwarded by HRD/WC to the employee by postal mail and generally received the weekend following the warrant date. On occasion, a check may be lost in the mail. If the check remains outstanding for more than 7 days, the adjuster will request a stop payment and reissue a replacement check. The process is as follows:

Upon notice from the employee or their counsel indicating that a check has not been received, the adjuster will first verify the mailing address where the payment was mailed. If the address is incorrect, the adjuster will correct the address in eCompManager.

If the address on the check was correct, the adjuster will process a stop payment request. To do so, the adjuster will prepare a stop and reissue request to be forwarded to the Treasurer’s Office. The Form must be sent to the Treasurer’s Office via email, signed and dated by the Adjuster on the Forms provided for the request. The adjuster will obtain the check number information from eCompManager.

Upon receipt of the request, the Treasurer’s office will verify with the bank that the check remains uncashed. If so, the Treasurer’s Office will process a stop payment on the outstanding check and reissue a new one.

If the check has been cashed, the Treasurer’s office will forward a copy of the cashed check to the adjuster. This information will then be provided to the employee or their legal representative.

Should the employee receive the check in the interim, the adjuster will advise the employee that they cannot cash the check. Instead, it should be returned to HRD/WC. The adjuster will note all actions into the eCompManager notes, along with the uploaded stop and re-issue request.

## AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE:

To determine the appropriate workers’ compensation rate, the partner agency must complete a 52 Average Weekly Wage Computation Schedule and forward it to HRD/WC along with the FORM 101 First Report of Injury Packet.

* The AWW includes salary, overtime, shift differential, tips and commissions. The figure does not include fringe benefits such as group life insurance, health and accident programs, and pension plans when paid by the employer.

The Average Weekly Wage Computation Schedule can be uploaded into eServices by attaching it to the FORM 101, or into eCompManager by the HRD/WC adjuster if the documentation is received via email or fax. The agency may instead submit a printout of wages for the injured worker, which will include the gross wages for the 52-weeks prior to the injury date.[[50]](#footnote-50)

Upon receipt of the Average Weekly Wage Computation Schedule or a wage statement, the adjuster must confirm with the agency that the employee is not seasonal or a subcontractor. In addition, the adjuster must confirm with the partner agency that fringe benefits such as education and training programs are not included in the average weekly wage rate.

CONCURRENT WAGES:

In cases where the injured employee also works for a second employer, the total earnings from all insured employers are considered in determining their average weekly wage.[[51]](#footnote-51)

When an adjuster determines that an employee has an additional employer, a concurrent wage form is sent to the injured employee and the partner agency is notified. An email will also be forwarded to the HRD/WC Vendor Coordinator to send wage forms to the concurrent employer. This request must include the name of the claimant, the claim number, and the name and address of the concurrent employer. The Vendor Coordinator will then send a request to verify the concurrent employment.

Upon receipt of the completed concurrent wage forms, the documentation will be scanned and uploaded into HRD/WC and forwarded to the adjuster mailbox. The adjuster will verify the concurrent earnings by forwarding a concurrent wage schedule to the concurrent employer. Upon receipt, the adjuster will verify that the concurrent employee is required to be covered by Massachusetts workers’ compensation insurance.

The adjuster must also determine whether the claimant is continuing to work at the concurrent employer, and/or is also disabled from that employment. The Average Weekly Wage and Indemnity Rate will then be recalculated to include the concurrent earnings. The adjuster will advise the partner agency immediately, and prior to any adjustment of benefits, in order to avoid an overpayment from sick time usage or violence pay. The adjuster will update the indemnity tab with the new wage rate information and enter a comment in the notes screen with the details of the new calculations. A supplemental payment will be generated to compensate the employee for the concurrent wages.

The HRD/WC adjuster will prepare a FORM 106 (Modification of Payment) indicating the previous Average Weekly Wage and Compensation Rates and the corrected rates. Copies of the Forms will be sent to the claimant, the partner agency and the DIA. A copy of the Forms are automatically uploaded and stored in eCompManager. When applicable, a copy is sent to the employee’s attorney.

## §13A(10) ATTORNEY FEE DEDUCTION:

In addition to an award of indemnity benefits, conference and hearing decisions often order HRD/WC to pay attorney fees to employee counsel. The attorney fee deduction allows the insurer to recover part of this fee from the claimant’s indemnity payment.[[52]](#footnote-52)

HRD/WC can deduct 22 percent of the amount that the injured worker would have received within the first month of the order. The attorney fee deduction is only applicable after the claimant receives payment in the following situations:

* Section 19 Agreement;
* Conference Order; and
* Hearing Decision.

The attorney fee deduction only applies to the following benefits:

* Temporary total disability benefits;
* Temporary partial disability benefits; and,
* Permanent and total Disability benefits.

An employee must receive an increase in indemnity benefits for this deduction rule to apply. Therefore, no deduction will be processed under the following scenarios:

* A conference order or hearing decision denying a modification or discontinuance of benefits; or,
* A conference order, hearing decision or voluntary agreement that reduces the claimant’s weekly indemnity benefits.

HRD/Finance processes attorney fee deductions upon receipt and review of conference orders and hearing decisions.

# THIRD PARTY RECOVERY / SUBROGATION

An employee may be injured as a result of an action that creates a liability in a third party.[[53]](#footnote-53) In these situations, HRD/WC will seek to recover all monies paid on the workers’ compensation claim. Third party negligence generally occurs when the employee is injured (1) while using an automobile, (2) while using a product, or (3) while using a premises that is not owned and operated by the partner agency. The process for reviewing a file for subrogation purposes is as follows:

Upon receipt of a Notice of Injury, the adjuster must review the case for a potential third party claim and forward an email to the HRD/WC Third Party Coordinator of any potential subrogation claims. In addition, once per week the claims supervisor runs a report listing all claims filed the previous week. Following their review, the claims supervisor emails the HRD/WC Third Party Coordinator of any potential 3rd party claims. The Third Party Coordinator will review the files and determine a course of action for pursuing a potential third party recovery in consultation with the partner agency.

* If it is determined that there is no third party recovery potential, a note by the HRD/WC Third Party Coordinator will be entered into eCompManager.
* If it is determined that there may be third party recoveries available, the HRD/WC Third Party Coordinator will note the file and add the claim to the third party diary located in the shared (W) drive.

## MOTOR VEHICLE LIABILITY:

Where a motor vehicle accident has occurred, the HRD Vendor Coordinator will request the adjuster on the file contact the partner agency and request a copy of the police report. If the partner agency is not in possession of the police report, the adjuster will contact the police department where the accident was located and secure the report. Upon receipt of the police report, the Coordinator will update eCompManager notes with the responsible driver’s information and their insurance provider. The Third Party Coordinator will then forward a lien notification letter to the responsible driver’s auto insurance carrier.

## PRODUCT LIABILITY:

In manufacturing warranty cases, following consultation with the partner agency, the Third Party Coordinator will contact the product manufacturer; advise of the employee’s injury and request who is the product liability insurer. The Third Party Coordinator will forward a notification of lien letter to the product owner’s insurance company notifying them of the lien in consultation with the partner agency.

## PREMISES LIABILITY:

In premises liability cases, the HRD/WC Third Party Coordinator will contact owner of the property where the injury occurred; advise of the employee’s injury and request name and address of the property insurer. The HRD/WC Third Party Coordinator will then forward a lien notification letter to the property owner’s insurance company.

In each of the above instances, the HRD/WC Third Party Coordinator will set a 200 day diary to review the file for any potential third party activity. In addition, the Coordinator will contact the third party insurer and the claimant’s counsel if represented for a status update. The HRD/WC Third Party Coordinator will continue to review and update the third party files every 60 days.

If the employee does not seek third party counsel and has not acted on a potential subrogation claim, the HRD/WC Third Party Coordinator in consultation with the partner agency will forward a Third Party Claims Review Packet to the Director of Workers’ Compensation for review with the Attorney General’s Office.

Upon completion of treatment or settlement of the workers’ compensation claim, the HRD/WC Third Party Coordinator will contact the representing attorney to provide final lien figures and request the monies expended by HRD/WC to be repaid on a completed §15 petition.

If the employee is not represented by counsel, the HRD/WC Third Party Coordinator will contact the 3rd party insurer to provide final lien figures and request total reimbursement of HRD/WC expenses.

In instances where employee counsel requests negotiation/reduction of the HRD/WC lien amount, agency counsel is notified by email of the request to negotiate the lien. The HRD/WC Third Party Coordinator will then enter a note in eCompServices of the referral to agency counsel and diary for 30-day lien updates from legal counsel.

Once resolved, the HRD/WC Third Party Coordinator will diary to follow up for receipt of the funds. Upon receipt, the third party spreadsheet will be updated on the shared drive.

# MEDICARE SECONDARY PAYER, § 111 REPORTING

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory reporting requirements with respect to Medicare beneficiaries who have insurance coverage under group health plan arrangements, and more specifically to Medicare beneficiaries who receive settlements, judgments, awards or other payments from workers’ compensation insurance programs. Therefore, HRD/WC is a Responsible Reporting Entity (RRE) and must notify Medicare pursuant to Section 111 of all workers’ compensation payments made by HRD/WC.

## PROCEDURES/IMPLEMENTATION:

HRD/WC CMS Coordinator forwards to the Center for Medicaid and Medicare Services (CMS) Monthly Query Input Files. The reporting data is queried in eCompManager on all active claims as defined by CMS. The data points include the following:

1. SSN
2. First initial of first name
3. First 6 character of the last name
4. Date of birth
5. Gender

Upon receipt of the data query by CMS, the Coordination of Benefits Contractor (COBC) will process the Query Input File and return a Query Response File to HRD/WC. The Query Response File will contain a response record for each input record, indicating the results within 45 days of file submission. The response will note whether the information submitted on the queried employee is identified as a Medicare beneficiary. With each identified beneficiary, a Health Insurance Claim Number (HICN) will be assigned in the Query Response File and used by CMS to identify each Medicare beneficiary.

IT will store the Medicare beneficiary’s HICN associated with each claim. Those claims will be reported to CMS the following quarter with the required information identified by the adjuster, including the ICD codes. Each claim is reported once, unless the claim’s information has changed, which would occur when HRD/WC is no longer responsible / liable for ongoing medical treatment, i.e. termination or denial of medical benefits. In that instance, the change is reported the following quarter.

The ICD codes are identified in IT by counting the number of times each code is associated with the claim. Once the codes have been identified, the adjuster will review each file that is reportable and determine which ICD codes correctly reflect the accepted Ongoing Responsibility for Medical (ORM). The application will allow the adjuster to check the correct ICD codes and store it them for quarterly reporting.

# ADDITIONAL PAYMENTS

## END OF COMPENSATION CALCULATIONS

Temporary and total disability[[54]](#footnote-54) and temporary and partial disability[[55]](#footnote-55) benefits have limitations on the number of weeks one may receive indemnity benefits. The time limits for these benefits are as follows:

1. §34 Temporary and total disability benefits - maximum of 156 weeks.
2. §35 Temporary and partial disability benefits - maximum of 260 weeks.
3. Combined §34 and §35 benefits - maximum of 520 weeks.

Once a claim exceeds the initial 180 day pay without prejudice period, the claim will appear on the Adjuster’s Active Claim List. At that time the adjuster must calculate an end of compensation date, which is when the benefits expire and is viewable by the partner agency in eServices.

Although eCompManager automatically assigns an end of compensation date, it may not be accurate because eCompManager does not consider prior periods of payment when an employee returned to work. Therefore, the adjuster must review the file to determine if there were payments made prior to a return to work by the employee in order to accurately determine the end of compensation date.

Adjusters have access to an End of Compensation Excel Spreadsheet located on the “W” drive. The adjuster completes the spreadsheet with the claimant’s name, claim number and date of injury. In the appropriate section, the adjuster inputs time periods where payments were made and the section the payments were made under. The Excel formulary will calculate the day through which benefits should be paid.

Upon completion of the spreadsheet, the adjuster uploads the calculations to eCompManager, notifies the partner agency, and updates the end of compensation date in the Claim Status Section. The claims adjuster must review the files annually to confirm that the end of compensation date is accurate.

If a negative number of days are calculated on the spreadsheet an overpayment has been made. The adjuster must then notify the agency immediately and follow the overpayment/recoupment procedure set out in the Best Practices Manual. End of compensation calculations do not apply to §34A permanent and total disability claims.

The end of compensation calculation on a §31 widow’s benefits claim is determined by the following:

Multiply 250 weeks of the maximum compensation rate on the date of the employee’s injury, plus all applicable COLA’s for those 250 weeks.

 Divided by

§31 Benefit Rate, which is sixty six percent of the employee’s average weekly wage.

Equals

The number of weeks a widow or other dependents has a right to dependents benefits.

When weekly payments have been made to an injured employee before the employee’s death, compensation under this section to dependents begins from the date of death of the employee.[[56]](#footnote-56)

COST OF LIVING ADJUSTMENT**:**

Claimants receiving dependent’s benefits or permanent and total disability benefits may be entitled to a Cost of Living Adjustment (COLA). The employee/claimant will begin receiving a COLA after they have received either benefit for at least 24 months. On October 1st of each year, the DIA will review and provide a Circular Letter with all of the adjustment percentages/factors for that year. A COLA rate will be assigned for each year of injury. [[57]](#footnote-57)

When a claim falls into the parameters of this section, the claims supervisor will send a CR-28 to the employee and their counsel. The CR-28 is sent annually on all COLA eligible claims.

Upon receipt of the completed form, the claims supervisor will review the claim to determine whether the compensation receiver is eligible for a COLA adjustment. If so, the claims supervisor will calculate the COLA rate based on multipliers and reimbursement factors that are released by the DIA each October 1st via a Circular Letter. Once the COLA multiplier is identified, the following formula is used to determine the new COLA rate:

 Base (Unadjusted) Compensation Rate x COLA Rate = New Reimbursement Rate

The claims supervisor will then notify the employee, the partner agency and their counsel of the new reimbursement/compensation rate and issue a check for any monies due between the October 1st and the payment period from which the new rate will be used. All adjustments will be detailed in the claims notes of eCompManager.

## MILEAGE REIMBURSEMENTS

If a claim is approved and medical benefits are paid, employees are entitled to receive reimbursement for mileage to and from covered medical appointments. The rate for such mileage reimbursement is based upon rates set by the Department of Industrial Accidents. The reimbursement rate is announced in a Circular Letter produced by the DIA on or about October 1st of each year.

To be reimbursed for mileage expenses, the injured worker must submit a request for mileage reimbursement on a form that is available in eServices. The request must include the date of the appointment, the location of where the appointment took place, a medical note/report of the appointment, and the mileage to and from the medical facility.

Upon receipt of the mileage reimbursement request, the adjuster will review the file to ensure that the dates of travel were due to the work injury. This audit is made by reviewing the medical bills and notes to confirm the corresponding dates of service by the treatment provider. If the treatment was not paid for by HRD/WC, or if there is no office note in the HRD’s possession for the visit, then the mileage will not be reimbursed.

If approved/confirmed, the adjuster calculates the mileage amount and schedules the payment. A note will be made in the eCompManager indicating how the reimbursement amount was calculated and when it was scheduled.

## FUNERAL EXPENSES:

In all cases where the employee’s death arose out of and in the course of employment, in consultation with the partner agency, HRD/WC may pay the reasonable expenses of burial, not exceeding 8 times the average weekly wage in the Commonwealth as of the date of death.[[58]](#footnote-58)

# ESCALATION OF DECISION MAKING PROCESS:

The escalation plan for managing the decision making process at HRD/WC ensures that everyone within the workers’ compensation organization has an awareness of the protocol and that the issue will resolve accordingly. In the rare instance where the escalation plan is undertaken, the objective is to mitigate risk in a timely manner while all parties work in consideration of the Commonwealth’s long term goals.

At each stage in the process, the issues will be set out in writing and note the following, if applicable:

* The impact the decision may have on the case;
* The cost impact to the Commonwealth;
* The potential impact to HRD/WC;
* The potential impact to the partner agency;
* A risk assessment;
* Resolution alternatives; and,
* Suggested resolution.

Issues that may warrant the initiation of the escalation process include:

* Whether to approve or deny a case;
* Whether to approve or deny a medical;
* Whether to reduce or terminate benefits within the pay without prejudice period;
* Whether to order an IME or investigation and when;
* Whether to file a request to modify/discontinue benefits;
* Whether to appeal a conference/hearing decision; or,
* Whether to resolve a claim by lump/sum settlement, and for how much.

Prior to the issue being raised, the adjuster/originator of the issue should first discuss their questions and/or concerns directly with the claims supervisor and partner agency, and work to resolve the issue at that level. The parties including the adjuster, claims supervisor, partner agency or any other stakeholder may choose to schedule a roundtable/meeting, which should take place in 3 business days to discuss and resolve the issue.

If an agreement cannot be reached through the roundtable/meeting, the escalation process will include the HRD Director of Workers’ Compensation who will then contact the Partner Agency Director of Workers’ Compensation, or if none, the Partner Agency Commissioner’s designee to review the issue.

If an agreement cannot be reached, the escalation process will move to the next level and include the Chief Human Resources Officer and the Partner Agency Head. If an agreement cannot be reached at the agency head level, the issue will be raised to the Secretary of Administration and Finance and the Secretary of the Partner Agency. If the partner agency is in the Executive Office, the Secretary of Administration and Finance will make the final decision.

Most importantly, the HRD/WC team focuses on developing and maintaining a collaborative approach with its partner agencies and all stakeholders. With this collaborative working relationship in mind, the expectation is that the escalation process will only be undertaken when issues are of such vital importance as to be critical in the handling of a case or workers’ compensation process.

Finally, Administration and Finance will work with Secretariats to cover workers’ compensation overage if total fiscal year workers’ compensation costs exceed the highest amount paid in the previous three fiscal years, including settlements.

# LITIGATION:

When an employee files a claim at the DIA or HRD/WC files a complaint for modification, suspension, termination or other relief, the claim or complaint initiates the litigation process at the DIA.

Prior to the filing of a claim or complaint, the adjuster in consultation with the partner agency and legal representative if appropriate develops a litigation management plan that includes the litigation strategy for achieving the goal of the complaint.[[59]](#footnote-59) The plan may include exhibits such as medical, IME, Investigation, Labor Market Survey, ISO Claims Search, Web Based Data, Retirement Application, etc.

The adjuster will clearly document the plan in eCompManager notes screen. In addition, prior to each DIA preceding the adjuster will discuss the claim or complaint with legal counsel and update eCompManager with the plan or result of the proceeding.[[60]](#footnote-60)

In addition, following each action at the DIA including conciliation, conference, §11A impartial, hearing, Reviewing Board, the Litigation Unit will enter a note in the legal notes section of eCompManager updating the adjuster. Opt out counsel will update the adjuster on all DIA actions via email. Legal counsel is expected to notify the adjuster within 5 business days of the action, if able.

During each step of the process the adjuster will discuss with the partner agency and their legal counsel the potential for a return to work or resolution of the claim, if applicable.

# RESOLVING WORKERS’ COMPENSATION CASES

In order to reduce long term workers’ compensation liabilities, resolution of certain cases may be the best strategy. Resolution of cases may be economically advantageous because it promotes file closings, avoids legal expenses and costs related to files that remain open, reduces the Commonwealth’s long term liability for the indemnity payments, loss of function benefits may be avoided and the mortality risk is eliminated. All files should be reviewed quarterly for potential resolution.

Following a quarterly review of a file, the adjuster, partner agency and/or legal counsel may determine that the most cost effective way to limit the Commonwealth’s liability is to resolve a case via settlement. In many instances, settlement will be considered once the claimant has been approved for Accidental Disability Retirement (ADR). Following a conversation with the partner agency, the adjuster, the partner agency and or their legal counsel will begin negotiations with the employee and/or their counsel.

Cases may be settled with or without liability:

1. Without liability – closes out future medical and vocational rehabilitation benefits.
2. With Liability - for ongoing medical that is reasonable, necessary and causally related to the industrial injury, it may continue to be the responsibility of HRD/WC to issue payments for medical treatment in consultation with the partner agency. Ongoing treatment after the settlement remains subject to UR review. In addition, the employee has the right to vocational rehabilitation services if found suitable by DIA/OEVR for up to two years following approval of the settlement.

If medical treatment continues for more than six (6) months following lump sum settlement, an IME, Record Review, Peer Review or Telephonic Medical Case Management may be considered after consultation with the partner agency and/or their legal counsel.

Factors to consider when resolving workers’ compensation cases include the following:

* Whether the employee was approved for Accidental Disability Retirement;
* Whether the employee is collecting a superannuation retirement;
* Whether the employee remains employed by the agency;[[61]](#footnote-61)
* The severity of the injury;
* Whether the employee has been adjudicated as permanently and totally disabled?
* Whether the employee is receiving weekly workers’ compensation benefits and at what rate?
* Whether the employee’s weekly workers’ compensation benefits are set to expire?
* Whether the claim is in litigation and at what stage;
* The employee’s life expectancy;
* The employee’s education and transferable skills;
* Whether the employee continues to treat medically;
* The exposure of future indemnity payments;
* The exposure of future medical payments;
* Any other strengths or weaknesses of either the employee or the insurer’s case; and,
* Potential offsets to benefits payable by Social Security thereby reducing the ultimate financial burden to the Commonwealth.

All workers’ compensation settlement negotiations are made in consultation with the partner agency. If the partner agency lacks the budget to lump sum settle a case, HRD will work with the partner agency and/or Administration and Finance to secure the necessary funds to pay the settlement.

# FRAUD

In consultation with the partner agency, when workers’ compensation fraud is suspected and the adjuster is able to confirm these suspicions by review of medical records, surveillance or wage documentation, the adjuster will bring the file to the attention of the Claims Supervisor for possible referral to the Attorney General’s Office (A.G.).

A referral to the Attorney General’s Office may be made by the adjuster or the partner agency who will prepare a written request outlining the facts of the case in chronological order.[[62]](#footnote-62) The following must be included / attached to the transfer memorandum, if applicable:

* A copy of the case file;
* DIA forms;
* Investigative reports and videos;
* Medical records including IME exams;
* DOR Wage Match Reports;
* ISO Reports; and,
* Copies of signed indemnity checks;

Once forwarded to the A.G’s Office, the adjuster will enter a note in eCompManager indicating that a referral has been made. Upon receipt of the file, the Attorney General’s Office will review and determine whether it will pursue criminal fraud charges against the injured worker. In addition, the adjuster in consultation with the partner agency will review whether a request to modify, discontinue or recoup is appropriate.

In circumstances where the A.G.’s Office will accept the file, the adjuster will request periodic updates as to the status of the criminal prosecution and respond to any requests made by A.G.’s Office. The adjuster will schedule periodic diaries to keep informed of the status of the fraud prosecution, enter status updates in eCompManager and review with partner agency.

If the A.’G.’s Office opts not to pursue the case, a notification of the decision will be provided to HRD/WC in writing. The adjuster will then work with the partner agency and legal counsel on whether to proceed with the filing of a complaint at the DIA for fraud, recoupment, modification or discontinuance. There is no appeals process with the A.G.’s Office on their determination of whether to prosecute.

# RISK MANAGEMENT

Risk Management is an important part of workers’ compensation cost control. The partner agency representative is the first workers’ compensation specialist to come in contact with the injured employee following a work related injury, so the partner agency has the greatest ability to investigate the incident and determine how best to avoid, prevent and reduce loses.

The initial investigatory process by the partner agency takes place when the employee is completing the Notice of Injury Report, witness statements are being gathered and the FORM 101 First Report of Injury is being filed.

Following the initial investigatory process, the partner agency workers’ compensation contact should notify the health and safety staff within the agency, if applicable, to investigate the injury. Issues to address by the safety inspector include the following:

* Date of Incident;
* Identify Description of injury;
* Identify the root causes that contributed to the incident; and,
* Make recommendations to prevent future injuries.

The partner agency workers’ compensation contact should also refer the health and safety staff to HRD/WC eServices website to review and follow all workplace injuries via OSHA reporting data.

In addition, the partner agency may develop Safety and Training Programs to prevent future injuries enhance return to works by focusing on the below noted points:

* Present health and safety training in a language and vocabulary that all employee’s understand;
* Examine workplace conditions where work related injuries occur;
* Make sure employees have and use safe tools and equipment;
* Review with supervisors and managers Log of Work-Related Injuries and Illnesses found on eServices to focus on the following:
	+ Claim frequency – the number of claims in a given period;
	+ Average claim size;
	+ Large claims;
	+ Medical only versus wage loss claims; and,
	+ Time of the day reports.
* Formalize an Injury and Illness Prevention Program to reduce the number and severity of workplace injuries focusing on the following elements:
	+ Management leadership
	+ Employee participation
	+ Hazard identification
	+ Hazard prevention and control
	+ Education and training
	+ Program evaluation
	+ Improvement

The partner agency may also be the first to observe and address occupational diseases and repetitive strain injuries. An occupational disease is any chronic ailment that occurs as a result of work or occupational activity. It is an aspect of occupational safety and health. An occupational disease is typically identified when it is shown that it is more prevalent in a given body of workers than in the general population, or in other worker populations. These injuries evolve over time, typically due to long term exposure.

In addition, repetitive strain injuries are a common source of injury, which may be detected first by the partner agency, which can put in place preventive measures such as ergonomic assessments, medical devices for prevention, education and training on proper techniques.

These two injury types are very costly and the partner agency is the first line of defense in prevention and intervention to mitigate the cost, impact and loss. A focus on risk management is critical to prevent and address these two injury types and drive overall prevention programs.

# IT SYSTEMS AND REPORTS

HRD/WC places our partner agencies at the heart of everything we do. We offer responsive IT systems to the Executive Branch, Constitutional Offices, the Legislature, Judiciary, District Attorneys, Sheriff’s Departments and Higher Ed., including the UMass system. HRD/WC offers digital services and tools that enable our partner agencies to interact with HRD/WC in an easy, fast and secure manner. The two systems that HRD/WC uses are as follows:

**eCompManager:** Internal HRD/WC application used to manage and process workers’ compensation cases.  The data includes the injured employee’s personal and employment information, and workers’ compensation medical and indemnity payments. Documents/images including medical records and bills, investigations, independent medical examinations, DIA Forms, correspondence and any other information on the case are uploaded to eCompManager. The HRD/WC Unit is a paperless process.

**eServices**:  To maintain HRD/WC’s dependable case handling and customer service approach, HRD/WC provides the following services through its portal eServices to its partner agencies. The eServices external application provides authorized partner agency users with the ability to report work related injuries to HRD/WC and review workers’ compensation data for the following information:

* Timely Claims Activity Summaries;
* Medical and Indemnity Warrant Payout Reports;
* Ability to print and manipulate Risk Management Reports;
* Ability to request, file and view Notice of Injury and First Report of Injury data;
* Ability to request file copies;
* Ability to schedule and review investigation reports;
* Ability to schedule and review Independent Medical Exam (IME);
* Ability to file a Return to Work / Change of Status Form;
* Ability to monitor claims activity including adjuster and UR notes;
* Ability to review payments issued for indemnity and medical;
* Ability to view workers’ compensation financial data with the ability to compare different years through the Dashboard; and,
* Report and review Occupational Safety and Health Act (OSHA) data as required by the Bureau of Labor Statistics (BLS).

HRD/WC continues to upgrade its eServices Reports to assist our partner agencies in their formal loss control prevention programs. These reports include full transparency to agencies of the cost of claims, help them understand the lost productivity, costs to the agency, impact to the worker, and look at active strategies to mitigate the losses through prevention, training, safety and progressive return to work or vocational retraining.

# APPENDIX A: TABLE OF TERMINOLOGY

Catastrophic Injury – where an individual has sustained loss of function involving, but not limited to, any of the following conditions:

Mangling, crushing or amputation of a major portion of an extremity;

*Traumatic injury to the spinal cord that has caused or may cause paralysis;*

*Severe burns that require burn center care; or,*

*Serious head injury, damage to internal organs, loss of vision in both eyes, or loss of hearing in both ears.*

Claimant – an individual seeking workers’ compensation benefits from the Commonwealth.

Confidentiality – the state whereby property, data, writings or information is being kept private.

Covered entity – an employer, i.e. the Commonwealth.

Dependents – members of the employee’s family who were wholly or partly dependent upon the earnings of the employee for support at the time of the injury or employee’s death.

Determination of suitability – an evaluation performed by DIA/OEVR on an employee as to the appropriateness of a vocational rehabilitation plan.

Disability – a physical or mental impairment that substantially limits one or major life activities.

Functional limitation – the residual effect of physical or psychiatric injury or occupational disease as related to capacity to work.

Impairment – a physiological disorder affecting one or more of a number of body systems, or a mental or psychological disorder.

Individual Written Rehabilitation Program – a document that sets out the employee’s individual rehabilitation program, which lists the services, cost and responsibilities of all participants.

Maximum weekly compensation rate – the average weekly wage in the Commonwealth according to the calculation on or after October 1st of the year preceding the date of injury.

Medical condition – the physical or mental status of an injured employee as determined by a medical provider.

Minimum weekly compensation rate – twenty percent of the average weekly wage in the Commonwealth according to the calculation on or after October 1st of the year preceding the date of injury.

Preferred provider arrangement – a contract between or on behalf of an organization such as the Commonwealth and a health care provider.

Provider – a practitioner, facility, or other organization providing health care services.

Reasonable accommodation – Alterations to job duties, facilities, or other aspects of employment which enable an employee to perform the essential functions of their employment under the Americans with Disability Act or G.L. c. 151B.

Request for reimbursement – a request for payment of health services.

Systemic Injury – an injury which affects an entire body system rather than an injury which limits function in one area.

Transferable skills – work related skills than can be adapted from one work setting to another.

Utilization Review – analysis and review of whether requested health care services are reasonable, appropriate and effective for the diagnosed condition

Vocational Rehabilitation – nonmedical services used to restore a disabled employee to suitable employment, including, but not limited to vocational evaluation, counseling, education, job placement assistance, workplace modification and retraining – including on-the job training for alternative employment with the same employer.

1. Note: All medical providers do not accept Mass Rates, which are set by the Executive Office of Health and Human Services). [↑](#footnote-ref-1)
2. See G.L. c. 152, §1(1) Average Weekly Wage [↑](#footnote-ref-2)
3. eCompManager is HRD/WC case management system. [↑](#footnote-ref-3)
4. 1. Minor injury; no likely lost time; no likely medical bills; 2. Small injury; no likely lost time; possible medical bills; 3. Moderate injury; possible lost time; probable medical bills; 4. Significant injury; probably 0 to 5 days of lost time and medical bills and 5. Severe injury; probably 5 plus days lost time and medical bills. [↑](#footnote-ref-4)
5. See G.L. c. 152, §7 Commencement of Payment and §8 Termination or Modification of Payments [↑](#footnote-ref-5)
6. If the adjuster and the partner agency disagree on the decision, please see Chapter XVIII Escalation of Decision Making Process. [↑](#footnote-ref-6)
7. See G.L. c. 30, §58, Injuries Sustained in Service of the State, Compensation [↑](#footnote-ref-7)
8. The plan should include guidance, advice, strategies, specific assignments and target dates to guide the claim toward closure. [↑](#footnote-ref-8)
9. Best practice indicates that maintaining engagement with the injured worker throughout his/her medical treatment reduces the risk of over-prescribing and addiction development. Within 2 days people know if they are having an adverse reaction to medication; if injured workers are not contracted until 5-10 days after prescribing it is often too late as the injured worker may already be exhibiting addictive behaviors. The nurse case manager should have early and frequent checkpoints with injured workers regarding medical treatment, specifically to check that the injured worker is not demonstrating adverse impacts from the medication. [↑](#footnote-ref-9)
10. It is critical to engage legal counsel at any point in the process where a potential legal issue may arise. [↑](#footnote-ref-10)
11. Review modified duty program with agency. [↑](#footnote-ref-11)
12. All new cases should be run through the ISO Claims Searches program. [↑](#footnote-ref-12)
13. If employee is covered by a collective bargaining agreement, confirm catastrophic leave paperwork is in process. If employee is covered by the Red Book, confirm employment status. [↑](#footnote-ref-13)
14. Confirm employment status with partner agency at 360 days if employee is covered by a collective bargaining agreement. [↑](#footnote-ref-14)
15. It is critical to engage legal counsel at any point in the process where a potential legal issue may arise. [↑](#footnote-ref-15)
16. An IME may only be ordered at 6 month intervals. [↑](#footnote-ref-16)
17. Consideration is to be given to the limitations of an IME, the inability to repeat the IME for 6-months, and the fact that the employee has the burden of proving all elements of their claim when determining whether to order an IME. [↑](#footnote-ref-17)
18. See G. L. c. 152 §45 [↑](#footnote-ref-18)
19. Rewrite – vendor failed to meet the original obligation. No additional monies are paid for the rewrite. [↑](#footnote-ref-19)
20. Addendum – additional information to incorporate into the original request. Additional monies may be required. [↑](#footnote-ref-20)
21. Unilateral modification can only occur within the pay without prejudice period. [↑](#footnote-ref-21)
22. See G.L. c. 152, §11D [↑](#footnote-ref-22)
23. An Earnings Report is sent on all claims following an initial 6-month period of disability. [↑](#footnote-ref-23)
24. Prior to terminating the employee’s benefits, the Adjuster contacts the employee or their counsel to verify receipt of the Earnings Statement and determine the reason it wasn’t returned. [↑](#footnote-ref-24)
25. If appropriate, the adjuster will review with agency counsel if additional documentation/information should be included in the packet to OEVR. [↑](#footnote-ref-25)
26. If the DIA requests a mandatory meeting the adjuster and partner agency should attend. [↑](#footnote-ref-26)
27. See G.L. c. 152 §8(6) [↑](#footnote-ref-27)
28. See Chapter VII: Adjuster Requirements 91 – 120 days / Adjuster Requirements 121 – 170 days (150 days) [↑](#footnote-ref-28)
29. See G.L. c. 152 §8(1) [↑](#footnote-ref-29)
30. There may be situations where a death benefits case is not automatically approved, or is terminated within the pay without prejudice period. [↑](#footnote-ref-30)
31. See G.L c. 152 §7 [↑](#footnote-ref-31)
32. See Chapter IV: Indicators of Fraud, National Insurance Crime Bureau. [↑](#footnote-ref-32)
33. See G.L c. 152 §8(2)(c) [↑](#footnote-ref-33)
34. See G.L. c. 152, §34 for unedited version of the statute [↑](#footnote-ref-34)
35. See G.L. c. 152, §35 for unedited version of the statute [↑](#footnote-ref-35)
36. See G.L. c. 152, §34A for unedited version of the statute [↑](#footnote-ref-36)
37. See G.L. c. 152, §31 for unedited version of the statute [↑](#footnote-ref-37)
38. See G.L. c. 152, §36 Specific Injuries (See Appendix for §36 Calculation Breakdown) [↑](#footnote-ref-38)
39. Large medical bills and detailed notes should be forwarded to the partner agency for review. [↑](#footnote-ref-39)
40. See G.L. c. 152 §§13/30 Medical Benefits [↑](#footnote-ref-40)
41. Vendor is Windham Group. [↑](#footnote-ref-41)
42. See 452 C.M.R. § 6.02 [↑](#footnote-ref-42)
43. Vendor is the Windham Group. [↑](#footnote-ref-43)
44. All surgical requests are reviewed with the partner agency. [↑](#footnote-ref-44)
45. HRD/WC must look at trend reporting, duration of prescriptions and provider monitoring when it comes to how narcotics are being prescribed and use that information to flag areas to investigate or review more closely and possibly for the assignment of a nurse case manager earlier in the process. [↑](#footnote-ref-45)
46. HRD/WC is presently staffed with one Nurse Case Manager. [↑](#footnote-ref-46)
47. See G.L. c. 152, §69 An employee who is entitled to any sick leave allowance may take such of his sick leave allowance payment as, when added to the amount of any disability compensation herein provided, will result in the payment to him of his full salary or wages. Employees may only use the sick time that they have to their credit as of the date of injury. [↑](#footnote-ref-47)
48. See G.L. c. 152, §11(D)(2) [↑](#footnote-ref-48)
49. The partner agency must be notified of any changes in weekly compensation rates because there is a direct impact on the amount of assault pay the employee is paid. [↑](#footnote-ref-49)
50. See G.L. c. 152, §1(1) [↑](#footnote-ref-50)
51. [↑](#footnote-ref-51)
52. See G.L. c. 152 §13(A)(10) and 452 C.M.R. 1.02 [↑](#footnote-ref-52)
53. See G.L. c. 152, §15 Third Party Recoveries [↑](#footnote-ref-53)
54. G.L. c. 152, §34 [↑](#footnote-ref-54)
55. G.L. c. 152, §35 [↑](#footnote-ref-55)
56. See G.L. c. 152, 32 Children under the age of eighteen years (or over said age, if physically or mentally incapacitated from earning) upon the parent with whom they are living at the time of the death or such parent, there being no surviving dependent parent; provided that in case of the death of an employee who at the time of his death living children by a former wife or husband, under the age of eighteen years (or over said age, if physically or mentally incapacitated from earning), said children shall be conclusively presumed to be wholly dependent for support upon such deceased employee, and the death benefits shall be divided between the surviving with or husband and all the children of the deceased employee in equal shares, the surviving wife or husband taking the same share as the child… [↑](#footnote-ref-56)
57. See G.L. c. 152, §34B [↑](#footnote-ref-57)
58. G.L. c. 152, §33 [↑](#footnote-ref-58)
59. Opt out counsel may develop a litigation strategy internally; however, the litigation strategy must be relayed to HRD/WC in a timely manner so the adjuster remains informed on the case status. [↑](#footnote-ref-59)
60. Communication between the adjuster, partner agency and legal counsel is essential in the proper handling of workers’ compensation cases. [↑](#footnote-ref-60)
61. See G.L. c. 152, §48 No lump sum agreement shall contain as part of a settlement a general or specific release that would serve as a bar to (i) employment with any employer, (ii) the receipt by the employee of any pay or benefits due him by an employer, (iii) the bringing of any future workers’ compensation claims or (iv) the bringing of any claims or wrongful discharge or breach of contract. [↑](#footnote-ref-61)
62. The Deputy Director of HRD/WC will maintain a list of all referrals to the Attorney General’s Office and the result of the recommendation. [↑](#footnote-ref-62)