SECTION A

WORKERS' COMPENSATION BOARD

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Section A: Workers' Compensation Board
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1. Introduction

The mission of the Workers' Compensation Board "is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation." 39-A M.R.S.A. §151-A.

To achieve this mission, the Board is specifically tasked with resolving disputes; ensuring compliance with the requirements of the Act and the Board's rules; regulating medical costs; and providing representation to injured workers who are unable to obtain the services of private attorneys. The Board must accomplish its objectives without exceeding its allocated revenue. The Board is not a General Fund agency. It is financed through an assessment on employers through their insurers or, if self-insured, directly on the employer as provided in the Act 39-A M.R.S.A. §154.

Each of these, and other related, areas are discussed in detail in the various sections of this report. A brief summary of the main functions is provided here.

In order to ensure compliance with the Act, employers and insurers are required to file information with the Board. The Board monitors the information that is filed to ensure it is accurate, complete, and timely. The goal is to identify and resolve cases at the first available level. When this is not possible, the cases move on to the next level of dispute resolution. This information also provides a foundation for the Audit Division. Specifically, auditors take a more in-depth look at an entity's compliance and payment accuracy. Additionally, auditors can provide training and guidelines to employers to facilitate compliance.

The Board also uses this information to ensure employers have workers' compensation coverage for their employees. A critical aspect of this effort is to prevent employers from misclassifying employees as independent contractors. Employers that misclassify employees not only place these employees at risk of not having any recourse if injured on the job, they also gain an unfair competitive advantage vis-à-vis employers that properly classify their workforce.

When employers and employees cannot agree on whether an injury is work-related or whether certain costs are related to a work injury, the Board provides a forum to resolve these issues. Dispute resolution starts with troubleshooting and progresses through mediation and if necessary, on to formal hearing. Since August 2012, parties can also appeal formal hearing decisions to the Board's Appellate Division.

The Advocate Division was established in 1997 to provide representation to employees who cannot obtain the services of a private attorney. The Advocate Division has grown significantly over the years. It continues to provide services to many employees who would otherwise have to represent themselves – a nearly impossible task for most injured workers.

Finally, in accordance with 39-A M.R.S.A. §209-A the Board maintains a medical fee schedule that regulates medical costs within the workers' compensation system while ensuring access to care for injured employees. The medical fee schedule is updated annually, and a comprehensive review of the medical fee schedule is performed every three years. The Board completed the comprehensive review in 2020.

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2. ENABLING LEGISLATION AND HISTORY OF MAINE WORKERS' COMPENSATION

I. ENABLING LEGISLATION

On January 1, 1993, Title 39, the Workers' Compensation Act of 1991, and all prior Workers' Compensation Acts, were repealed and replaced with Title 39-A, the Workers' Compensation Act of 1992.

II. REVISIONS TO ENABLING LEGISLATION

The following are legislative changes enacted since 1993.

- **§ 102(4).** Clarified that, for injuries on and after January 1, 2020, fringe benefits that do not continue during incapacity must be included in the average weekly wage to the extent that the inclusion does not result in a weekly benefit amount greater than 2/3 of 125% of the state average weekly wage at the time of injury. Previously, the benefit cap was 2/3 of the state average weekly wage at the time of injury.
- **§ 102(11)(B-1).** Tightened the criteria for wood harvesters to obtain a predetermination of independent contractor status.
- **§ 102(13-A).** Tightened definition of independent contractor and made it the same as the definition used by Department of Labor.
- **§ 113.** Permits reciprocal agreements to exempt certain nonresident employees from coverage under the Act.
- **§ 151-A.** Added the Board's mission statement.
- **§§ 151, Sub-§1.** Established the Executive Director as a gubernatorial appointment and member and Chair of the Board of Directors. Changed the composition of the Board from eight to seven members.
- **§ 153(9).** Established the monitoring, audit & enforcement (MAE) program.
- **§ 153-A.** Established the worker advocate program.
- **§ 201(6).** Clarified rights and benefits in cases which post-1993 work injuries aggravate, accelerate, or combine with work-injuries that occurred prior to January 1, 1993.
- **§ 205(2).** If a notice of controversy is not filed within 14 days of when an employer has notice that a work-related injury occurred, then payments must begin. But if the insurer's failure to pay is due to a factual mistake, act of God or unavoidable circumstances, then insurers are excused from paying a penalty for failing to pay within that 14-day period. If a notice of controversy is not filed within 45 days of notice of the occurrence of the injury, then benefits may only be stopped pursuant to the 21-day discontinuance process in § 205 (9) (B) (1) unless the failure to file a notice of controversy was due to an act of God.

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- **§ 211.** Increased maximum weekly benefit level to 125% of the state average weekly wage for injuries occurring on and after January 1, 2020. For injuries before that date, the weekly maximum was 100% of the state average weekly wage.
- **§§ 212 and 213.** Changed benefit determination to 2/3 of gross average weekly wages from 80% of after-tax wages for dates of injury on and after January 1, 2013.
- **§212 (4).** Provides cost-of-living adjustments in cases of total incapacity after payment of 5 years of benefits.
- **§ 213.** Eliminates the permanent impairment threshold for dates of injury on and after January 1, 2013 and establishes 520 weeks as the maximum duration for partial incapacity benefits with certain exceptions.
- **§ 213(1)**. Establishes 624 weeks as the maximum duration for partial incapacity benefits for dates of injury on and after January 1, 2020.
- **§ 213(1-A).** Defines "permanent impairment" for the purpose of determining entitlement to partial incapacity benefits.
- **§ 213(1-B).** Clarifies that the 18% whole person impairment test for receipt of long term partial incapacity benefits effective January 1, 2013 will not apply to injury dates on and after January 1, 2020. Partial incapacity benefits for injuries on and after January 1, 2020, will be payable for 12 years without regard to the amount of a claimant's impairment.
- **§215 (1-B).** Grants the 500 week death benefit to parents of deceased employees who leave no dependents and whose injuries occur or and after January 1, 2020. Previously, payments were made to the Employment Rehabilitation Fund.
- **§ 217(9).** Establishes that an injured worker participating in employment rehabilitation is protected from having his/her case reviewed except under limited circumstances involving either a return to work or because the employee reached the durational limitation for partial incapacity benefits.
- **§221 (1) (B)** states that as a general rule, the coordination of benefits section applies to paid time off.
- **§221 (3) (A) (2)** provides that workers' compensation benefits should be reduced by the after-tax value of paid time off income received by claimants during periods of incapacity.
- **§221 (3) (H)** creates an exception and disallows a reduction in workers' compensation benefits for paid time off if the PTO benefit payment is mandated by an employer or paid to an employee upon separation from employment.
- **§ 224.** Clarified annual adjustments made pursuant to former Title 39, §§ 55 and 55-A.
- **§ 301.** Notice changed to 30 days from 90 days for injuries on and after January 1, 2013 and, for injuries on and after January 1, 2010, notice deadline was changed to 60 days.
- **§§ 321-A & 321-B.** Reestablished the Appellate Division within the Board.
- **§ 325 (6)** sets the maximum attorney's fees at 10% in lump-sum settlements for cases with injuries that occurred on or after January 1, 2020.
- **§ 328-A.** Created rebuttable presumption of work-relatedness for emergency rescue or public safety workers who contract certain communicable diseases.

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- **§§ 355-A, 355-B, 355-C, and 356.** Created the Supplemental Benefits Oversight Committee.

III. State Agency History

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

The Early Years of Workers' Compensation

A transition from the common law tort claim system into the statutory structure we know today occurred on January 1, 1916. Under our common law tort system, an injured worker had to sue his employer and prove negligence to obtain any remedy. Workers' compensation was conceived as an alternative to the tort system for those injured at work and because of their work. Instead of litigating negligence, under this "new" system, injured workers would receive statutorily mandated benefits for lost wages and medical treatment. Employers correspondingly lost legal defenses such as assumption of risk or contributory negligence. Injured workers gave up remedies beyond lost wages and medical treatment such as pain and suffering and punitive damages. This "grand bargain," as it has come to be known in the national literature, remains a fundamental feature of today's workers' compensation system. Perhaps as a sign of the times, in Maine financing and administration of benefit payments remained in the private sector, either through insurance policies or self-insurance. Workers' compensation disputes still arise in this no fault system. For example, disputes address whether an employee's incapacity is related to work; the amount of weekly benefits due the injured worker; and what, if any, earning capacity has been lost. Maine, like most other states, established an agency to process these disputes and perform other administrative responsibilities. Disputes under this system became simpler. Injured workers rarely had lawyers. Expensive, long term, and medically complicated claims, such as cumulative trauma and chemical exposures, were decades away.

Adjudicators as Fact Finders

In 1929, the Maine Federation of Labor and an early employer group, "Associated Industries", opposed a Commissioner's re-nomination. Testimony from both groups referred to decision reversals by the Maine Supreme Court. This early feature of Maine's system, review of decisions by the Supreme Court, still exists, although today these appeals are discretionary. The Supreme Court decides legal issues; it does not conduct de novo hearings. In Maine, our state agency adjudicator, today an Administrative Law Judge (ALJ), is the final fact finder.

In the 1980s, Commissioners became full time and an informal conference process was introduced in an attempt to resolve disputes early in the claim cycle, before need for a formal hearing. Additionally, the agency expanded its physical presence, opening regional offices in Augusta, Bangor, Caribou, Lewiston, and Portland all supported by the central administrative office in Augusta. In 1987, three full-time Commissioners were added, bringing the total from 8 to 11, in addition to a Chair. In recent years, the Board has reduced the number of staff hearing claims to nine, from a high of 11.

Until 1993, Commissioners, (those who now are ALJs), were gubernatorial appointments, subject to confirmation by the Legislature's judiciary committee. The need for independence of its quasi-judicial

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function was one of the reasons why the agency was established as an independent, free-standing institution, rather than as a part of a larger administrative department within the executive branch. The small scale of state government in 1916 no doubt also played a role in this structural decision.

Transition to the Modern Era

During the 1970s, Maine, along with several other states, made changes to their workers' compensation laws in an effort to ensure that the laws were functioning equitably. These changes included: Making coverage compulsory for most employers; increasing the maximum weekly benefit; removing durational limitations for total and partial benefits; and, making it easier for injured workers to secure legal services.

Statutory changes and evolving medical knowledge also brought a new type of claim into the system. The law no longer required an injury happen "by accident." Doctors began to connect repetitive overuse conditions to a claimant's work and thus brought these conditions within the workers' compensation coverage. Gradual, overuse injuries frequently recover more slowly. This requires benefit payments for longer periods than many accidental injuries. These claims were also more likely to involve litigation. Over the course of time, rising costs transformed workers' compensation into a contentious political issue in the 1980s and early 1990s.

The political environment of the 1980s and early 1990s was extraordinary for Maine's workers' compensation system. Contentious legislative sessions directly related to workers' compensation occurred in 1982, 1985, 1987, 1991, and 1992. In 1991, the governor tied a veto of the state budget to changes in the Workers' Compensation Act. The consequence of this action was a three week state government shutdown.

In 1992, the Legislature created a Blue Ribbon Commission to examine our system and recommend changes. The Commission's report made a series of proposals which were ultimately enacted. Inflation adjustments for both partial and total wage loss benefits were eliminated. The maximum benefit was set at 90% of state average weekly wage. A limit of 260 weeks of benefits was established for partial incapacity. These changes represented benefit reductions for injured workers, particularly those with long term incapacity. Additionally, the provision of the statute concerning access to legal representation was changed. This made it exceedingly difficult for injured workers to secure legal representation.

Maine Employers' Mutual Insurance Company (MEMIC) was also created at this time. It replaced the assigned risk pool and offered a permanent coverage source. Despite differing views on the nature of the problems within the system, virtually all observers agree MEMIC played a critical role in helping stabilize Maine's workers' compensation system.

Based on a recommendation of the Blue Ribbon Commission, the Workers' Compensation Board was created to directly involve labor and management representatives in the administration of the agency.

The Board of Directors was initially comprised of four Labor and four Management members, appointed by the Governor based on nomination lists submitted by the Maine AFL-CIO and the Maine Chamber of Commerce. The eight Directors hired an Executive Director who was responsible for the day to day operations of the agency. During the late 1990s, the Board of Directors deadlocked on important issues such as the appointment of Hearing Officers, adjustments to the partial benefit structure under § 213, and the agency budget. By 2002, this became a matter of legislative concern. Finally, in 2004,

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legislation was enacted making the Executive Director a tie-breaking member of the Board as well as its Chair. The Executive Director is a gubernatorial appointment, subject to confirmation by a legislative committee and the Senate. With this arrangement, gridlock due to tie votes is no longer an issue. The Executive Director casts deciding votes when necessary. However, the objective is still to foster cooperation and consensus between the Labor and Management caucuses. This now occurs regularly.

The agency was criticized in the late 1980s and early 90s for not doing more with its data gathering. The Board installed a relational database in 1996, with modern programming language; the result was an improvement in data collection. Today, filings of First Reports and first payment documents are systematically tracked and benchmarked. Significant administrative penalties have been pursued in some cases. Better computer applications and the Abuse Unit have improved the task of identifying employers, typically small employers, with no insurance. Now coverage hearings are regularly scheduled. The Board mandated the electronic filing of First Reports beginning on July 1, 2005. The Board has also mandated the electronic filing of claim denials; this became effective in June 2006. We are presently considering other areas where electronic filing would be appropriate as part of our EDI effort.

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3. Dispute Resolution

I. Introduction

The Workers' Compensation Board has five regional offices throughout the state. These offices manage and process disputed claims. The regional offices are where troubleshooting, mediation and formal hearings take place. Our regional offices are located in Augusta, Bangor, Caribou, Lewiston and Portland.

II. Four Tiers of Dispute Resolution

Title 39-A, the Maine Workers' Compensation Act, establishes a four-tiered dispute resolution process: troubleshooting, mediation, formal hearing, and the Appellate Division. The Appellate Division is discussed in section 14 of this report.

Troubleshooting

Troubleshooting is the initial stage of the Dispute Resolution process. During troubleshooting, a Claims Resolution Specialist, frequently called a Troubleshooter, calls employees and employers and attempts to resolve the parties' disagreement. Many times, additional information, such as medical reports, must be obtained to facilitate a resolution. Our Claims Resolution Specialists are neutral; they provide assistance and information to all parties. If the parties are not able to resolve their dispute, the claim is referred to the next step, mediation. Troubleshooters conduct their work via telephone. As a result, the COVID-19 pandemic did not require any operational changes in the manner in which Troubleshooters conduct their work.

Mediation

Claims unresolved at troubleshooting are scheduled with a mediator in one of our regional offices. Normally, mediations are conducted in person at a regional office or by other electronic means. Due to the COVID-19 pandemic, since March 2020, all mediations have been conducted telephonically.

In a typical case, the mediator asks the party seeking benefits to provide an explanation and rationale for the benefits being sought. The mediator then requests that other parties explain their concerns and identify what benefits they are willing to pay or why they are not prepared to do so. In addition to asking for proposals from the parties, the mediator may suggest a resolution in an attempt to find an acceptable compromise. If mediation resolves the claim, the mediator completes a formal agreement that is signed by the parties. The terms of the agreement are binding on those involved. If the case is not resolved at mediation, the next step is the formal hearing process. Even if a voluntary resolution is not reached at mediation, participation at mediation often benefits the parties by narrowing the issues that require formal adjudication.

Formal Hearing

At the formal hearing stage, parties are required to exchange information, including medical reports, and answer Board discovery questions concerning the claim. After required discovery has been completed, the parties file a "Joint Scheduling Memorandum." This document lists the witnesses and estimates the hearing time needed. Medical witness depositions are often scheduled to elicit or dispute expert testimony. At the hearing, witnesses for both parties testify and other, usually documentary,

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evidence is submitted. In most cases, the parties are represented either by an attorney or a worker advocate. Following the hearing, position papers are submitted, and the Administrative Law Judge thereafter issues a final written decision. Due to the COVID-19 pandemic, the Board has been conducting all formal hearing proceedings via remote technology.

III. Troubleshooting Statistical Summary

The following table shows the number of filings assigned and disposed at troubleshooting, the number of filings pending at the end of each year, and the average amount of time a file remained in troubleshooting for the period 2011 through 2020.

Troubleshooting

Filings Assigned, Disposed, and Pending

Year	Assigned	Disposed	Pending 12/31	Av Days at TS
*2011	13,660	13,438	697	28
2012	14,526	14,514	685	24
2013	13,351	13,358	678	26
2014	14,035	14,067	646	32
2015	14,663	14,819	490	32
2016	14,936	14,741	685	25
2017	15,697	15,608	664	26
2018	15,872	15,624	921	22
2019	15,494	15,792	569	22
2020	14,160	14,176	469	25

*Beginning in 2011, the Board changed the way cases are counted. In the past, our count was based on the number of parties. In 2011, we started counting the "disputed issues." This change was made to more accurately report on the work of the Board, not just the number of participants within our system.

IV. Mediation Statistical Summary

The following table shows the number of filings assigned and disposed at mediation, the number of cases pending at the end of each year, and the average amount of time a case remained in mediation for the period 2011 through 2020.

Mediations

Cases Assigned, Disposed, and Pending

Year	Assigned	Disposed	Pending 12/31	Av Days at MDN
2011	2,231	2,362	583	66
2012	2,766	2,738	555	50
2013	2,522	2,556	521	61
2014	2,755	2,789	487	57
2015	2,534	2,513	487	48
2016	2,449	2,509	406	55
2017	2,644	2,597	473	57
2018	2,500	2,488	472	64
2019	2,384	2,428	487	66
2020	1,829	1,952	383	72

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V. Formal Hearing Statistical Summary

The following table shows the number of filings assigned and disposed, along with the number of lump sum settlements approved, the number of cases pending at the end of each year, and the average time a case was pending before a decree was issued for the period 2011 through 2020.

Formal Hearing

Cases Assigned, Disposed, and Pending

Year	Assigned	Disposed	†Lump Sum Settlements	Pending 12/31	Av Months to Decree
2011	1,440	1,445		1,206	*10.8
2012	1,398	1,427	667	1,144	*12.1
2013	1,321	1,311	702	1,154	*9.7
2014	1,333	1,376	734	1,111	*10
2015	1,272	1,281	556	1,102	*10.9
2016	1,424	1,299	600	977	*10.7
2017	1,741	1,821	874	889	*10.5
2018	1,755	1,917	700	686	*9.2
2019	1,581	1,597	920	669	9.8
2020	1,438	1,461	884	639	8.5

* This figure represents all cases within the system. In prior years, certain cases were excluded. Claims processing has been slowed by a shortage of IME physicians in certain specialties, awaiting Medicare approval, and staff retirements.

† These figures were not recorded in prior years, but they are a significant part of the formal hearing process, so they will be included going forward.

4. OFFICE OF MONITORING, AUDIT & ENFORCEMENT

I. HISTORY

The Maine Legislature, in 1997, established the Office of Monitoring, Audit and Enforcement (MAE). The multiple goals of this office are: (1) monitoring and auditing payments and filings; (2) providing timely and reliable data to policymakers; and (3) identifying those insurers, self-administered employers, and third-party administrators (collectively "insurers") who are not in compliance with minimum standards established under our Act.

II. TRAINING

In recent years, the Board has endeavored to provide education and training to the workers' compensation industry. To do so, the Board has dedicated human and other resources in order to train/educate insurers, self-insured employers, claim adjusters, administrators, employers and, health care providers.

The Board normally offers a two day "open training" three times a year. Due to the pandemic, these sessions were not held in 2020. When they are held, training sessions provide a general overview of the Board and its divisions, as well as specific training in claims-handling techniques such as form filing, average weekly wage (AWW) calculations, and calculation of benefits due in a wide variety of scenarios a claim handler is likely to encounter. These sessions are very popular, both for those new to Maine claims, and as a review and update for the seasoned claims handler. Open training modules are available on the Board's website and have been used more extensively in the absence of in-person training, as have telephone and email contact with the Audit department with specific claims handling questions. Training newsletters are emailed to approximately 800 subscribers. The newsletter is also available on the Board's website. These writings address a broad range of claims-handling topics, report on Board activities that impact claims management, and give general guidance regarding rule and statute changes.

The Board also offers on-site training sessions which provide the entity being trained the opportunity to experience customized and specific-to-their-needs training. The six hour session focuses on the core of the open training sessions – form filing, average weekly wage calculation, and benefit calculation. These presentations provide the opportunity to review the entity's recent compliance and audit results, and address specific problems and issues they may have encountered. One on-site training session was held in 2020 before the pandemic forced cancellation of any additional sessions. Again, web based resources and telephone/email contact have provided increased assistance in the place of in-person sessions.

The Board also offers a two-day session on the Medical Fee Schedule; one day for claims administrators/payers and one day for medical providers. In 2020, the Medical Fee Schedule sessions, held prior to the pandemic, had 55 attendees.

In 2017, the Board began offering employer-specific training, focusing on employer obligations under the Workers' Compensation Act, and how to facilitate prompt claims handling with their insurer/claim administrator. Normally held twice each year, the pandemic forced sessions to be cancelled in 2020. As is the case with other training areas, resources are available on the Board's website.

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The Board typically provides training at an annual continuing education program known as Comp Summit. The Board also staffs an information booth at Comp Summit where it provides information on training and other Board resources to attendees. Comp Summit was not held in 2020 due to the pandemic.

Finally, the Board continues to provide access and assistance by telephone and email to claim handlers who have specific questions on difficult or unusual claims. The Audit Department receives an average of 12-15 such calls or emails a week through which it provides guidance on proper claims-handling.

III. Monitoring

The Board's Monitoring department publishes quarterly and annual reports that detail compliance with benchmarks established by the Board. Due to a data collection lag, the annual compliance reports are usually not approved by the Board until the second or third quarter of the following calendar year. This year, the 2019 Annual Compliance Report was approved by the Board on October 13, 2020.

The following sections, taken from the 2019 report, show that compliance with the Board's benchmarks is trending in a negative direction. The Board will be looking for ways to increase compliance with its benchmarks in 2021.

Lost Time First Report Filings

• Compliance with the lost time first report filing obligation exists when the lost time first report is filed (accepted Electronic Data Interchange (EDI) transaction, with or without errors) within 7 days of the employer receiving notice or knowledge of an employee injury that has caused the employee to lose a day's work.

• When a medical only first report was received and later converted to a lost time first report, if the received date minus the date of the employer's notice or knowledge of incapacity was less than zero, the filing was considered compliant.

Initial Indemnity Payments

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

Initial Memorandum of Payment Filings

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

Initial Indemnity Notice of Controversy Filings

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

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

Wage Information

• Compliance with this benchmark (WCB-2 and WCB-2b forms) exists when the wage information is filed within 30 days of the employer receiving notice or knowledge of incapacity. Note: This benchmark began in July of 2019.

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Quarterly Compliance from the 2019 Annual Compliance Report

	Benchmark	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Lost Time First Report Filings Received within 7 Days	85%	83%	83%	82%	81%
Initial Indemnity Payments Made within 14 Days	87%	87%	86%	86%	86%
Initial Memorandum of Payment Filings Received within 17 Days	85%	85%	85%	82%	84%
Initial Indemnity Notice of Controversy Filings Received within 14 Days	90%	93%	93%	94%	95%
Wage Information (WBC-2) Received with 30 days of an employer's notice of knowledge of a claim for compensation	75%	N/A	N/A	71%	70%
Wage Information (WCB-2B) Received with 30 days of an employer's notice of knowledge of a claim for compensation	75%	N/A	N/A	71%	71%

Annual Compliance from the 2019 Annual Compliance Report

	1997[1]	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Lost Time First Report Filings Received within 7 Days	37%	86%	87%	85%	85%	84%	83%	83%	83%	83%	82%
Initial Indemnity Payments Made within 14 Days	59%	89%	89%	90%	91%	90%	87%	89%	90%	88%	86%
Initial Memorandum of Payment Filings Received within 17 Days	57%	86%	89%	89%	90%	89%	86%	88%	89%	87%	84%
Initial Indemnity Notice of Controversy Filings Received within 14 Days		94%	95%	95%	95%	94%	94%	93%	93%	94%	94%

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IV. Audit

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

The Board is reviewing its audit procedures with the goal of making the process more efficient. Hopefully, a more efficient audit process will play a role in raising the compliance with benchmarks and other requirements of the Act.

A. Compliance Audits

The following audit was completed in 2020:

- National Interstate Insurance Company

The Draft Audit Report was completed and the Final Audit Report is pending for the following entity:

- FutureComp

The initial Exit Conference has been accepted and Draft Audit Reports are pending for the following entities:

- Chubb National Insurance Group
- Constitution State Services
- CorVel Corporation
- Cottingham & Butler Claims Services, Inc.
- Macy's Retail Holdings
- Protective Insurance Company

Initial Exit Conference has been completed for the following entities:

- Acuity Mutual
- Brotherhood Mutual

Audits are in process for the following entities:

- Hannaford Retail Services
- Maine Employers Mutual Insurance Company
- State of Maine Office of Workers' Compensation
- Synernet

B. Complaints for Audit

The audit program has a Complaint for Audit process. Through this process, a complainant requests the Board conduct an investigation to determine if the insurer, self-administered employer, or third-party administrator violated 39-A M.R.S.A. §359 by engaging in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims and/or has

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violated §360(2) by committing a willful violation of the Act, committing fraud, or making intentional misrepresentations. The complainant also asks that the Board assess all applicable penalties. In 2020, the Board received five audit complaints.

C. Employee Misclassification

The misclassification of an employee presents a serious problem for affected employees, employers, and our state economy. Misclassified employees are often denied access to the critical benefits and protections to which they are entitled under our Act. Employers that comply with the Act's coverage requirement are placed at a competitive disadvantage when bidding against employers that misclassify workers as independent contractors. Employee misclassification also generates substantial losses to our state Treasury, Social Security and Medicare, as well as to state unemployment insurance.

In 2020, the MAE program completed one large employee misclassification audit and had three others pending and almost complete, but are waiting for additional information from employers. Completing these type of audits has proven to be difficult because of travel restrictions and delays due to the COVID pandemic.

V. Enforcement

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

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5. Office of Medical/Rehabilitation Services

I. Medical Fee Schedule

A. Background

The goal of the Board’s medical fee schedule is “to ensure appropriate limitations on the cost of health care services while maintaining broad access for employees to health care providers in the State.” 39-A M.R.S.A. § 209-A(2).

B. Methodology

The Board’s medical fee schedule reflects the methodologies underlying the federal Centers for Medicare and Medicaid Services’ (CMS) inpatient, outpatient and professional services payment systems. In particular, the fee schedule uses procedure codes, relative weights or values (together “relative weights”) and conversion factors or base rates (together “conversion factors”) to establish maximum reimbursements.

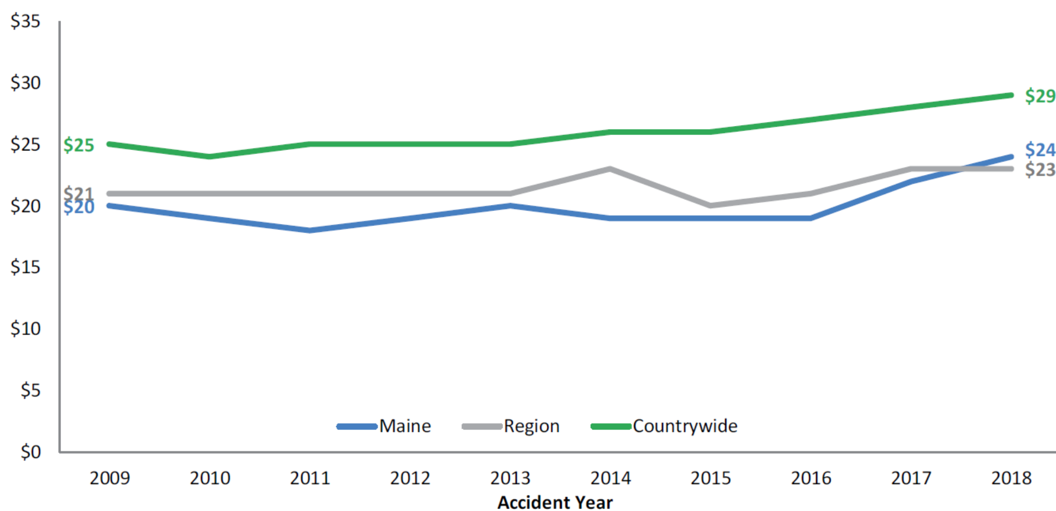
In the case of both procedure codes and relative weights, the Board does not exercise discretion in assigning codes to procedures or relative weights to coded services. The Board, in an effort to simplify our rule, incorporated the codes and weights underlying the federal CMS inpatient facility, outpatient facility and professional services payment systems.

The Board’s rule contains the final element of the equation to determine the maximum reimbursement for a service, i.e. the applicable conversion factor. Separate conversion factors exist for anesthesia, all other professional services, inpatient and outpatient acute care facilities, inpatient and outpatient critical access facilities and ambulatory surgical centers.

According to the National Council on Compensation Insurance (NCCI), Maine’s overall medical average cost per lost-time claim is lower than the region and countrywide averages.

Chart 2

Overall Medical Average Cost per Lost-Time Claim (in 000s)



Source: NCCI’s Calendar-Accident Year Call for Compensation Experience. Region includes CT, DC, MD, NH, RI, and VT. Countrywide data AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

C. Annual and Periodic Updates

The Act requires two types of updates: annual updates by the Executive Director and periodic, more comprehensive, updates undertaken by the Board. Annual updates are completed during the last quarter of each calendar year. Periodic updates are required every three years beginning in 2014.

D. Education and Training

The Board offers two "open training" sessions on Board Rule Chapter 5, aka the Medical Fee Schedule: one for claim administrators/medical bill reviewers and one for health care providers/ provider billing and office staff. These sessions provide a general overview of the fee schedule, as well as specific training in workers' compensation billing and reimbursement.

Fifty-five adjusters, employers, providers, and others involved in workers' compensation attended the 2020 sessions. In addition, open training modules are available on the Board's website. Training newsletters are emailed to approximately 800 subscribers. The newsletter is also available on the Board's website. These writings address a broad range of medical fee schedule topics and report on Board activities that impact claims management. The Board also offers on-site training sessions which provide the entity being trained the opportunity to experience customized and specific-to-their-needs training.

Finally, the Board continues to provide access and assistance by email to any who have specific questions regarding the fee schedule or have difficult/unusual medical bills. The Board receives an average of 12-15 such emails a week.

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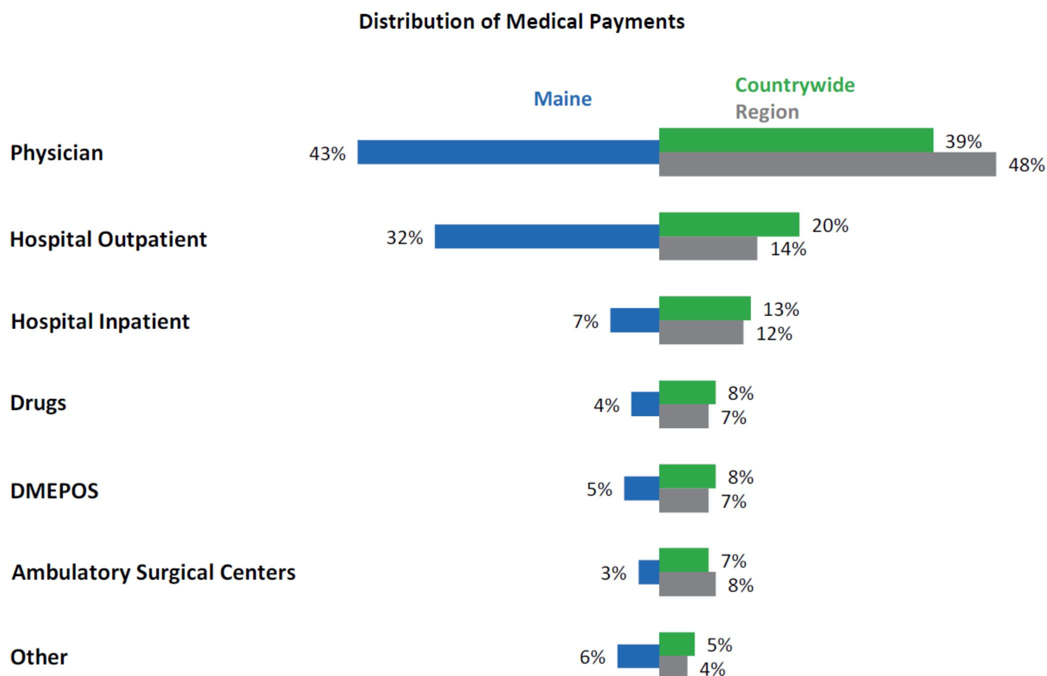
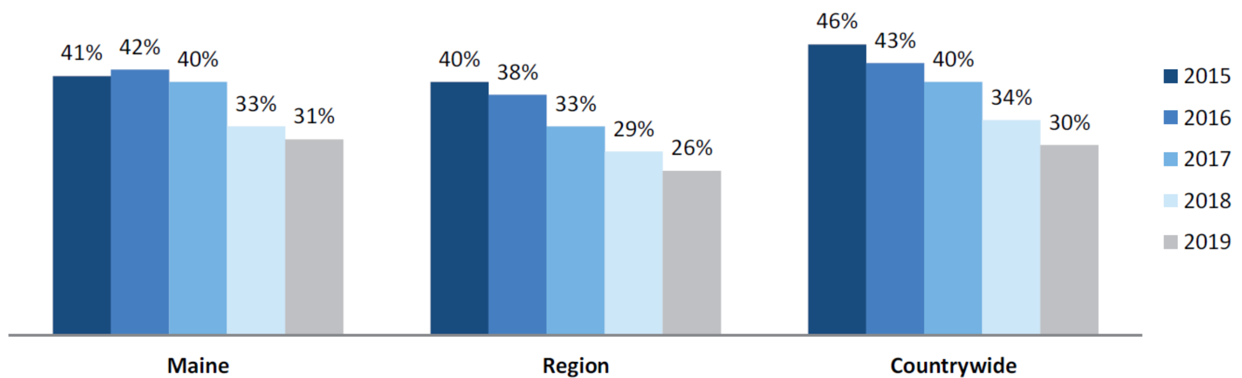
II. MEDICAL UTILIZATION REVIEW

The Board does not currently have approved treatment guidelines. In its October 2020 Medical Data Report, NCCI compares Maine's distribution of medical payments by type of service to region and countrywide data as follows:



The issue of opioid use and misuse by injured workers is a major concern in the workers' compensation community as well as to society in general. In 2016 the Maine legislature passed LD 1646, An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program. This legislation applies to all opioid prescribing in Maine. NCCI is monitoring the legislation's impact on opioid prescribing in workers' compensation. According to data from NCCI, the share of drug claims with at least one opioid prescription has decreased 10% from 2015 to 2019.

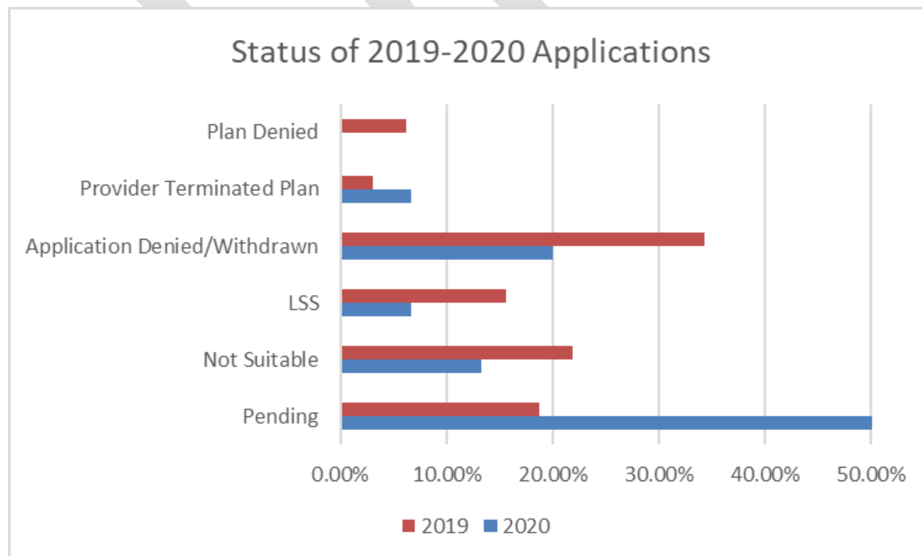
Share of Drug Claims With at Least One Opioid Prescription by Service Year



III. Employment Rehabilitation

The Board's employment rehabilitation services program is governed by Title 39-A M.R.S.A. §217 and Board Rule Chapter 6. In 2018, the Board rewrote Chapter 6. The changes became effective September 1, 2018. The new rules bring clarity to the vocational rehabilitation process and provide guidelines for providers. In addition, under the new rule providers are now appointed by the Board of Directors.

In 2020, the Board received 15 applications from injured workers for employment rehabilitation services, which represents a 53% decrease from 2019. The chart below shows the status of the 2019 and 2020 applications as of December 31, 2020.



IV. Independent Medical Examiners

Pursuant to 39-A M.R.S.A. §312, an independent medical examiner can be appointed and tasked with providing an opinion regarding medical questions that arise in disputed cases. The Board received 358 requests for independent medical exams in 2020 and the Board's independent medical examiners conducted 273 exams.

In 2020, the Board added two orthopedic surgeons to its list of approved independent medical examiners; a much needed specialty.

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6. WORKER ADVOCATE PROGRAM

I. INTRODUCTION

The Worker Advocate Program provides legal representation without cost to injured workers pursuing claims before the Workers' Compensation Board. In order for an injured worker to qualify for Advocate representation, the injury must have occurred on or after January 1, 1993; the worker must have participated in the Board's troubleshooter program; the worker must have failed to informally resolve the dispute; and finally, the worker must not have retained private legal counsel.

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

II. HISTORY

As noted earlier in this report, the Maine Legislature in 1992 re-wrote the Workers' Compensation Act. They repealed Title 39 and enacted Title 39-A. One of the most significant changes impacting injured workers was the elimination of the attorney fee "prevail" standard. Under Title 39, attorneys who represented injured workers were entitled to Board ordered fees from employers/insurers if they obtained benefits for their client greater than any offered by the employer, i.e., if they "prevailed." Since the enactment of Title 39-A (effective January 1, 1993 for claims after that date), the employer/insurer no longer has liability for legal fees regardless of whether the worker prevails, and, in addition, fees paid by injured workers to their attorneys are limited to a maximum of 30% of accrued benefits with settlement fees capped.

These changes made it difficult in many instances for injured workers to obtain legal counsel—unless they had a serious injury with substantial accrued benefits or a high average weekly wage. Estimates suggest upwards of 40% of injured workers did not have legal representation after this change was enacted. This presented challenges for the administration of the workers' compensation system. By 1995, recognition there was a problem prompted the Workers' Compensation Board of Directors to establish a pilot "Worker Advocate" program.

The pilot program was staffed by a non-attorney Advocate and was limited to the representation of injured workers through mediation. The pilot was a success and the Board expanded the program to five non-attorney Advocates, one for each regional office; however, representation remained limited to mediations. Ultimately, in recognition of both the difficulties facing unrepresented workers and the success of the pilot program, the Legislature in 1997 amended Title 39-A and formally created the Worker Advocate Program.

The 1997 legislation resulted in a substantial expansion of the existing operation. Most significantly, the new program required Advocates to provide representation at mediation and formal hearings. The additional responsibilities associated with this representation require greater skill and more work than previously required. Some of the new responsibilities include: participation in depositions, attendance at

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hearings, drafting joint scheduling memorandums, drafting motions, drafting post-hearing position letters, working with complex medical reports, conducting settlement negotiations, and analysis and utilization of the statute, our Rules, and case law.

III. The Current Worker Advocate Program

At present, the Board has 12 Advocates in our five regional offices. Advocates are generally required to represent all qualified employees who apply to the program. This contrasts with private attorneys who have more discretion regarding who they represent. The statute provides exceptions to this requirement where the program may decline to provide assistance. In 2014, the Board adopted a new Rule on Advocate representation allowing advocates to cease representation in cases where injured workers are uncooperative; e.g., refusing to respond to requests for meetings, information, etc. The Rule is based on the applicable Maine Bar Rules. While not frequently used, in the situations the Rule does apply, it helps advocates better manage their caseloads and spend time more productively with employees who need assistance, and less time chasing uncooperative clients. It is important to note relatively few cases are rejected.

Cases are referred to the Advocate Program only when there is a dispute—as indicated by the employee, employer, insurer, or a health care provider. When the Board is notified of a dispute, a Claims Resolution Specialist (commonly referred to as a “troubleshooter”) works to facilitate a voluntary resolution. If unsuccessful, the Board determines if the employee qualifies for the assistance of the Advocate Program, and, if so, a referral is made.

As reported in the dispute resolution section of this report, if troubleshooting is not successful, cases are forwarded to mediation. Advocates representing an injured worker at mediation must first obtain medical records and other evidence related to the injury and the worker’s employment. Advocates meet with the injured worker to explore the claim and review issues. They also gather information from health care providers and others. Advocates are often called upon to explain the legal process (including the Act and Board Rules) to injured workers. They frequently discuss medical issues, review work restrictions and assist workers with unemployment and health insurance matters. Advocates provide injured workers with other forms of interim support, as needed. Many of these interactions produce evidence and information necessary for subsequent formal litigation, if the case proceeds to formal hearing.

At mediation, the parties appear before a Mediator, discuss the claim, present the issues, and work to secure a resolution. The Mediator facilitates, but has no authority to require the parties to reach a resolution or to set the terms of an agreement. If the parties resolve the claim, the agreement is reduced to writing in a binding record. A significant number of cases are resolved before, at, and after mediation; of every 100 disputes reported to the Board, approximately 75 are resolved by the end of the mediation stage of dispute resolution, and thus avoid formal hearings.

Cases not resolved at mediation typically involve factual and/or legally complex disputes. These claims usually concern circumstances where facts are unclear or there are differing interpretations of the Act and applicable case law. If a voluntary resolution fails at mediation, the case frequently proceeds to a formal hearing.

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The hearing process is initiated when an Advocate files petitions (after assuring there is adequate medical and other evidence to support a claim). Before a hearing, the parties exchange information through voluntary requests and formal discovery. Preparation for hearing involves filing and responding to motions, preparing the employee and other witnesses, preparation of exhibits, analysis of applicable law and review of medical and other evidence. At a hearing, Advocates, like any lawyer, must elicit direct and cross examination testimony from the witnesses, introduce exhibits, make objections and motions, and, at the conclusion of the evidence, file position papers that summarize the facts and credibly argue the law in the way most favorable to the injured worker. Along the way, the Advocates also often attend depositions of medical providers, private investigators, and labor market experts. Eventually, a decision is issued or the parties agree on either a voluntary resolution of the issues or a lump sum settlement. In recent years, the average timeframe for the entire process is about 11 months, although it can be significantly shorter or longer depending on the complexity of medical evidence and the need for independent medical evaluations.

In 2020 the COVID-19 pandemic required the Board to end in-person interviews with clients and the Board moved to "virtual" proceedings, with the parties participating by telephone and other electronic means.

IV. CASELOAD STATISTICS

Injured workers in Maine have made substantial utilization of the Advocate Program. Advocates represented injured workers at approximately 63% of the cases pending at mediation in 2020. The following table reflects the number of Advocate cases mediated from 2010 through 2020. In 2016, the Advocate Division upgraded its case management and statistics software.

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Advocate Cases at Mediation

Year	Filings Assigned	Filings Disposed	Cases Pending at Board 12/31	%of All Cases Pending at Board
2010	1,006	1,156	271	60%
2011	975	896	246	42%
2012	1,703	982	294	53%
2013	1,465	1,540	270	55%
2014	1,688	1,486	307	64%
2015	1,621	1,410	326	66%
2016	1,608	1,089	228	56%
2017	1,831	1,075	311	66%
2018	1,908	1,122	260	47%
2019	2,271	1,661	307	63%
2020	1,866	1,564	242	63%

Note: Mediation "filings" are petitions, Notices of Controversy and Indications of Controversy. The Advocate Division opens one "client file" per date of injury. One Advocate Division "case" includes all filings pending before a mediator for an injured worker.

Since becoming fully staffed, the Advocate Program has represented injured workers in approximately 30% of all Board formal hearings. In some years, Advocates clear more formal cases than were pending at the start of the year. Given the much greater scope of responsibility inherent in formal hearing cases, Advocates have performed well in their expanded role. The following table represents the number of cases handled by Advocates at formal hearing from 2010 through 2020.

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Advocate Cases at Formal Hearing

	Filings Assigned	Cases Assigned	Cases Disposed	Cases Pending at Board 12/31	%of All Cases Pending at Board
2010	463		515	306	26%
2011	438		374	242	20%
2012	444		289	338	29%
2013	476		281	377	31%
2014	461		293	305	26%
2015	503		275	326	29%
2016	693		382	333	34%
2017	808		306	324	36%
2018	821		399	246	30%
2019	813	284	331	230	34%
2020	776	343	288	272	43%

Note: Formal Hearing "filings" are petitions. The Advocate Division opens one "client file" per date of injury. One Advocate Division "case" includes all filings pending before an ALJ for an injured worker.

The Advocates represented the injured worker in approximately 43% of the cases pending at formal hearings at the end of 2020.

V. Summary

The Advocate Program was created to address a need in the administration of the workers' compensation system. The statutory expansion of program duties in 1997 created needs in the program. In order to meet the obligations in the statute, the Workers' Compensation Board has diverted resources from other divisions to the Advocate Program. Currently the program has 12 Advocates with a support staff of 16 (two of whom are part-time) and a supervising Senior Staff Attorney. Services are provided in five regional offices: Augusta, Bangor, Caribou, Lewiston, and Portland. The Advocate Division experienced staff shortages in 2020, with hiring limited due to the pandemic. Credit should be given to the Advocates and staff who worked well under very difficult circumstances to continue our mission of serving Maine's injured workers.

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7. INFORMATION MANAGEMENT

The Board's technology needs are overseen by the Board's Deputy Director of Information Management, who coordinates with the State of Maine Office of Information Technology (OIT). Two OIT employees are dedicated to fulfilling the Board's programming needs on the main database, Progress. The Advocate Program uses the software program Practice Master to manage caseloads.

I. 2020 UPDATE

A. Recording Software

Early in the year, new computers were installed in the Board's hearing rooms with the latest version of For the Record (FTR) recording software and Windows 10.

B. COVID-19 Change in Workflow

In March, most Board employees began working from home as much as possible. Those with desktop computers were upgraded to laptops and everyone was set up with remote access to the State's system.

C. Video Conferencing

The Board discontinued in-person hearings due to the pandemic beginning in March. CourtCall, Microsoft Teams, and Zoom are the platforms offered for video conferencing.

D. Public Use Computers

With hearings being conducted primarily by video, it became apparent that some hearing witnesses did not have the proper technology to participate. As a result, public use computers were secured for each office. In order to ensure the safety of staff, the computers may only be used in certain circumstances, and use requires the approval of an administrative law judge.

E. Employer Database

OIT programmers completed an extensive project to improve the functionality of the Board's employer database. Since November of 2018, the Board had been maintaining two employer databases. The new database, which was launched on September 21, 2020, combines the two databases into one which can now be maintained and updated regularly by Board staff.

F. Bangor Regional Office Upgrades

The Bangor Regional Office underwent a network upgrade and had their phone systems changed to Voice over Internet Protocol (VoIP). All other offices were upgraded in 2019.

G. Reports

Significant progress was made in 2020 with respect to the Board's ability to create reports from the data gathered by the Board. As a result, caseloads, timelines, filings, and accuracy of data entry can be better monitored. As a result of these efforts, the Board has been able to monitor and track COVID-19 cases on a weekly basis.

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H. Data Quality

The agency spent a significant amount of time on database cleanup projects. One major focus has been to ensure that only licensed insurers, self-insurers, and third-party administrators are in the database. As a corollary, the Board is also verifying that claims and policies are attached to the proper entities. This work will continue well into 2021.

II. Upcoming Projects and Challenges

A. Employer Database

In continuing with its data quality project, the agency will be focusing on extensive cleanup of its employer database. This project will have four components:

1. Clean up existing data. Remove duplicate addresses, remove employers set up in error, remove closed employers with no coverage policies, waivers, or claims, review active/closed statuses etc.
2. Monitor incoming data. Establish a program that will monitor the data posted to the employer database to ensure quality control.
3. Post employer information updates and additions directly from proof of coverage EDI transactions.
4. Self-insurers. Since self-insurers are not required to file proof of coverage via EDI, we obtain self-insured employer information by reaching out each year. The Board will be reviewing this process to see how more thorough and accurate data can be obtained from each self-insured employer.

B. Server Upgrade

As part of OIT's modernization effort, Progress will be moving onto new servers in early 2021.

C. Progress Update

Once on the new servers, the programmers will upgrade Progress to version 12, as required by the license agreement.

D. EDI Claims 3.1 & Database Migration

Because of the pandemic, the Board is not able to fund these projects at this time. The projects remain a priority as they will enable more information to be filed electronically with the Board as well as providing a better long-term database solution for the Board. The Board will move forward on these projects as soon as practicable.

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8. BUDGET AND ASSESSMENT

Since 1992, Board operations have been funded by a statutory assessment. The Board receives no General Fund support. Assessments are paid by Maine's employers, both insured and self-insured. By establishing a funding assessment, the Legislature intended the entities using the workers' compensation system pay for the system costs. The Legislature also placed an annual cap on the dollar amount that may be assessed, limiting the amount of revenue the Board is allowed to generate. This cap has been adjusted numerous times over the years. Most recently, in 2016, the Legislature increased the assessment cap to $13,000,000.

The Board's budget is limited to the revenue raised from the annual assessment. Other minor amounts of revenue are collected from the sale of publications and some fines and penalties; less than 1% of total revenue in FY 2020. The Board collects other fines and penalties not available for Board expenses; the Legislature has directed those amounts be paid into one of two dedicated accounts, the Rehabilitation Fund or the General Fund. The Board approved budget for fiscal year 2021, the second year of the current biennium, is $12,566,245. The approved budgets for the upcoming biennium are $13,218,131 for fiscal year 2022 and $ 13,389,962 for fiscal year 2023.

The Board's funding mechanism also includes a reserve account. Reserve account monies may be used to assist in funding personnel and administrative expenditures, and other reasonable costs of administering the Workers' Compensation Act. A vote by the Board of Directors is required to authorize the use of reserve account funds and the Bureau of Budget and the Governor approve the resulting increase in the Board's allotted budget via the financial order process. The disbursement of reserve account funds must also be reported to the joint standing committee of the Legislature with jurisdiction over Labor matters.

The bar chart entitled "Actual and Projected Expenditures" shows actual expenditures through FY 2020 and projected expenditures for fiscal years 2021, 2022 and 2023. The chart also shows the assessment cap and the amounts assessed through FY 2021 (July 1, 2020 – June 30, 2021).

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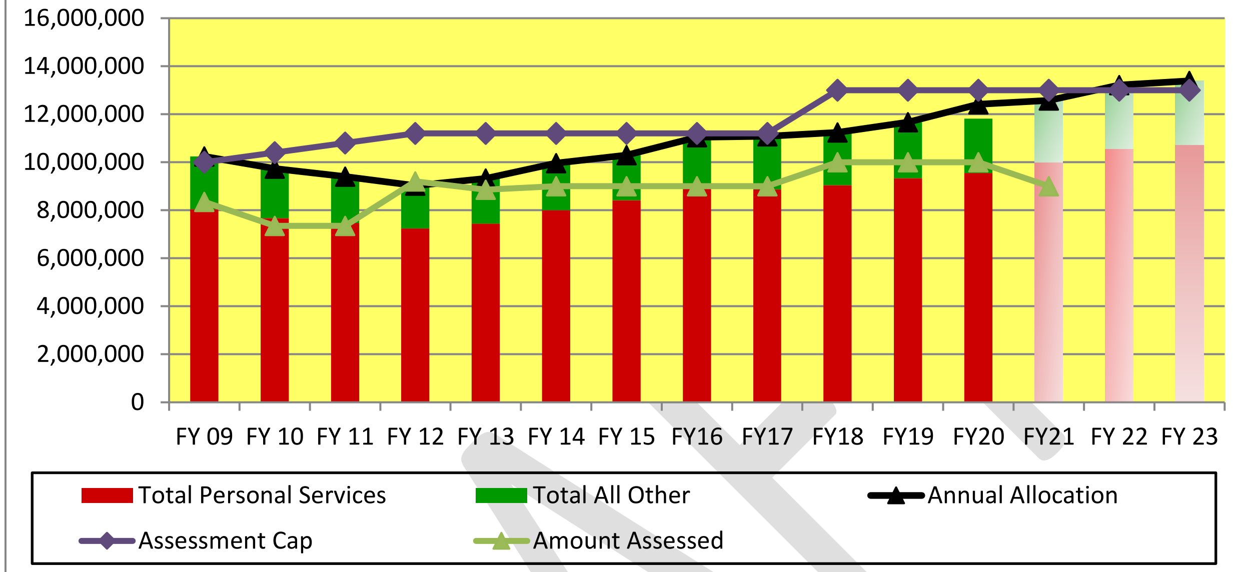

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9. Claims Management Unit

The Claims Management Unit (CMU) operates using a "case management" system. Individual claims managers process all submissions for an individual claim from start to finish. This ensures payments to injured workers are accurate and that proper forms are completed. Insurance carriers, claims administrators and self-insured employers benefit from having a single contact in the unit.

The CMU coordinates with the Monitoring section of the MAE Program to identify carriers who fail to submit required filings on time. CMU staff also verifies the raw data that is later used to create our quarterly reconciliation reports. The CMU also participates in compliance and payment training workshops with the MAE Program on a quarterly basis.

Claims managers must consider all factors that can affect indemnity payments including the date of injury, Cost of Living Adjustments (COLAs), maximum benefits rates and fringe benefits. When incorrect information is filed, CMU staff must research prior filings, contact carriers for additional information and perform mathematical calculations to ensure payments are correct.

Electronic Data Interchange (EDI) for filing First Reports of Injury and Notices of Controversy helps carriers identify potential issues early in the life of a claim. Electronic filing reduces manual data entry which allows the unit to address more serious problems.

The CMU is responsible for annually producing the "State Average Weekly Wage Notice." Insurance carriers use this information to determine the COLAs and maximum benefits allowed for the upcoming year.

The following is a brief description of the different steps taken to process the most-frequently filed claim information.

Petitions – Staff must locate or create the physical file. The relevant information is entered into the database and the file is sent to the appropriate regional office.

Answers to Petitions - The information is verified and entered in the database.

Notices of Controversy (NOC) - Initial NOCs are filed electronically. Corrections are submitted on paper and claims managers enter the revisions to the original NOC into the database system.

Wage Statements – Claims staff calculate the average weekly wage in accordance with the Statute, Board rules and Law Court decisions. The average weekly wage for the claim is entered into the database.

Schedule of Dependent(s) and Filing Status Statements - This information is required only for dates of injury between 1/1/93 and 12/31/12. The data submitted is entered into the database.

Fringe Benefit Worksheets- The received data is entered into the database.

First Reports of Injury (FROI) - Claims staff ensure that the date of injury matches the First Report of Injury that has been filed via Electronic Data Interchange (EDI). If there is a discrepancy or the claim

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cannot be located in the database, the claims manager contacts the appropriate carrier to resolve the issue.

Memorandum of Payment, Discontinuance or Modification of Compensation, Consent between Employer and Employee - The form is checked for accuracy. Dates, compensation rates and the average weekly wage are compared to information previously filed. If there is a discrepancy, the claims manager examines the file, contacts the appropriate insurance adjuster and may request amendments or new submissions be filed, if needed, to resolve the issue(s).

21-Day Certificate or Reduction of Compensation - The dates, the payment rate, and the average weekly wage are compared to prior filings for accuracy. The claims manager verifies whether the suspension or reduction complies with Board rules. If there is an issue, the claims manager contacts the carrier to explain the error(s) and request a new certificate.

Lump Sum Settlement - The form and attached documents are reviewed to verify all required information has been provided. A claims manager contacts Board staff or parties to resolve any discrepancies or secure missing information.

Statement of Compensation Paid - The information on this form is compared to information previously reported. A large number of these forms contain errors requiring staff to research the file, contact the person who filed the form and request corrected or missing forms.

BREAKDOWN OF CLAIM FORMS FILED WITH THE WORKERS' COMPENSATION BOARD
Information filed from January 1, 2020 to December 31, 2020.

Information/Form	EDI	CMU	TOTAL
Employer's First Report of Occupational Injury or Disease	**27,139**	**100**	**27,239**
Notice of Controversy	**10,283**	**592**	**10,875**
Petitions		**3,563**	**3,563**
Answers to Petitions		**572**	**572**
Wage Statement		**9,308**	**9,308**
Schedule of Dependent(s) and Filing Status Statements		**4**	**4**
Fringe Benefits Worksheet		**8,923**	**8,923**
Memorandum of Payment		**5,696**	**5,696**
All other payment forms, including: • Discontinuance or Modification of Compensation • Consent Between Employer and Employee • 21-Day Certificate of Discontinuance or Reduction of Compensation • Lump Sum Settlement		**14,398**	**14,398**
Statement of Compensation Paid		**12,982**	**12,982**

Currently the Employer's First Report of Occupational Injury or Disease and the Notice of Controversy are filed electronically. All other required filings are submitted in paper form and are manually entered into the Board's case management database system.

10. Insurance Coverage Unit

The Insurance Coverage Unit is responsible for filings and records regarding workers' compensation insurance coverage. Board rules require employers doing business in Maine to file proof of a workers' compensation insurance policy (known as "coverage") with the Board. When an injured worker makes a claim for benefits, the claim must be linked to that employer's coverage policy.

The Coverage staff provides information to insurers, employers, insurance adjusters and the public regarding insurance coverage requirements. Staff matches insurance coverage to employers, creates and updates employer records, and researches the history of an employer's insurance coverage when there is a question regarding which insurer is responsible for paying workers' compensation benefits. Employers identified as needing but not having workers' compensation coverage are notified by letter and asked to contact the Coverage Unit. Coverage staff resolve the matter, when possible, or provide the employer additional information to correct records or complete filing. The Unit is also responsible for processing applications to waive the requirement to have workers' compensation coverage, maintain waiver records, and rescind waivers upon request of the applicant or when applicants do not meet the statutory requirements.

In 2009, the Board implemented electronic filing for proof of workers' compensation insurance. The coverage reporting system was upgraded in November 2018. The advent of electronic filing has allowed Coverage staff to focus on research and resolution of problems. The majority of routine filings (initial proof of coverage, endorsements and renewals) flow through the electronic filing system without staff intervention while filings requiring research are routed to staff. Electronic filing has reduced data entry and enhanced identification of problems and trends with coverage filings. Changes to the Board's computer program associated with electronic filing have improved linking coverage to employers and claims, and reduced the amount of research needed to identify whether there is coverage and the insurer responsible for a particular workers' compensation claim.

For the twelve (12) month period January 2020 through December 2020, the Board received and processed 51,926 proof-of-coverage filings. The Coverage Unit processed 797 waiver applications. Part of matching coverage to specific employers involves resolving instances of "no recorded coverage." In 2020, 1,225 "no record of coverage" letters were sent to employers requesting information to verify if they were subject to the coverage requirement, and if so, whether they had workers' compensation insurance. Information received in response to these letters allowed Coverage staff to determine 494 employers fell under one of the exemptions to the coverage requirement.

The Coverage staff works closely with the Abuse Investigation Unit on problems associated with coverage enforcement. The Unit cooperates with the MAE program to identify carriers and self-insureds who consistently fail to file required information in a timely manner.

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10A. PREDETERMINATION UNIT

The Predetermination Unit processes applications for predetermination of employment status. These forms can be used to get a predetermination as to whether an individual (or in some cases a group of workers) is an independent contractor. The applications are filed by the worker alone; this makes it easier for the applicant to use the form with multiple hiring entities, but makes it impossible to review each working relationship. Filing any of the three different predetermination forms, discussed below, is voluntary under the Maine Workers' Compensation Act.

The Legislature adopted a uniform "independent contractor" definition in 2012. This definition became effective on January 1, 2013. At that time, the Board reduced the number of predetermination forms from five to three and adopted a new form titled "Application for Predetermination of Independent Contractor Status to Establish A Rebuttable Presumption" (form WCB-266). This form replaced three old forms, WCB-264, WCB-265 and WCB-261. The Board also uses two other applications that are exclusive to wood harvesters. The "Application for Certificate of Independent Status" (form WCB-262) is used by a wood harvester so he or she can apply for a certificate of independent status. The "Application for Predetermination of Independent Contractor Status to Establish Conclusive Presumption" (form WCB-260) is a two-party application that is completed by a land owner and a wood harvester. Approval of either form WCB-260 or WCB-262 precludes a wood harvester from filing a workers' compensation claim if he or she is injured while harvesting wood.

In calendar year 2020, the Predetermination Unit received 5,476 applications. All complete applications were processed within 30 days of filing as required by the statute, and most were processed within several days of receipt. 5,012 applications were approved, both conclusive and rebuttable, and 1 was denied. 506 applications could not initially be processed because they were incomplete or used an outdated form. The applicants were contacted by phone or letter, asked for additional information or sent an updated form. Of that group, 464 applications were successfully processed but the remaining 42 applications were not completed because the applicant did not reply or provide the requested information.

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11. COORDINATION WITH OTHER AGENCIES

The Workers' Compensation Board is an independent agency charged with performing discrete functions within state government. Additionally, the Board coordinates and collaborates with other agencies.

I. DEPARTMENT OF LABOR

The Board and the Department of Labor (DOL) used to share an employer database. The shared database was used by the Board to identify employers operating without required workers' compensation coverage. The Board and DOL no longer share that database. We are currently working together on a plan to ensure the Board has access to the data it needs to perform its oversight function.

The Board, DOL and other interested parties worked together to create a uniform "independent contractor" definition that is used for both workers' compensation and DOL purposes. The definition has been in effect since January 2013. The Board also works with DOL's vocational rehabilitation staff. In order to return injured workers to suitable employment as quickly as possible, the Board refers injured workers to qualified employment rehabilitation specialists, who evaluate the workers and develop rehabilitation plans. Some of these referrals are made to DOL staff. The Board and DOL continue to monitor the effectiveness of the plans.

The Bureau of Labor Standards (BLS), a division within DOL, uses claim information gathered by the Board to produce statistical reports on workplace safety. These reports are used by the Board, policy makers, and others to understand and improve workplace safety. BLS is currently working with the Board to develop and define procedures for filing claim information electronically.

II. BUREAU OF INSURANCE

While the Board has primary responsibility for implementing Maine's Workers' Compensation Act, the Bureau of Insurance (BOI) is responsible for overseeing certain aspects of Maine's system that require the two agencies to work cooperatively. A primary area of collaboration revolves around the Board's annual assessment. In order to ensure proper and adequate funding, the Board works with BOI to obtain information on premiums written, predictions on market trends, and paid losses information for self-insured employers. This information is utilized by the Board when calculating the annual assessment figures.

The Board's Monitoring, Auditing, and Enforcement (MAE) Unit works directly with BOI on compliance and enforcement cases pursuant to 39-A M.R.S.A. § 359(2). When insurers, self-insurers and/or third-party administrators are found, after audit, to have failed to comply with the requirements of the Act, the Board certifies this information and forwards it to BOI. BOI then takes appropriate action to ensure questionable claims handling is addressed.

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III. OTHER AGENCIES

The Board has entered into agreements with other agencies to provide services that used to be provided in-house. For instance, the Board's human resources needs are managed in conjunction with the Bureau of Human Resources.

The Board also works with the Office of Information Technology (OIT), another DAFS Bureau, with respect to computer hardware and software.

The Board works with the Department of Health and Human Services (DHHS) to assist in recovering past due child support payments and to ensure MaineCare does not pay for medical services that should be covered by workers' compensation insurance.

The Board also works with the Maine Health Data Organization to gather information regarding payments for medical services made by private third-party payors. The Board uses this data to evaluate whether its medical fee schedule sets appropriate limits on payments for health care services while maintaining broad access to care for injured workers.

Finally, the Board works with the Attorney General's office on matters ranging from employee misclassification to representation on collection matters when penalties are assessed and not paid consistent with the judgement.

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12. ABUSE INVESTIGATION UNIT

The Abuse Investigation Unit (AIU) is responsible for enforcing the administrative penalty provisions of the Workers' Compensation Act. The AIU investigates allegations of fraud, illegal or improper conduct, and violations associated with mandatory filings, payments and insurance coverage. The Unit has five (5) professional staff members and is supervised by the Board's Deputy General Counsel. Currently, multiple AIU staff members are also assisting other areas of the Board because of the pandemic and staff shortages. AIU personnel conduct investigations, file complaints and petitions, represent the Board at administrative penalty hearings, and decide penalty cases.

AIU staff is also responsible for managing billing and penalty payments, and for initiating collection through Maine Revenue Services and the Attorney General's office in the form of civil and criminal actions. As part of this work, AIU is responsible for complying with requirements established by the Department of Administrative and Financial Services, and the Office of the State Controller.

The Unit's legal work is focused on enforcement of the coverage obligations in the Act. AIU staff investigates whether businesses have proper workers' compensation insurance; files complaints against businesses that are out of compliance; represents the AIU in administrative penalty hearings; and, when able, negotiates consent agreements resolving violations. The AIU investigates possible employment misclassification tips and coordinates with the Department of Labor and OSHA when necessary. The Unit is also responsible for defending appeals of "coverage" penalty decisions to the Board's Appellate Division.

AIU coordinates its work with the Board's Coverage Division and the Monitoring, Audit and Enforcement Program (MAE). It represents the MAE unit when a dispute arises as a result of an audit. AIU works with the Attorney General's office to enforce subpoenas, and to identify and refer cases for criminal prosecutions against employees and employers who have committed egregious or repeated violations of the Workers' Compensation Act.

Because of the COVID-19 pandemic, hearings against potential uninsured employers were temporarily put on hold.

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13. GENERAL COUNSEL REPORT

The Workers' Compensation Board is responsible for overseeing and implementing the Workers' Compensation Act. The Board, in performing these functions, can propose legislation and rules when it deems change is necessary. The Board has the authority to act in adjudicatory and appellate roles.

I. LEGISLATION

Following the enactment of significant amendments to the Workers' Compensation Act during the first regular session of the 129th Legislature, the second regular session ended with no changes to Title 39-A.

II. RULES

The Workers' Compensation Act confers rulemaking authority upon the Board. Since adopting revisions to its rules in 2018, the rules have not been amended.

The Board completed its annual update and its three year comprehensive review of the medical fee schedule in 2020 as required by 39-A MRSA § 209-A. Base rates and conversion factors for professional and outpatient fees were not increased.

III. ADJUDICATORY HEARINGS

39-A MRSA §§ 315 and 318 authorize administrative law judges to conduct hearings as part of the Board's statutory dispute resolution process. Litigants participated in person before the pandemic, but hearings are now being conducted remotely by CourtCall, Zoom or Microsoft Teams.

IV. APPELLATE DIVISION

39-A MRSA §§ 321-A established the Appellate Division. It acts as an appeals court for decisions issued by administrative law judges at the hearing level. Panels of three administrative law judges decide cases, usually after oral arguments are presented by lawyers for litigants. During the COVID-19 shutdown, live arguments were suspended. The Appellate Division experienced a brief interruption in its processes but regained its footing midway through the year. Counsel now present arguments by remote media and appellate decisions are being issued. In 2020, the Appellate Division issued 28 decisions.

V. MAINE SUPREME JUDICIAL COURT APPEALS

39-A MRSA § 322 authorizes parties to appeal Appellate Division decisions to the Law Court. These appeals are discretionary. In 2020, three such appeals were taken and two appellate decisions were issued by the Law Court.

VI. AGENCY STUDIES

Pursuant to P.L. 2019, c. 344, the Board was tasked with producing three reports for consideration during the Second Regular Session of the 129th Maine Legislature. The first such study pertained to the

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Worker Advocate Program. The board evaluated the level of advocate pay, the availability of resources available in the litigation process and the demands put upon the advocate program. The study concluded that worker advocates may not be receiving compensation that is commensurate with their work and that additional litigation tools would allow them to better represent litigants.

A study of additional protections for injured workers whose employers did not properly secure workers' compensation coverage was also conducted. The working group examined contractor-under liability and weighed the benefits of establishing a fund to pay claims for uninsured injured workers. While the stakeholders agreed that a myriad of problems result when employers fail to provide insurance for their employees, the group was not able to reach a consensus on recommendations to solve the problem.

The third study was conducted to evaluate issues related to the availability of vocational rehabilitation programs for injured workers and work search obligations for employers and employees. Due to a decrease in applications for vocational rehabilitation, the group decided it was premature to recommend changes to the Board's rehabilitation procedures. Also, the working group could not come to a consensus on the question of whether a rule should be created that shifts to the employer the responsibility to provide a listing of available jobs to injured workers. Opponents supported the existing rule, which calls for administrative law judges to consider a range of relevant factors when determining whether an employee conducted a good faith work search.

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14. APPELLATE DIVISION

The Board's Appellate Division has completed its eighth full year of operation after being reinstituted by the Legislature on August 30, 2012. The Appellate Division is authorized to hear and decide appeals from decisions issued by Administrative Law Judges (ALJs). With the renewed operation of the Appellate Division, the parties now have an automatic right of appeal from a decision issued by an ALJ.

Prior to August 30, 2012, a party aggrieved by a decision could ask for a referral to the Board of Directors for review, or they could file a petition for appellate review with Maine's Law Court. Requests for Board review were few in number and limited to cases of significance to the operation of the workers' compensation system. Appeals to the Law Court were (and still are) discretionary, and the Law Court accepted only a small percentage of cases for review.

Four Hundred and forty notices of intent to appeal have been filed since August 2012; 32 were filed in 2020. The Division has held oral arguments in 190 cases. Oral argument was limited in 2020 due to the COVID-19 public health emergency. All arguments were held remotely, via teleconference, or decisions were based on the written submissions of the parties alone. Since 2012, the Division has held argument before ten *en banc* panels (one in 2020) and issued written decisions in 282 cases (28 issued in 2020). One hundred six appeals (seven in 2020) have been dismissed as a result of post-appeal settlement, withdrawal by the parties, or procedural default. The remaining cases are under consideration by Appellate Division panels or are in various stages of the briefing process.

Ten Petitions for Appellate Review of Appellate Division decisions were filed with the Law Court in 2020. The Law Court granted review in three cases and issued two decisions. In *Lorraine Somers v. S.D. Warren*, 2020 ME 137, the Court affirmed the Appellate Division's determination that the employer was not authorized to discontinue partial incapacity benefit payments pursuant to a board decree without having first complied with Me. W.C.B. Rule, ch. 2, § 5(1), which required an employer to notify the employee of the right to request an extension for financial hardship before discontinuance. The rule has since been amended to place the notice requirement on the board.

In *Darla Potter v. Cooke Aquaculture,* 2020 ME 144, the Court affirmed the Appellate Division's determination that the employee, who was injured while working on the employer's offshore salmon farm, was not a "seaman" pursuant the Jones Act, 46 U.S.C.S. § 30104, and was therefore subject to board jurisdiction and not the exclusive jurisdiction of federal maritime law.

One additional case is pending before the Law Court: *Charest v. Hydraulic Hose and Assemblies*, Me. W.C.B. No. 20-10 (App. Div. 2020). The issue for decision is whether the employer's ongoing obligation to pay benefits and the Social Security payments received by the employee served to toll the limitations period.

Appellate Division decisions of interest include *Larrabee v. City of South Portland, et al.,* Me. W.C.B. No. 20-23, in which the Division examined what proof was necessary to negate the "Firefighter Presumption," 39-A M.R.S.A. § 328. The case involved a firefighter who had two heart attacks towards the end of his 35-year career. The panel determined that it was incumbent on the municipal employers to present evidence that firefighting did not cause the employee's gradual cardiovascular injury, and not simply to present evidence that alternative risk factors likely caused the injury.

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Appellate Division decisions are available at:
http://www.maine.gov/wcb/Departments/appellate/appellatedecisions.html

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15. COVID-19 DATA

I. FIRST REPORTS OF INJURY RELATED TO COVID-19

When a claimed injury causes an employee to lose a day or more of work, a First Report of Injury must be filed with the Board. These are referred to as lost-time First Reports of Injury. The following charts detail the number of lost time First Reports of Injury related to COVID-19 received by the Board through January 16, 2021.

A. Lost Time First Report of Injury filings by employer category (as defined by the Board) along with the percentage of such reports by category:

Employer Category	Lost Time First Reports Received	Percent of Lost Time First Reports
Healthcare - Facility	955	35%
Residential Facilities	859	32%
State	330	12%
Retail - Grocery	133	5%
Municipal	115	4%
Healthcare - Physician Office	56	2%
Healthcare - Home Health	52	2%
Community & Social Service	36	1%
Employee Staffing	33	1%
Transportation Services - Ambulance	26	1%
Trades	22	1%
Transportation Services - Other	19	1%
Retail - Other	17	1%
Bars and/or Restaurants	16	1%
Aquaculture	11	0%
Fuel Dealer	9	0%
Boatyard and Marina	7	0%
Fitness and Recreation	7	0%
Cleaning & Janitorial Service	4	0%
Education - Colleges & Universities	3	0%
Paper Mill	3	0%
Wholesale	2	0%
Moving and Storage	2	0%
Professional Services	1	0%
Turnpike Authority	1	0%
Pest Control Services	1	0%
Telecommunication Services	1	0%
Security Services	1	0%
Manufacturing	1	0%
Banking & Insurance	1	0%
Grand Total	**2724**	

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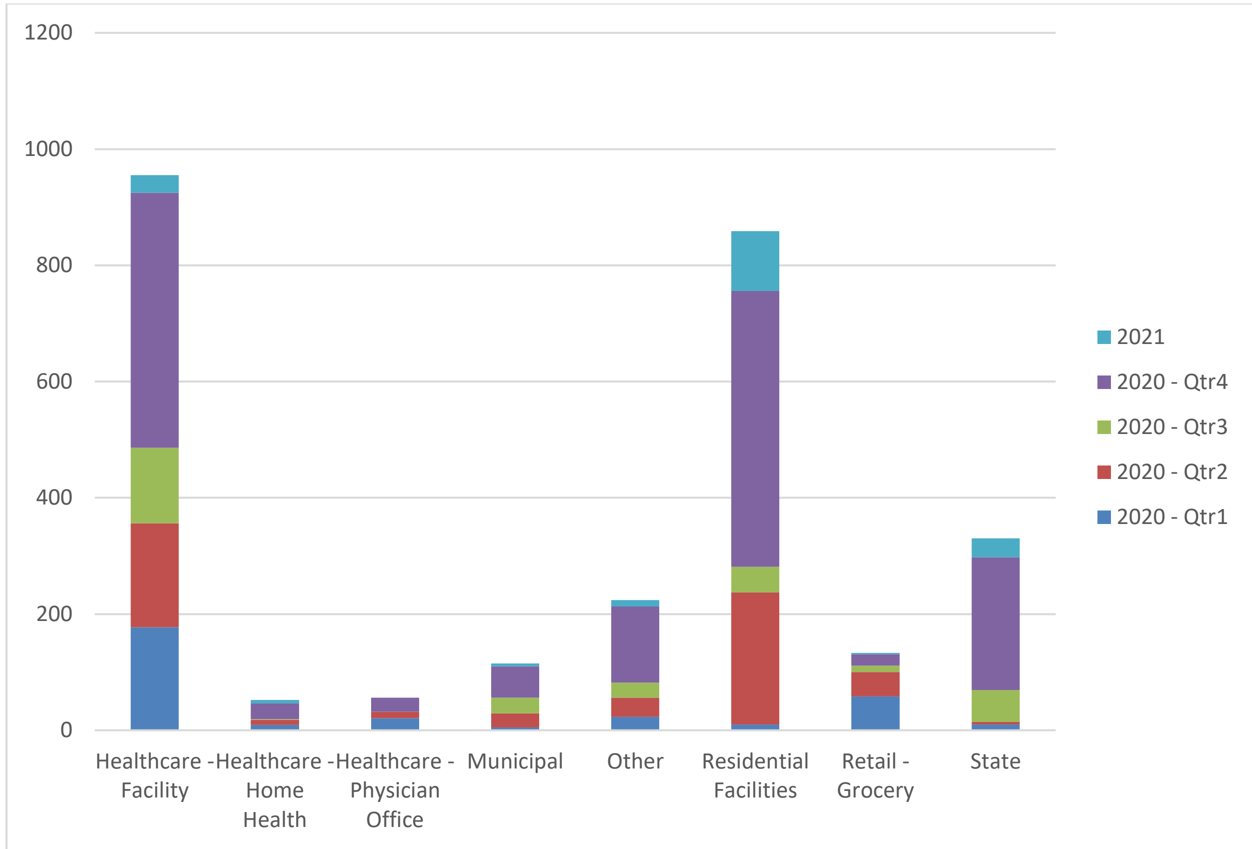
B. Lost time First Report of Injury filings by employer category -- top categories and “other” – grouped by the calendar quarter in which the injury happened.



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The following chart provides a more detailed breakdown of lost time First Report of Injury filings:

	2020										2021	
Employer Category	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
Healthcare - Facility	5	172	79	60	40	69	18	43	52	183	204	30	955
Residential Facilities		10	82	105	40	12	23	9	9	202	264	103	859
State		10	2	1	1	11	8	36	75	103	51	32	330
Retail - Grocery		58	31	9	2	6	3	2	2	6	12	2	133
Municipal		5	5	13	6		25	2	12	24	18	5	115
Healthcare - Physician Office		21	11						1	8	15		56
Healthcare - Home Health		9	1	7	1			1	3	19	5	6	52
Community & Social Service			3	2	5	1	2			13	9	1	36
Employee Staffing			1	1	4	3	2	1		4	16	1	33
Transportation - Ambulance		15	1	3			1	4	2				26
Trades		1	1	1	1				6	3	5	4	22
Transportation - Other		2	1			1			1	3	9	2	19
Retail - Other		3	1	1	1	1			2	1	6	1	17
Bars and/or Restaurants				1	1	1	1	4	1	6	1		16
Aquaculture										11			11
Fuel Dealer										1	8		9
Boatyard and Marina										7			7
Fitness and Recreation										2	4	1	7
Cleaning & Janitorial Service					3							1	4
Colleges & Universities								1		1	1		3
Paper Mill								2		1			3
Wholesale										2			2
Moving and Storage		1									1		2
Professional Services									1				1
Turnpike Authority										1			1
Pest Control Services							1						1
Telecommunication Services		1											1
Security Services			1										1
Manufacturing										1			1
Banking & Insurance											1		1
Grand Total	**5**	**308**	**220**	**204**	**105**	**105**	**84**	**105**	**167**	**602**	**630**	**189**	**2724**

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C. Lost time First Report of Injury filings by job category (as defined by the Board) along with the percentage of such reports by category by category:

Job Category	Lost Time First Reports Received	Percent of Lost Time First Reports
Nurse/Nurse Practitioner	541	20%
CNA	423	16%
Direct Support Professional	328	12%
Clinical Support Services	282	10%
Customer Service	183	7%
Administrative Support Services	182	7%
Corrections	171	6%
Facilities Support Services	166	6%
Laborer	77	3%
Rehab Services	64	2%
Physician/Physician Assistant	61	2%
Skilled Labor	49	2%
Law Enforcement	38	1%
Firefighter	32	1%
EMT/Paramedic	28	1%
Courts	23	1%
Driver - Other	21	1%
Driver - Ambulance	11	0%
Aquaculture	11	0%
Unknown	9	0%
Educational Support Services	5	0%
Teacher	4	0%
Engineer	3	0%
Child Care	3	0%
Transportation Support Services	2	0%
Technician	2	0%
Security Guard	1	0%
Dental Hygienist	1	0%
Personal Care Services	1	0%
Tax Examiner	1	0%
Professor	1	0%
Grand Total	**2724**	

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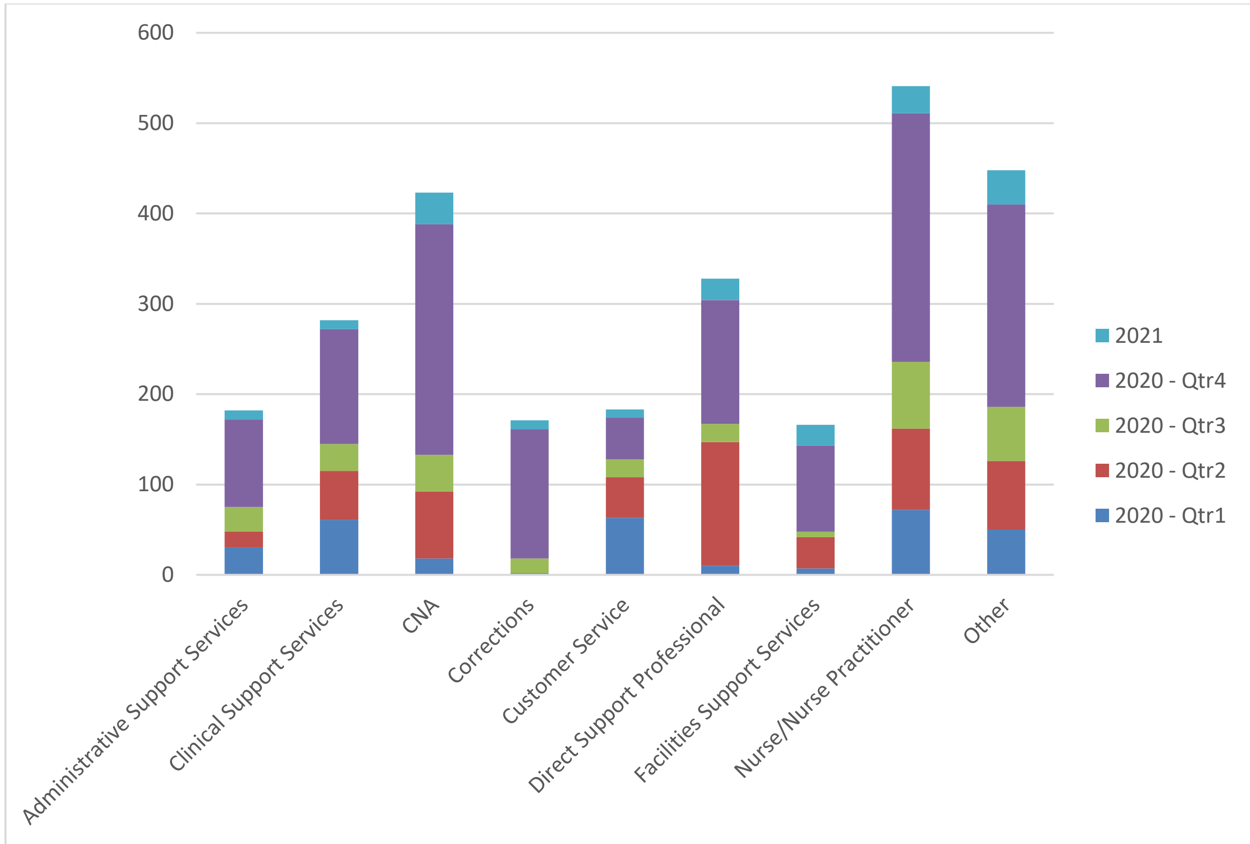
D. Lost time First Report of Injury filings by job category -- top categories and “other” – grouped by the calendar quarter in which the injury happened.



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The following chart provides a more detailed breakdown of lost time First Report of Injury filings:

	2020											2021	
Job Category	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
Nurse/Nurse Practitioner	2	70	38	27	25	42	8	24	29	121	125	30	541
CNA		18	34	27	13	20	13	8	10	96	149	35	423
Direct Support Professional		10	43	62	32	12	8		5	59	73	24	328
Clinical Support Services	3	58	19	23	12	8	10	12	13	55	59	10	282
Customer Service		63	32	11	2	9	6	5	5	19	22	9	183
Administrative Support Services		30	7	9	2	2	4	21	14	41	42	10	182
Corrections		2					15	1	49	65	29	10	171
Facilities Support Services		7	14	15	6	1	2	3	2	43	50	23	166
Laborer			1	1			1	7	18	14	29	6	77
Rehab Services		10	18	9	2	2	1			10	8	4	64
Physician/Physician Assistant		16	4	5	1	7	1	2	2	10	13		61
Skilled Labor		2	1		2			12		13	9	10	49
Law Enforcement		2	2	3	1	1	4		10	8	5	2	38
Firefighter		3	2	6	2		7		5	7			32
EMT/Paramedic		10	2	1	4		1	3	1	5	1		28
Courts								5		10	1	7	23
Driver - Other		1	2	1		1				3	9	4	21
Driver - Ambulance		5		3			1	1	1				11
Aquaculture										11			11
Unknown											4	5	9
Educational Support Services									1	4			5
Teacher							1	1	1	1			4
Engineer					1					1	1		3
Child Care										3			3
Transportation Support Services										1	1		2
Technician				1			1						2
Security Guard			1										1
Dental Hygienist									1				1
Personal Care Services										1			1
Tax Examiner		1											1
Professor										1			1
Grand Total	**5**	**308**	**220**	**204**	**105**	**105**	**84**	**105**	**167**	**602**	**630**	**189**	**2724**

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E. The following chart combines the information regarding total First Reports of Injury by employer and job category:

Employer/Job Category	Lost Time FROIs	Percent of all Lost Time FROIs	Percent of FROIs within Employer Category
Healthcare - Facility	**955**	**35%**	
Administrative Support Services	87		9%
Clinical Support Services	259		27%
CNA	118		12%
Direct Support Professional	3		0%
EMT/Paramedic	7		1%
Facilities Support Services	34		4%
Nurse/Nurse Practitioner	360		38%
Personal Care Services	1		0%
Physician/Physician Assistant	56		6%
Rehab Services	30		3%
Residential Facilities	**859**	**32%**	
Administrative Support Services	40		5%
Clinical Support Services	1		0%
CNA	287		33%
Customer Service	3		0%
Direct Support Professional	270		31%
Driver - Other	1		0%
Facilities Support Services	118		14%
Laborer	1		0%
Nurse/Nurse Practitioner	112		13%
Physician/Physician Assistant	1		0%
Rehab Services	16		2%
Unknown	9		1%
State	**330**	**12%**	
Administrative Support Services	45		14%
Clinical Support Services	1		0%
Corrections	153		46%
Courts	23		7%
Customer Service	7		2%
Direct Support Professional	20		6%
Educational Support Services	2		1%
Engineer	1		0%
Facilities Support Services	1		0%
Laborer	33		10%
Law Enforcement	19		6%
Nurse/Nurse Practitioner	6		2%
Rehab Services	1		0%
Skilled Labor	16		5%
Tax Examiner	1		0%
Technician	1		0%

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Category / Occupation	Count	% of Total	% of Category
Retail - Grocery	**133**	**5%**	
Customer Service	132		99%
Laborer	1		1%
Municipal	**115**	**4%**	
Administrative Support Services	1		1%
CNA	1		1%
Corrections	18		16%
Driver - Other	6		5%
Educational Support Services	3		3%
EMT/Paramedic	7		6%
Engineer	1		1%
Firefighter	32		28%
Laborer	12		10%
Law Enforcement	19		17%
Nurse/Nurse Practitioner	1		1%
Skilled Labor	10		9%
Teacher	4		3%
Healthcare - Physician Office	**56**	**2%**	
Administrative Support Services	4		7%
Clinical Support Services	19		34%
CNA	4		7%
Dental Hygienist	1		2%
Facilities Support Services	4		7%
Nurse/Nurse Practitioner	16		29%
Physician/Physician Assistant	4		7%
Rehab Services	4		7%
Healthcare - Home Health	**52**	**2%**	
Administrative Support Services	2		4%
Clinical Support Services	1		2%
CNA	10		19%
Direct Support Professional	6		12%
Nurse/Nurse Practitioner	20		38%
Rehab Services	13		25%
Community & Social Service	**36**	**1%**	
Child Care	3		8%
CNA	1		3%
Direct Support Professional	29		81%
Nurse/Nurse Practitioner	3		8%
Employee Staffing	**33**	**1%**	
Administrative Support Services	1		3%
Clinical Support Services	1		3%
CNA	2		6%
Facilities Support Services	3		9%
Laborer	3		9%
Nurse/Nurse Practitioner	23		70%

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Transportation Services - Ambulance	**26**	**1%**	
Customer Service	1		4%
Driver - Ambulance	11		42%
EMT/Paramedic	14		54%
Trades	**22**	**1%**	
Laborer	13		59%
Skilled Labor	9		41%
Transportation Services - Other	**19**		
Retail - Other	**17**		
Bars and/or Restaurants	**16**		
Aquaculture	**11**		
Fuel Dealer	**9**		
Boatyard and Marina	**7**		
Fitness and Recreation	**7**		
Cleaning & Janitorial Service	**4**		
Education - Colleges & Universities	**3**		
Paper Mill	**3**		
Wholesale	**2**		
Moving and Storage	**2**		
Professional Services	**1**		
Turnpike Authority	**1**		
Pest Control Services	**1**		
Telecommunication Services	**1**		
Security Services	**1**		
Manufacturing	**1**		
Banking & Insurance	**1**		
Grand Total	**2724**		

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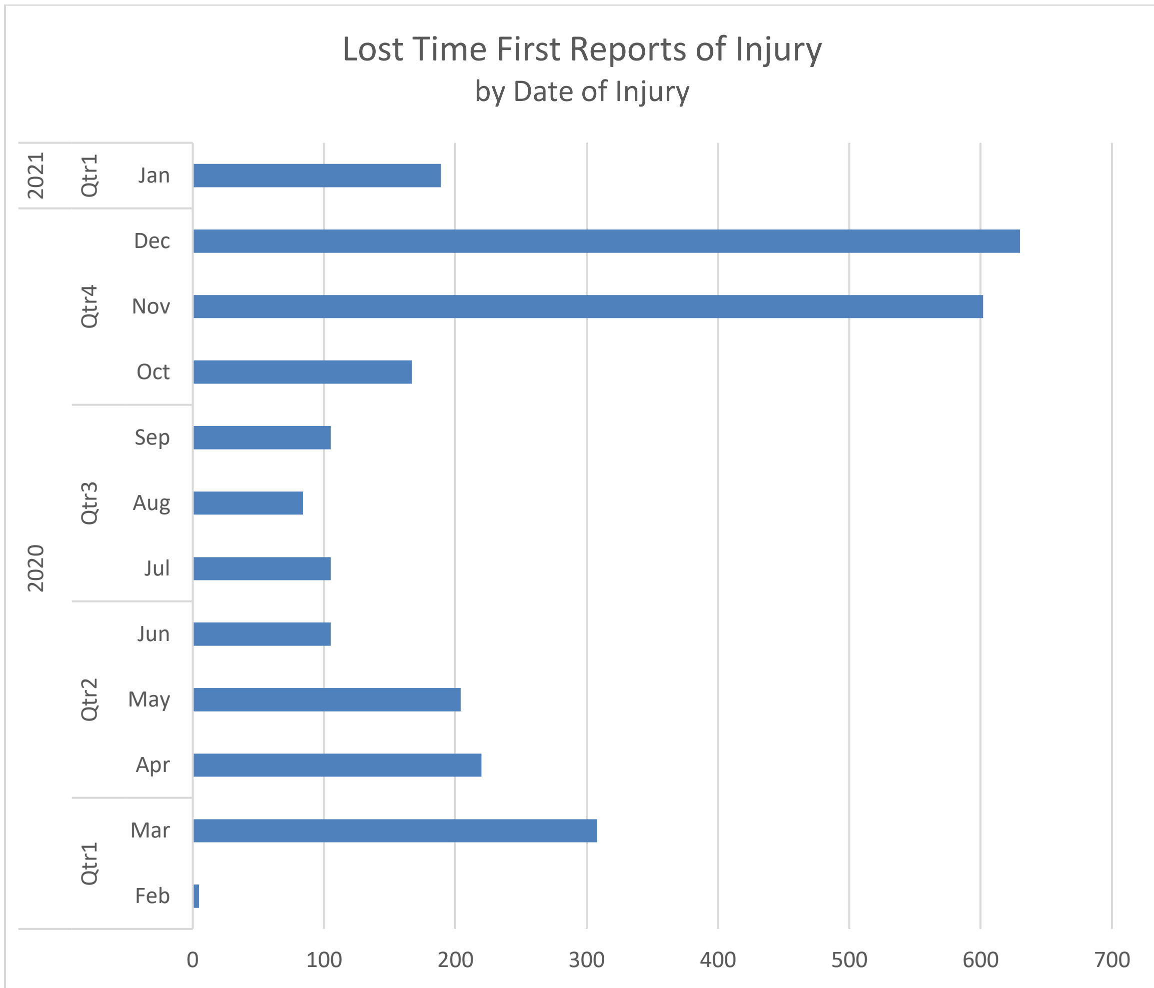
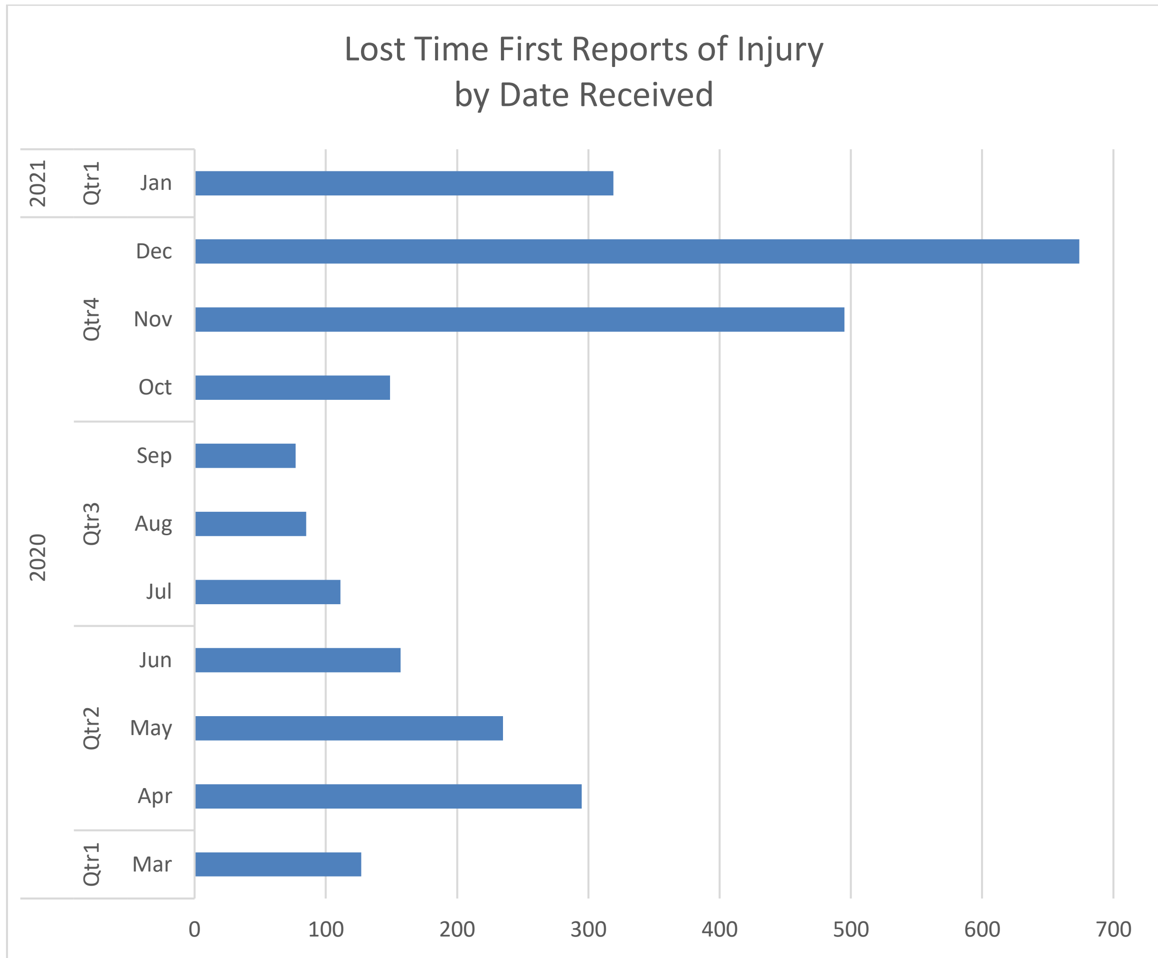
F. Distribution of FROIs by date of injury grouped by quarter and month.



G. Distribution of FROIs by the date the Board received it; grouped by quarter and month.



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H. Distribution of Injury by Age Group

Age Group	Lost Time First Reports	Percent of All Lost Time First Reports
<20	67	2%
20-29	638	23%
30-39	666	24%
40-49	490	18%
50-59	540	20%
60-69	286	10%
70-79	34	1%
80+	3	0%
Grand Total	**2724**	

This chart shows the same information sorted by the month in which the injury occurred.

	2020										2021	
Age Category	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
<20		3	3	4	2		4	1	1	19	25	5	67
20-29	2	75	60	43	30	35	22	12	36	133	147	43	638
30-39	1	70	49	43	37	32	18	26	45	154	148	43	666
40-49	1	54	41	56	11	16	17	20	33	115	101	25	490
50-59	1	59	44	39	18	14	12	29	37	118	126	43	540
60-69		41	21	17	6	8	9	17	14	54	72	27	286
70-79		6	1	2	1		2		1	9	10	2	34
80+			1								1	1	3
Grand Total	**5**	**308**	**220**	**204**	**105**	**105**	**84**	**105**	**167**	**602**	**630**	**189**	**2724**

II. DISPOSITION OF COVID-19 RELATED CLAIMS

When a lost time First Report of Injury (FROI) is filed, the insurer/self-insurer responsible for handling the claim will either:

- Report that the injured worker returned to work within 7 days – the statutory waiting period – meaning the injured worker is not eligible for lost time benefits; or
- File a Notice of Controversy (NOC) indicating it will not pay lost time benefits; or
- File a Memorandum of Payment (MOP) indicating the injured worker is being paid by the insurer or is receiving salary continuation payments from the employer for whom the injured employee worked.

Some claims that are initially denied (i.e. a NOC is filed) will ultimately be paid. The charts that follow show the breakdown of how COVID-19 claims have been handled so far. Claims that were initially denied but later resulted in payments to injured employees are included in one of the paid categories.

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For purposes of the "Lost Time First Report Analysis" charts, claims that are "open" (meaning no information beyond the lost time FROI has been received by the Board) are excluded.

The charts captioned "Claims for Compensation Analysis" are a subset of cases in which injured workers have not returned to work within the 7-day waiting period. Those claimants have either been paid or their claims have been denied. It is worth noting that the percentage of claims paid directly by the employer (31%) is significantly higher than it is for non-COVID-19 claims. Typically, only 1% of claims are paid directly by employers.

These charts are based on lost time FROIs identified by insurers as COVID-19 claims. They were received by the Board through January 16, 2021.

A. Disposition, on an industry wide basis, of lost time FROIs received by the Board:

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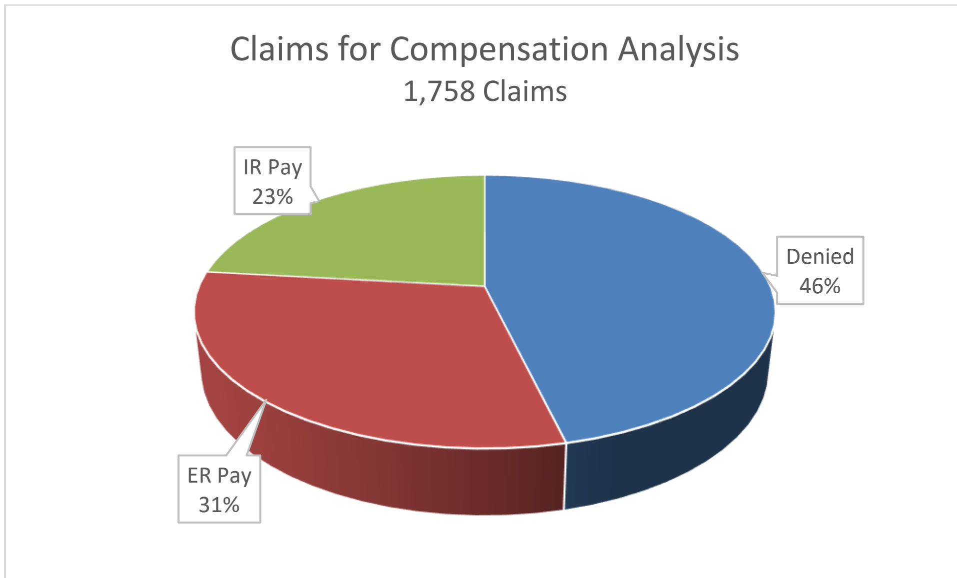
B. Disposition, on an industry-wide basis, of claims for compensation:



The following chart details how claims for compensation are treated by claim administrators over time. This chart shows it takes approximately two months before all claims for compensation are received by the Board and for the disposition (i.e., paid or denied) of claims to stabilize.

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DOIs		As of February 28, 2020	As of March 31, 2020	As of April 30, 2020	As of May 31, 2020	As of June 30, 2020	As of July 31, 2020	As of August 31, 2020	As of September 30, 2020	As of October 31, 2020	As of November 30, 2020	As of December 31, 2020
Feb DOIs	Denied	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Sal Con	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	IR Pay	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Total CFCs	**0**	**0**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
March DOIs	Denied		38%	51%	52%	51%	51%	51%	50%	49%	49%	49%
	Sal Con		51%	46%	42%	41%	41%	41%	42%	42%	42%	42%
	IR Pay		11%	3%	6%	7%	8%	8%	9%	9%	9%	9%
	Total CFCs		**53**	**149**	**216**	**217**	**217**	**220**	**218**	**219**	**219**	**219**
April DOIs	Denied			67%	50%	42%	44%	43%	43%	43%	42%	42%
	Sal Con			28%	26%	27%	28%	29%	29%	29%	29%	29%
	IR Pay			5%	24%	31%	28%	28%	28%	28%	29%	29%
	Total CFCs			**57**	**156**	**177**	**179**	**182**	**180**	**180**	**179**	**179**
May DOIs	Denied				48%	53%	33%	34%	31%	31%	31%	30%
	Sal Con				19%	21%	43%	42%	45%	44%	44%	44%
	IR Pay				33%	26%	24%	23%	25%	25%	25%	26%
	Total CFCs				**42**	**137**	**161**	**166**	**159**	**163**	**163**	**162**
June DOIs	Denied					62%	31%	28%	28%	28%	28%	28%
	Sal Con					8%	22%	22%	22%	21%	21%	21%
	IR Pay					30%	47%	50%	50%	51%	51%	51%
	Total CFCs					**37**	**68**	**68**	**68**	**67**	**67**	**67**
July DOIs	Denied						88%	28%	26%	26%	27%	27%
	Sal Con						0%	4%	4%	4%	4%	4%
	IR Pay						13%	67%	70%	70%	68%	69%
	Total CFCs						**8**	**67**	**70**	**70**	**73**	**74**
August DOIs	Denied							69%	60%	41%	40%	38%
	Sal Con							5%	13%	14%	14%	14%
	IR Pay							26%	27%	45%	47%	48%
	Total CFCs							**42**	**55**	**58**	**58**	**58**
Sept. DOIs	Denied								77%	70%	70%	69%
	Sal Con								15%	23%	23%	23%
	IR Pay								8%	7%	7%	9%
	Total CFCs								**13**	**70**	**69**	**70**
October DOIs	Denied									100%	88%	76%
	Sal Con									0%	8%	14%
	IR Pay									0%	4%	10%
	Total CFCs									**59**	**107**	**118**
Nov. DOIs	Denied										81%	46%
	Sal Con										15%	30%
	IR Pay										4%	24%
	Total CFCs										**134**	**411**
Dec. DOIs	Denied											75%
	Sal Con											5%
	IR Pay											19%
	Total CFCs											**149**

III. Comparison of 2019 and 2020 Data

The following charts compare 2019 and 2020 data for lost time First Reports of Injury and the disposition of claims for compensation. Since there were no COVID-19 related claims in 2019, these charts present the data both with and without COVID-19 claims.

2020 - All			% Change v 2019
Lost Time First Reports of Injury			
1 - RTW	5341	40%	-23%
2 - Denied	2756	21%	28%
3 – ER Pay	567	4%	336%
4 - IR Pay	3641	27%	-21%
5 - Open	1004	8%	68%
Grand Total	13309		-7%
Claims for Compensation			
2 - Denied	2756	40%	28%
3 – ER Pay	567	8%	336%
4 - IR Pay	3641	52%	-21%
Grand Total	6964		1%

2020 - No COVID			% Change v 2019
Lost Time First Reports of Injury			
1 - RTW	4785	44%	-31%
2 - Denied	2020	19%	-6%
3 – ER Pay	106	1%	-18%
4 - IR Pay	3249	30%	-29%
5 - Open	751	7%	26%
Grand Total	10911		-24%
Claims for Compensation			
2 - Denied	2020	38%	-6%
3 – ER Pay	106	2%	-18%
4 - IR Pay	3249	60%	-29%
Grand Total	5375		-22%

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