**90-351 WORKERS' COMPENSATION BOARD**

**Chapter 1: PAYMENT OF BENEFITS**

**§ 1. Claims for Incapacity and Death Benefits**

1. Within 14 days of notice or knowledge of a claim for incapacity or death benefits for a work-related injury, the employer or insurer will:

A. Accept the claim and file a Memorandum of Payment checking "Accepted"; or

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

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

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

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

A. The employer files a Notice of Controversy; and

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

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

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

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

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

**§ 2. Payment without Prejudice**

1. Payment without prejudice does not constitute a payment scheme.

2. If no payment scheme exists, the employer may reduce or suspend the payment of benefits pursuant to 39-A M.R.S.A. §205(9)(B)(1). The provisions of 39-A M.R.S.A. §214 do not apply to compensation payments that are made without prejudice.

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

**§ 3. Provisional Orders**

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

**§ 4.** *[Reserved]*

**§ 5. Fringe Benefits**

1. Fringe or other benefits shall be defined as anything of value to an employee and dependents paid by the employer which is not included in the average weekly wage. When the employer has paid the employee a sum to cover any special expense incurred by the employee by the nature of the employee’s employment, that sum shall not be considered a fringe benefit. For those companies which self­fund health and dental coverage, the value of such health and dental coverage shall be equal to the cost to the employee for maintaining such coverage pursuant to the federal C.O.B.R.A. provisions less the employee’s pre-injury contributions.

A. A "fringe or other benefit" pursuant to §102(4)(H) shall include, but is not limited to, the following:

(1) For those who do not self-fund, the employer’s cost to provide health, dental and disability insurance benefits less the employee’s contribution;

(2) For those who self-fund disability, the employer’s cost to provide disability benefits less the employee’s contribution;

(3) The employer’s cost to provide pension benefits, including 401(k), 403(b), or equivalent plan matching funds that cease being paid because the employee is not working. The employer’s obligation to include 401(k), 403(b), or equivalent plan matching funds ends when the employee returns to work for the employer;

(4) The fair market value of employer-provided meals and/or housing;

(5) The employer’s cost of providing utilities and other costs associated with the provision of housing; and

(6) The value of using a company vehicle for personal purposes; and

(7) The employer’s cost to provide life insurance benefits less the employee’s contribution.

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

(1) The cost of uniforms provided by the employer for use in the employment;

(2) Employer contribution to Social Security, unemployment insurance or workers’ compensation insurance;

(3) A company vehicle for which the employee must reimburse the employer for personal use;

(4) Charitable contributions and/or matching gifts;

(5) Company sponsored picnics and other social activities; and

(6) Reimbursements for travel, parking, etc.

2. **Average Weekly Wage Calculation**

A. In all cases of more than seven (7) days lost time, the employer/ insurer shall calculate the employee’s average weekly wage as of the date of the injury and file form WCB­2.

B. The employer/insurer shall determine the value of all fringe benefits on the date of injury and shall file form WCB-2B within the timeframe established in 39-A M.R.S.A. §303. The employer/insurer shall recalculate the employee’s average weekly wage when fringe benefits cease being paid by the employer. The employer must notify the insurer and the employee within seven (7) days when fringe benefits cease. The insurer or self-insured employer shall file form WCB-4 if the inclusion of fringe benefits results in increased compensation to the employee.

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

3. **Calculating benefits**

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

**§ 6. Notices of Controversy**

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

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

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

**§ 8.** The Employment Status Report (WCB-230) shall be distributed as follows: (1) Employee, (2) Insurer, and (3) Employer.

**§ 9.** The Request for Expedited Proceeding (WCB-250) shall be attached to the front of the appropriate petition and supporting documents.

**§ 10. Cancer Presumption for Firefighters**

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

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

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

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

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

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

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

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

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

i. Active claims;

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

iii. Claims that are beyond the statute of limitations;

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

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

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

i. Active claims;

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

iii. Claims that are beyond the statute of limitations.

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

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

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EFFECTIVE DATE OF PERMANENT RULE:

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

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April 2, 2012 – filing 2012-94, Section 1 only

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August 18, 2014 – filing 2014-168

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September 1, 2018 – filing 2018-122