CODE of MARYLAND REGULATIONS

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

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Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 01 General Administrative

Authority: Health-General Article, §4-303; Labor and Employment Article, §§9-307, 9-309, 9-310.2, 9-314, 9-404, 9-405, 9-410, 9-602, 9-603, 9-610.1, 9-625, 9-635, 9-689, 9-701, 9-709, 9-710, 9-711, 9-721, 9-731, 9-736, 9-739, and 9-6A-07; Insurance Article, §§19-405 and 19-406; State Government Article, §10-1103; Annotated Code of Maryland

14.09.01.01

.01 Definitions.

A. In this subtitle, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Affidavit" means a written statement the contents of which are affirmed under the penalties of perjury to be true.

(2) "Certified mail" means mail deposited with the United States Postal Service, postage prepaid and return receipt requested.

(3) "Claimant" means a person filing a workers' compensation claim and includes:

(a) A covered employee;

(b) A dependent of a deceased covered employee; or

(c) An individual authorized to act on behalf of a dependent of a deceased covered employee.

(4) "Commission" means either the Workers' Compensation Commission or its designee.

(5) "Disputed workers' compensation claim" means a:

(a) Newly filed claim from the date it is filed until the employer or insurer commences paying the claim or until the consideration date has expired;

(b) New claim in which issues have been filed;

(c) Pending claim in which one or more issues have been filed; or

(d) Claim that is pending on appeal.

(6) "Final award" means the award of compensation determined by the Commission after exhaustion of all applicable appeals, regardless of whether the award is increased or decreased as a result of any appeal.

(7) "Formal set-aside allocation" means a document reflecting a comprehensive analysis and projection of future injury-related medical needs and associated costs.

(8) "Healthcare provider delegate" means administrative or support staff designated by a health care provider to have access to basic claim information for the purpose of obtaining settlement, claim and hearing status information.

(9) "Individual" means a human being.

(10) "Insurer" means:

(a) A stock corporation or mutual association that is authorized under the Insurance Article, Annotated Code of Maryland, to provide workers' compensation insurance in the State;

(b) The Chesapeake Employers' Insurance Company authorized under Insurance Article, Title 24, Subtitle 3, Annotated Code of Maryland;

(c) A governmental self-insurance group that meets the requirements of Labor and Employment Article, §9-404, Annotated Code of Maryland;

(d) A self-insurance group of private employers that meets the requirements of Insurance Article, §§25-301—25-308, Annotated Code of Maryland; or

(e) An individual employer that self-insures in accordance with Labor and Employment Article, §9-405, Annotated Code of Maryland.

(11) "Insurer delegate" means administrative or support staff, designated by an insurer, to have access to all claim documents in all claims in which the insurer is a party for the purpose of filing documents and managing claims.

(12) "Non-compromise case" means a case in which the employer/insurer has not contested liability or in which the Commission has found liability and in which the settlement compensates the claimant for anticipated future medical expenses.

(13) "Person" means:

(a) An individual;

(b) A general or limited partnership;

(c) A joint stock company;

(d) An unincorporated association or society;

(e) A municipal or other corporation;

(f) An incorporated association;

(g) A limited liability partnership;

(h) A limited liability company;

(i) The State, its agencies or political subdivisions; or

(j) A governmental entity.

(14) "Proxy" means administrative or support staff, designated by an attorney, to have access to all claim documents in all claims in which the attorney has entered the attorney's appearance for the purpose of filing documents and managing claims.

(15) "Role" means the functionality and type of account for which a user is authorized in the WFMS system and includes attorney, attorney proxy, employer, insurer, healthcare provider, insurer delegate and healthcare provider delegate.

(16) "State average weekly wage" means the State average weekly wage in effect on the date of the accident or date of disablement.

(17) "Subpoena" means a written order directed to a person and requiring attendance at a particular time and place to take the action specified.

(18) "Subsequent Injury Fund" or "SIF" means the statutorily created entity, funded by assessments on workers' compensation awards and settlements, that may be a party to a claim and which pays benefits attributable to a compensable injury to previously injured body parts.

(19) "Undisputed workers' compensation claim" means a claim in which all issues have been:

(a) Withdrawn;

(b) Resolved by a decision of the commission that is not appealed; or

(c) Resolved on appeal.

(20) "Uninsured Employers' Fund" or "UEF" means the statutorily created entity, funded by assessments on workers' compensation awards and settlements, that may be a party to a claim and which pays workers compensation awards made against an uninsured employer.

(21) "Web-Enabled File Management System" or "WFMS" means the Commission's subscriber-based web-enabled electronic file management system designed to facilitate the filing and adjudication of workers' compensation claims.

14.09.01.02

.02 Commission Forms.

A. Forms prepared by the Commission, and made available on the Commission's website or through WFMS, are mandatory and shall be used for filing claims, notices, requests, motions, and other papers as required by law, or by these regulations.

B. Where the Commission has not created a form but has directed that the party or attorney prepare its own petition or motion, the party or attorney shall draft and file the required papers.

14.09.01.03

.03 Service of Papers.

A. Service by Commission.

(1) The Commission shall serve notice of its orders and decisions, by:

(a) Electronic means, if the party's attorney of record consents or, if the party is unrepresented, the party consents; or

(b) First class mail to the last known address of each party's attorney of record or, if the party is unrepresented, to the unrepresented party.

(2) Parties and attorneys of record shall notify the Commission promptly of a change of address.

(3) For all other notices, where service by electronic means has not been authorized by statute or regulation, the Commission shall serve notice by first class mail.

B. Service by Parties.

(1) Except as otherwise provided in these regulations, a copy of every paper, form, or document filed with the Commission by a party shall be served promptly on all other parties.

(2) If a party is represented by an attorney, service shall be made upon the attorney unless service on the party is directed by the Commission.

(3) Service may be made by:

(a) Handing the papers to the party or attorney;

(b) Leaving the papers at that person's office with an individual in charge, or, if there is no one in charge, leaving the papers in a conspicuous place in the office, or, if the office is closed or the person has no office, leaving the papers at the person's usual place of residence with an individual of suitable age and discretion residing there; or

(c) Mailing the papers to the address most recently stated in a paper filed by the party or attorney, or if not stated, to the last known address.

(4) Service by mail is complete upon mailing.

(5) Each paper filed that is required to be served shall be accompanied by a certificate of service, signed by the party or the party's attorney, showing the date and manner of making service on each of the other parties.

14.09.01.04

.04 Filing Forms and Documents with the Commission.

A. Forms and documents may be filed with the Commission by one of the following methods:

(1) Electronically through the WFMS;

(2) In person; or

(3) By mail addressed to the Commission's principal office in Baltimore City.

B. All documents filed with the Commission after 4:30 p.m., electronically or otherwise, are considered to be received by the Commission on the next business day.

14.09.01.05

.05 Hours of Business.

Except for legal holidays, the hours of business of the Commission are Monday through Friday, 8 a.m. to 4:30 p.m.

14.09.01.06

.06 Waiver of Strict Compliance.

When justice so requires, the Commission may waive strict compliance with these regulations.

14.09.01.07

.07 Powers and Duties of Commissioners.

A. A Commissioner shall:

(1) Conduct a full, fair, and impartial hearing;

(2) Take action to avoid unnecessary delay in the disposition of the proceedings; and

(3) Maintain order.

B. A Commissioner has the power to regulate the course of the hearing and the conduct of the parties and authorized representatives, including but not limited to, the power to:

(1) Administer oaths and affirmations;

(2) Issue subpoenas for witnesses and the production of evidence;

(3) Rule upon offers of proof and receive relevant and material evidence;

(4) Consider and rule upon motions and requests;

(5) Examine witnesses and call witnesses as necessary to ensure a full and complete record;

(6) Limit repetitious testimony and reasonably limit the time for presentations;

(7) Grant a continuance of a hearing;

(8) Issue orders as are necessary to secure procedural simplicity and administrative fairness and to eliminate unjustifiable expense and delay;

(9) Conduct the hearing in a manner suited to ascertain the facts and safeguard the rights of the parties to the hearing; and

(10) Impose appropriate sanctions for the failure to abide by this chapter or any lawful order of the Commissioner.

14.09.01.08

.08 Referral for Fraud.

A. Pursuant to Labor and Employment Article, §9-310.2(a), Annotated Code of Maryland, any party may request that the Commission refer the case to the Insurance Fraud Division of the Maryland Insurance Administration for investigation.

B. A party requesting a referral to the Insurance Fraud Division shall complete the Fraud Referral form provided by the Commission.

14.09.01.09

.09 Web-Enabled File Management System.

A. The WFMS is a subscriber-based web-enabled electronic file management system designed to facilitate the filing and adjudication of workers' compensation claims.

B. An attorney, employer, insurer, or healthcare provider may register for a no-cost subscription to the WFMS by:

(1) Completing an online application available at the Commission's website; and

(2) Satisfying the requirements applicable to the type of account (role).

C. After filing the online application, an attorney seeking to register for a subscription shall appear before a Commission official to validate his or her identify by:

(1) Scheduling an appointment with a court reporter at a remote hearing site; or

(2) Appearing before the public service unit at the Commission's principal office.

D. An attorney shall present a valid government-issued photo identification to validate his or her identity.

E. Each attorney seeking to use the WFMS shall register for and maintain his or her own individual subscription.

F. No law firm subscriptions are permitted.

G. Conditions of use.

(1) A subscriber shall:

(a) Provide the Commission with current contact information and update this information as it changes; and

(b) Abide by the terms of the service agreement.

(2) A WFMS subscription may be suspended or terminated if the subscriber:

(a) Fails to provide the Commission with a current email address and contact information;

(b) Fails to protect the subscriber's user name and password;

(c) Uses the system in a manner inconsistent with its stated purpose;

(d) Permits unauthorized use of the subscriber's account; or

(e) Violates the terms of the service agreement.

H. Proxies.

(1) An attorney subscriber may authorize administrative or support staff to function as the attorney's proxy.

(2) The proxy shall complete an online proxy application.

(3) The attorney subscriber may validate the proxy's registration electronically by selecting and acknowledging the proxy.

(4) An attorney may not designate another attorney as a proxy.

(5) Once validated, the proxy may have access to all claim documents in all claims in which the attorney has entered the attorney's appearance.

(6) The attorney subscriber is responsible for all actions and conduct of the attorney's designated proxies.

(7) The attorney proxy shall abide by the terms and conditions of the subscription.

(8) An attorney proxy may not use any other subscriber's account to access the WFMS system.

I. Insurer Delegates.

(1) An insurer subscriber may authorize administrative or support staff to function as the insurer's delegate.

(2) The insurer delegate shall complete the online insurer delegate application.

(3) The insurer subscriber may validate the insurer delegate's registration electronically by selecting and acknowledging the delegate.

(4) Once validated, the insurer delegate may have access to all claim documents, excluding protected and confidential documents, in all claims in which the insurer is a party.

(5) The insurer subscriber is responsible for all actions and conduct of its delegates.

(6) If an insurer subscriber's access is terminated, the access afforded to its delegates will also be terminated.

(7) An insurer delegate shall use his or her individual subscription to access the WFMS system.

(8) An insurer delegate may not use any other subscriber's account to access the WFMS system.

(9) An insurer delegate shall abide by the terms and conditions of the subscription.

(10) An insurer subscriber may not designate another subscriber as the insurer's delegate.

J. Healthcare Provider Delegates.

(1) A healthcare provider subscriber may authorize administrative or support staff as the healthcare provider's delegate

(2) The healthcare provider delegate shall complete the online healthcare provider delegate application.

(3) The healthcare provider subscriber may validate the healthcare provider delegate's registration electronically by selecting and acknowledging the delegate.

(4) Once validated, the healthcare provider delegate may have access to claim documents, excluding protected and confidential documents, for the purpose of obtaining settlement, claim and hearing status information.

(5) The healthcare provider subscriber is responsible for all actions and conduct of its delegates.

(6) If a healthcare provider subscriber's access is terminated, the access afforded to its delegates will also be terminated.

(7) A healthcare provider delegate shall use his or her individual subscription to access the WFMS system.

(8) A healthcare provider delegate may not use any other subscriber's account to access the WFMS system.

(9) A healthcare provider delegate shall abide by the terms and conditions of the subscription.

(10) An healthcare provider subscriber may not designate another subscriber as the healthcare provider delegate.

14.09.01.10

.10 Notices Concerning Claims — Posting by Employer.

The employer shall keep conspicuously posted at places of employment controlled or operated by the employer all written notices provided to the employer by the Commission or the employer's insurance carrier (or prepared by the employer, if self-insured) that give instructions or convey information to persons interested in or entitled to benefits under Labor and Employment Article, Title 9, Annotated Code of Maryland.

14.09.01.11-.17

(To be deleted).

14.09.01.26-.27

(To be deleted).

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 02 Requirements for Filing and Amending Claims

Authority: Labor and Employment Article, §§9-309, 9-402, 9-404, 9-701, 9-709, 9-710, and 9-711, Annotated Code of Maryland

14.09.02.01

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Apostille" means a certificate issued under the Apostille Convention authenticating the origin of a public document.

(2) "Apostille Convention" means the Hague Convention of 5 October 1961 Abolishing the Requirement of Legalisation for Foreign Public Documents.

(3) "Authorization for Disclosure of Health Information" means the executed release authorizing the disclosure of protected health information in accordance with Labor and Employment Article, §§9-709, 9-710, and 9-711, Annotated Code of Maryland.

(4) "Certified copy" means a duplicate of an original document that is certified as a true and accurate copy by the officer having custody of the original.

(5) "Competent authority" means an authority designated by a Contracting State as competent to issue apostilles.

(6) "Foreign State" means a foreign sovereign state or country.

(7) "Notarized" means signed by the person or persons authorized or required to sign the document, the signing of which was witnessed by a notary public, accompanied by the notary's official notary seal.

(8) "State of origin" means the country where the document was created or issued.

(9) "State Party" means a State that has joined the Apostille Convention, for which the Convention is in effect.

14.09.02.01-1

(To be deleted).

14.09.02.02

.02 Requirements for Filing and Amending Claims.

A. Claim for Benefits.

(1) To initiate a claim for benefits, an employee shall file a claim form with the Commission.

(2) The Commission shall reject and return to the claimant a claim form that does not contain sufficient information to process the claim, including:

(a) The employee's name;

(b) The employee's address;

(c) The employee's date of birth;

(d) The date of the accident or occupational disease;

(e) The member of the body that was injured;

(f) A description of how the accidental injury or occupational disease occurred; and

(g) The employee's employer's name and address.

(3) If the information set forth in §A(2) of this regulation is unavailable or does not exist the claimant shall:

(a) Enter all zeros (0) in the spaces provided for the information; and

(b) Attach a signed statement certifying that the information is unavailable or does not exist.

(4) The employee shall sign the claim form certifying that the information submitted on the claim form is accurate.

(5) When completing the claim form, the claimant shall sign an authorization for disclosure of health information directing the claimant's health care providers to disclose to the claimant's attorney, the claimant's employer, the employer's insurer, or any agent thereof, the claimant's medical records that are relevant to:

(a) The member of the body that was injured by an accident or occupational disease, as indicated on the claim form; and

(b) The description of how the accidental injury or occupational disease occurred, as indicated on the claim form.

(6) Revocation of Authorization.

(a) A claimant may revoke an authorization for disclosure of health information in writing.

(b) The claimant shall serve a copy of the written revocation on all parties in the case.

(7) The Commission shall reject and return to the claimant a claim form that does not contain a signed authorization for disclosure of health information.

(8) Date of Filing.

(a) A claim is considered filed on the date that a completed and signed claim form, including the signed authorization for disclosure of health information, is received by the Commission.

(b) For any claim form that has not been rejected or returned as incomplete under §A(2) of this regulation, the Commission's date of receipt is determined by the date stamp affixed on the claim form.

(9) Electronic Submission.

(a) A claim that is submitted electronically is not considered filed until the signed claim form, including the signed authorization for disclosure of health information, is received by the Commission.

(b) The Commission's date of receipt is determined by the date stamp affixed on the claim form.

B. Social Security Number.

(1) Voluntary Disclosure of Social Security Number.

(a) On the claim form, the Commission shall request the Social Security Number of each claimant for workers' compensation benefits.

(b) The disclosure of the Social Security Number by the claimant on the claim form is voluntary.

(2) Use of Social Security Number.

(a) The Commission may use the Social Security Number for the following purposes:

(i) Verifying wage records of a claimant;

(ii) Verifying the identity of a claimant;

(iii) Identifying a claimant who has changed his or her name;

(iv) Verifying medical records necessary to adjudicate workers' compensation claims;

(v) The administration and enforcement of Maryland's workers' compensation laws;

(vi) The collection of any debts owed as a result of the claimant's failure to pay child support under Title 10 of the Family Law Article; and

(vii) Assisting in the enforcement of child support orders as required by State and federal laws.

(b) The Commission may not use the social security number for any purpose not authorized under this regulation or by state or federal law.

C. Amendment of Claim to Add or Remove a Body Part.

(1) A claimant may amend a claim to add or remove a member of the body by filing with the Commission a claim amendment form.

(2) A claimant shall serve a copy of a claim amendment form on the parties of record.

(3) The claimant shall sign the claim amendment form certifying that the information submitted on the claim amendment form is accurate.

(4) When completing the claim amendment form, the claimant shall sign an authorization for disclosure of health information authorizing the claimant's health care providers to disclose to the claimant's attorney, the claimant's employer, the employer's insurer, or any agent thereof, the claimant's medical records that are relevant to the member of the body identified by the claim amendment form.

(5) The Commission shall reject and return to the claimant a claim amendment form that does not contain a signed authorization for disclosure of health information.

14.09.02.03

.03 Amendment of Claim to Add an Additional Party, Including the Subsequent Injury Fund and Uninsured Employers' Fund.

A. A party may amend a claim to add another party by filing a Request to Implead a Party form.

B. A party may amend a claim to add an employer, a statutory employer, an insurance carrier, the Subsequent Injury Fund or the Uninsured Employers' Fund.

C. Impleading the Subsequent Injury Fund.

(1) A party impleading the Subsequent Injury Fund more than 30 days before a scheduled hearing date shall file a Request to Implead a Party form and shall serve the SIF with a copy of the form.

(2) A party impleading the SIF within 30 days of a scheduled hearing date shall:

(a) File a Request to Implead a Party form;

(b) Serve the SIF with a copy of the form; and

(c) File with the form a declaration setting forth the moving party's prima facie case for alleging the involvement of the SIF, including, but not limited to, identification of the evidence the party intends to rely on to prove the liability of the SIF.

(3) Within 10 days of filing the Request to Implead a Party form, and any other required documents, the impleading party shall provide the following to the SIF and all other parties to the claim:

(a) All prior awards or settlements, identified by claim number if available, to the claimant for permanent disability made or approved by the Commission, or by a comparable Commission of another state, or the District of Columbia;

(b) All relevant medical evidence relied on to implead the SIF; and

(c) A certification providing that a copy of the Request to Implead a Party form, along with all required information and documents, have been mailed to the SIF and all other parties to the claim.

(4) A party who fails to comply with this regulation or causes unreasonable delay without good cause is subject to an assessment of costs and reasonable attorney fees under Labor and Employment Article, §9-734, Annotated Code of Maryland.

14.09.02.04

.04 Death and Funeral Benefits.

A. Election for Counties and Municipal Corporations.

(1) A county or municipal corporation may elect for the death benefits provisions of Labor and Employment Article, §§9-683.1—9-683.5, Annotated Code of Maryland, to apply to its public safety employees subject to the statutory presumption set forth in Labor and Employment Article, §9-503, Annotated Code of Maryland.

(2) A county or municipal corporation may make this election by:

(a) Completing an online form, available at the Commission's website; and

(b) Attaching a copy of the county or municipal corporation's ordinance or resolution making the election.

(3) The Commission shall issue a date-stamped notice advising the county or municipal government of its receipt of the election.

(4) The date stamp of the Commission's notice will be used as the effective date of the election.

(5) All death benefit claims arising out of a death that occurred after the date of election are subject to the death benefits provisions set forth in Labor and Employment Article, §§9-683.1—9-683.5, Annotated Code of Maryland.

B. Dependent Claim for Death Benefits.

(1) To initiate a claim for death benefits, a dependent of the deceased employee or an individual authorized to act on behalf of the dependent claimant shall file a dependent death benefits claim form with the Commission.

(2) The Commission may reject and return to the dependent claimant or authorized individual a claim form that does not contain sufficient information to process the claim including:

(a) The dependent claimant's name and, if applicable, the authorized individual's name;

(b) The dependent claimant's address and, if applicable, the authorized individual's address;

(c) The deceased employee's name;

(d) The deceased employee's address;

(e) The deceased employee's date of birth;

(f) The date of the accident or occupational disease;

(g) The member of the deceased employee's body that was injured;

(h) A description of how the accidental injury or occupational disease occurred;

(i) The deceased employee's date of death; and

(j) The deceased employee's employer's name and address.

(3) If the information set forth in §B(2) of this regulation is unavailable or does not exist the claimant shall:

(a) Enter all zeros (0) in the spaces provided for the information; and

(b) Attach a signed statement certifying that the information is unavailable or does not exist.

(4) Signature.

(a) The dependent claimant or authorized individual shall sign the dependent death benefit claim form.

(b) An authorized individual shall submit documentation establishing his or her authority to act on behalf of the dependent claimant with the claim form.

(5) Submission of Supporting Documentation.

(a) When completing the dependent death benefits claim form, the dependent claimant or authorized individual shall submit:

(i) An authorization for disclosure of health information signed by the dependent claimant or authorized individual, directing the deceased employee's health care providers to disclose to the dependent claimant's attorney, the deceased employee's attorney, the deceased employee's employer, the employer's insurer, or any agent thereof, the deceased employee's medical records that are relevant to:

1. The member of the body that was injured by an accident or occupational disease, as indicated on the claim form; and

2. The description of how the accidental injury or occupational disease occurred, as indicated on the claim form;

(ii) A certification of funeral expenses, if the dependent claimant is making a claim for funeral benefits, which shall:

1. Include the name of the deceased employee;

2. Include an attached itemized statement of the services performed and corresponding costs;

3. Be signed by the provider of the funeral services or undertaker;

4. Be signed by the person authorizing the burial or other services; and

5. Be notarized;

(iii) A certified copy of the certificate of death for the deceased employee;

(iv) A certified copy of the certificate of marriage for the dependent claimant and deceased employee, if the dependent claimant is the surviving spouse of the employee; and

(v) A certified copy of the certificate of birth for the dependent claimant, if the dependent claimant is the surviving child of the deceased employee.

(b) Prior to the scheduled hearing on the death claim, the dependent claimant or authorized individual who filed the claim shall submit:

(i) Proof of family income at the date of the accidental personal injury or disablement;

(ii) An affidavit attesting to the authenticity of the documents submitted as proof of family income; and

(iii) If applicable, copies of any legal documents or orders directing the deceased employee to pay child support or alimony.

(c) Proof of family income may include:

(i) Payroll stubs or wage records covering the 14-week period prior to the accidental injury or date of disablement;

(ii) W-2s;

(iii) 1099 forms or other evidence of earnings from self-employment; and

(iv) Tax returns.

(d) If the dependent claimant or authorized individual does not have access to proof of income records for some alleged dependent claimants, the dependent claimant or authorized individual shall submit evidence demonstrating the efforts made to obtain these records, including any Commission subpoenas.

(6) Revocation of Authorization.

(a) A dependent claimant or authorized individual may revoke an authorization for disclosure of health information in writing.

(b) The dependent claimant or authorized individual shall serve a copy of the written revocation on all the parties in the case.

(7) The Commission shall reject and return to the dependent claimant or authorized individual a dependent death benefits claim form that does not contain a signed authorization for disclosure of health information.

(8) Date of Filing.

(a) A claim is considered filed on the date that a completed and signed claim form, including the signed authorization for disclosure of health information, is received by the Commission.

(b) The Commission’s date of receipt is determined by the date stamp affixed on the claim form.

(9) Electronic Submission.

(a) A dependent death benefits claim that is submitted electronically is not considered filed until the signed claim form, including the signed authorization for disclosure of health information, is received by the Commission.

(b) The Commission's date of receipt is determined by the date stamp affixed on the claim form.

C. Claim for Funeral Benefits Only.

(1) If the deceased employee has no dependents, any person or entity responsible for paying, or who has paid, the deceased employee's funeral expenses may initiate a claim for funeral benefits by filing with the Commission a signed funeral benefits only claim form certifying that the information submitted on the form is accurate.

(2) The Commission may reject and return to the filing party a funeral benefits only claim form that does not contain sufficient information to process the claim including:

(a) The filing party's name and address;

(b) The deceased employee's name and address;

(c) The deceased employee's employer's name and address;

(d) The date of accident or occupational disease; and

(e) The deceased employee's date of death.

(3) When the information set forth in §D(2) of this regulation is unavailable or does not exist, the claimant shall:

(a) Enter all zeros (0) in the spaces provided for the information; and

(b) Attach a signed statement certifying that the information is unavailable or does not exist.

(4) When completing the funeral benefits only claim form the filing party shall attach a certification of funeral expenses, which shall:

(a) Include the name of the deceased employee;

(b) Include an attached itemized statement of the services performed and corresponding costs;

(c) Be signed by the provider of the funeral services or undertaker;

(d) Be signed by the person authorizing the burial or other services; and

(e) Be notarized.

14.09.02.05

.05 Foreign Documents.

A. When a document or public record required by this chapter was created or issued in a foreign state the Commission may not accept as supporting documentation:

(1) Photocopies;

(2) Facsimile copies;

(3) Notarized copies; or

(4) Documents with alterations or erasures.

B. When a document or public record required by this chapter was created or issued in a foreign state and the state of origin is a State Party to the Apostille Convention, the party submitting the document shall:

(1) Have a competent authority of the State of origin issue an apostille for the original or a certified copy of the document; and

(2) Attach to the apostilled document, an English translation of the document prepared pursuant to this regulation.

C. When a document or public record required by this chapter originated in a foreign State and the State of origin is not a State Party to the Apostille Convention, the party submitting the document shall:

(1) Submit the public document with a written declaration (certificate) authenticating the signature/seal/stamp, signed in the State of origin which, if falsely made, would subject the maker to a criminal penalty under the laws of that foreign State;

(2) Attach to the document and certificate, a final certification as to the genuineness of the signature and official position of:

(a) The individual executing the certificate; or

(b) Any foreign official who certifies the genuineness of signature and official position of the executing individual, or is the last in a chain of certificates that collectively certify the genuineness of signature and official position of the executing individual; and

(3) Attach to the document and certificate or certificates, an English translation of the document prepared pursuant to this regulation.

D. A final certificate may be made by a secretary of an embassy or legation, consul general, consul, vice consul, or consular agent of the United States, or a diplomatic or consular official of the foreign State who is assigned or accredited to the United States.

E. English Translation.

(1) An English translation of any document authenticated by an apostille or by a final certificate shall include:

(a) The typed or printed name and telephone number of the interpreter or translator; and

(b) A signed certification by the interpreter or translator that the translation is true, accurate, and complete.

(2) A party shall have the English translation prepared by:

(a) An interpreter or translator whose name appears on the State of Maryland Court Interpreter Registry; or

(b) The embassy of the state from which the document originates.

F. An attorney who advances the cost of having a foreign document authenticated, translated, or both, is entitled to recover the actual amount expended.

14.09.02.06

.06 Claim for Unpaid Compensation of Deceased Claimant.

A. A person seeking unpaid compensation payments as a dependent of a deceased covered employee under Labor and Employment Article, §9-632, 9-640, or 9-646, Annotated Code of Maryland, shall file an Issue Form in the same claim.

B. A person seeking these benefits shall produce at the hearing proof of dependency and proof of death which may include a death certificate, marriage certificate, and birth certificate or order of adoption for any surviving children.

14.09.02.07

.07 Notice to Employer/Insurer of Claim.

A. After a claim is filed, the Commission shall send a Notice of Claim to all parties listed on the claim form and identified through the Commission's database of insurers and employers.

B. Insurer Identified.

(1) If an insurer has been identified, the Commission shall send a Response to Employee's Claim form to the insurer for completion.

(2) The insurer shall file a completed Response to Employee's Claim form with the Commission.

C. No Insurer Identified.

(1) If no insurer has been identified, the Commission shall send a Response to Employee's Claim form to the employer.

(2) The employer shall file a completed Response to Employee's Claim form with the Commission.

(3) If an employer is not insured, the Commission shall send a Response to Notification to Employer for Insurance Information form to the employer and a questionnaire to the claimant.

(4) The employer shall file the completed form with the Commission and send copies of the completed form to the Uninsured Employers' Fund.

(5) The claimant shall file the completed questionnaire with the Commission and concurrently send a copy to the Uninsured Employers' Fund.

(6) No hearings on issues filed by the claimant shall be scheduled until the claimant has completed and filed the claimant's questionnaire.

D. If no Response to Employee's Claim form is filed by the consideration date an automatic order will be issued finding the claim compensable.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 03 Hearing Procedures

Authority: Health-General Article, §§4-303 and 4-305; Labor and Employment Article, §§9-309, 9-3010, 9-311, 9-602, 9-625, 9-635, 9-701, 9-717, 9-720, 9-721, 9-726, 9-731, and 9-739; Annotated Code of Maryland

14.09.03.01

.01 Definitions.

A. In this chapter, the following term has the meaning indicated.

B. "Person in interest" means:

(1) An adult on whom a health care provider maintains a medical record;

(2) A person authorized to consent to health care for an adult pursuant to a grant of authority; and

(3) A duly appointed personal representative of a deceased person.

14.09.03.02

.02 Filing and Withdrawing Issues.

A. At the beginning of the claim, the employer or insurer may raise issues by filing the Response to Employee's Claim form (C40).

B. After the claim has commenced, any party may raise an issue by filing an Issues form, available on the Commission website.

C. The following kinds of issues may be raised by filing an Issues form:

(1) Whether the employee sustained an injury causally related to an accident that arose out of and in the course of employment;

(2) Whether the disability of the employee is causally related to the accidental injury;

(3) Whether the employee sustained a compensable hernia;

(4) Whether the employee sustained an occupational disease;

(5) Average weekly wage;

(6) Limitations;

(7) Jurisdiction;

(8) Statutory employment;

(9) Medical expenses;

(11) Attorneys' fees/costs;

(12) Penalties;

(13) Whether the employee is entitled to temporary partial and temporary total disability benefits;

(14) The nature and extent of a permanent disability to specified body parts;

(15) Authorization for medical treatment; and

(16) Other issues when articulated with specificity.

D. On the Issues form, the party shall state with clarity issues to be determined and shall, if relevant:

(1) Include the inclusive dates of any temporary total disability;

(2) For permanent disability, identify each part of the body affected, and any alleged psychiatric disability;

(3) Specifically plead permanent total disability;

(4) Include the specific medical treatment sought; and

(5) For any medical expenses, attach a list identifying each amount owed and to whom the amount is owed.

E. The party who has raised issues may withdraw those issues by:

(1) Filing a Request for Action on Filed Issues form; or

(2) Verbally requesting that the issues be withdrawn at the scheduled hearing.

F. A party that has filed issues and is not ready to proceed at the hearing shall withdraw the issues.

G. A party that withdraws issues may not refile the same issues for a period of 90 days.

H. A party may request an exemption from the prohibition against refiling issues within the 90-day period by filing a Request for Hearing on Previously Withdrawn Issues form. Any supporting documentation shall be attached to the form.

I. If the Commission grants the request for exemption, the Commission shall:

(1) Issue a memorandum granting the request; and

(2) Schedule a hearing on the previously withdrawn issues.

J. A party who fails to comply with this regulation, or causes unreasonable delay without good cause, may be subject to an assessment of costs and reasonable attorney fees under Labor and Employment Article, §9-734, Annotated Code of Maryland.

14.09.03.03

.03 Hearing Notices.

A. The Commission shall schedule a hearing on the issues identified on the Issues form, or on the Response to Employee's Claim form (C40), unless a hearing is already scheduled or set to be scheduled, and shall send written notice to all parties of the scheduled hearing date.

B. A hearing notice issued by the Commission shall contain:

(1) The date the notice was issued;

(2) The date, time and place of the hearing; and

(3) A statement providing information concerning the procedures for making a request for an accommodation or an interpreter.

14.09.03.04

.04 Interpreters and Other Accommodations.

A. Interpreter and Other Accommodations.

(1) If a party or witness cannot adequately hear, speak, or understand the spoken or written English language the Commission shall provide an interpreter or other reasonable accommodation service necessary for the party or witness to participate fully in the Commission proceedings.

(2) If a party, witness or individual having business with the Commission requires another form of accommodation to participate in Commission proceedings, the Commission shall take reasonable steps to provide a reasonable accommodation for the individual.

B. Request Required.

(1) Within 10 days of the date the Notice of Hearing is issued, an individual requiring an interpreter or other accommodation shall make a request to the Commission Interpreter Program Office that specifies:

(a) The identity of the individual requiring the service;

(b) Date and location of hearing;

(c) The language or other accommodation service being requested;

(d) Contact information for the service/accommodation requestor or their representative; and

(e) Any other information that may assist the Commission in providing the requested interpreter service or accommodation.

(2) A request for interpreter or other accommodation may be made by:

(a) Telephoning the Commission's LEP telephone line available on the Commission website;

(b) Sending an email to the email address for the Commission Interpreter Program Office available on the Commission website; or

(c) Telephoning the Commission's main telephone line through the TTY service through Maryland Relay available on the Commission's website.

(3) Upon receipt of a timely request for services, the Commission Interpreter Program Office shall:

(a) Issue a reservation number to the requesting individual; and

(b)

(i) Schedule an interpreter, or accommodation service; or

(ii) Engage in a dialogue about the requested accommodation.

C. Except as provided in §D of this regulation, the Commission shall pay the fee for interpreter or other reasonable accommodation service requested pursuant to this regulation.

D. Notification of Cancellation and Fees.

(1) An individual who has received a reservation number under §B(2) of this regulation may cancel the requested service by notifying the Commission Interpreter Program Office, in the manner prescribed by the Commission, that the requested service is no longer required.

E. An individual may be assessed the service minimum fee if:

(1) A matter is resolved more than 2 days prior to the hearing; and

(2) The service is not cancelled.

F. A party may not provide his or her own interpreter.

14.09.03.05

.05 Subpoenas.

A. Use of Subpoenas. A subpoena is required to compel the person to whom it is directed to attend, give testimony, and produce designated documents or tangible things at a Commission proceeding or at a deposition held pursuant to Labor and Employment Article, §9-719(b), Annotated Code of Maryland.

B. Procedure for Obtaining Subpoena.

(1) On the request of an attorney entitled to the issuance of a subpoena the Commission shall issue a subpoena signed and sealed but otherwise blank that shall be filled in before service.

(2) On the request of a non-attorney individual entitled to the issuance of a subpoena the Commission shall provide a blank form of the subpoena which shall be filled in and returned to the Commission clerk to be signed and sealed before service.

(3) To the extent practicable, subpoenas shall be served at least 10 days before the hearing.

C. Form of Subpoena.

(1) Every subpoena shall contain:

(a) The caption of the claim and claim number;

(b) The name and address of the person to whom it is directed;

(c) The name of the person at whose request it is issued;

(d) The date, time, and place where attendance is required; and

(e) A description of any documents or tangible things to be produced.

D. Medical Records Subpoenas.

(1) Every subpoena seeking the production of medical records shall comply with Health General Article, §4-306, Annotated Code of Maryland.

(2) A party seeking medical records by subpoena shall:

(a) Complete the Notice of Intent to Subpoena Medical Records and Certificate of Service form; and

(b) Send by certified mail a copy of the Notice of Intent to Subpoena Medical Records to the person in interest and his or her counsel.

(3) Within 30 days of the date that the Notice of Intent to Subpoena Medical Records was mailed, a person in interest may oppose the disclosure of his or her medical records by:

(a) Filing the Objection to Subpoena of Medical Records form with the Commission; and

(b) Sending a copy of the Objection form to all parties by first class mail.

(4) Upon receipt of an Objection to Subpoena of Medical Records, the Commission shall schedule a hearing to determine:

(a) Whether the subpoena should be quashed;

(b) Whether the subpoena should be limited in scope or otherwise modified; and

(c) Other appropriate relief.

E. Service of Subpoenas.

(1) Subpoenas may be served by:

(a) Personal delivery by an individual 18 years old or older who is not a party to the proceeding or related by blood or marriage to a party to the proceeding; or

(b) Certified mail to the person at the address specified in the subpoena request.

(2) The subpoena may not be enforced pursuant to Labor and Employment Article, §9-717, Annotated Code of Maryland, absent proof of service by certified mail or personal delivery.

(3) Costs of certified mailing or personal delivery of the subpoena are the responsibility of the person requesting the service.

(4) Proof of service by certified mail or personal delivery is the responsibility of the person requesting the subpoena.

F. Return of service shall be made as follows:

(1) When service is by certified mail, by the filing of the original return receipt; or

(2) When service is by personal delivery, by the filing of an affidavit, signed by the individual who made service, containing:

(a) The name of the individual served;

(b) The date on which the individual was served;

(c) The particular place of service; and

(d) A statement that the server is 18 years old or older and not a party to the proceeding or related by blood or marriage to a party to the proceeding.

G. Enforcement of Subpoenas.

(1) If an individual fails to comply with a properly served subpoena, pursuant to Labor and Employment Article, §9-717, Annotated Code of Maryland, the party wishing to enforce the subpoena shall file with the Commission a written request for the enforcement of the subpoena.

(2) The request shall:

(a) State, with specificity:

(i) When and how the subpoena was served; and

(ii) Why the testimony or documents sought are necessary for the resolution of the issue; and

(b) Be accompanied by copies of the subpoena, and any certificate of service, return receipt, or affidavit.

(3) Upon determining that the subpoena was issued and served in compliance with the law, the Commission may and, on request of a party to the proceeding, shall apply to the appropriate circuit court for an order to show cause why the individual should not be imprisoned for failing to comply with a subpoena.

14.09.03.06

.06 Average Weekly Wage.

A. Preliminary Determination. For the purpose of making an initial award of compensation before a hearing in the matter, the Commission shall determine the claimant's average weekly wage from gross wages, including overtime, reported by the claimant on the employee's claim form.

B. Filing of Wage Statement. As soon as practicable, the employer/insurer shall file a wage statement containing the following information:

(1) The average wage earned by the claimant during the 14 weeks before the accident, excluding the time between the end of the last pay period and the date of injury, provided that periods of involuntary layoff or involuntary authorized absences are not included in the 14 weeks;

(2) Those weeks the claimant actually worked during the 14 weeks before the accident;

(3) Vacation wages paid; and

(4) Those items set forth in Labor and Employment Article, §9-602(a)(2), Annotated Code of Maryland.

C. Determination at First Hearing.

(1) Calculation of the average weekly wage shall be adjudicated and determined at the first hearing before the Commission.

(2) All parties shall be prepared to produce evidence from which the Commission can determine an accurate average weekly wage at the first hearing.

(3) If the Commission determines that an inaccurate average weekly wage resulted in the overpayment or underpayment of benefits, the Commission may order:

(a) A credit against future permanent disability benefits;

(b) The payment of additional compensation; or

(c) Any other relief the Commission determines is appropriate under the circumstances.

D. Uninsured Employers' Fund. The Uninsured Employers' Fund may contest the average weekly wage determined by the Commission under §A or C of this regulation, along with other issues as authorized by Labor and Employment Article, §9-1002, Annotated Code of Maryland, by filing issues on the form prescribed by the Commission.

14.09.03.07

.07 Disclosure of Medical Information.

A. Parties' Continuing Duty to Disclose Medical Information.

(1) When a claim or an issue is filed with the Commission, each party promptly shall provide to all other parties copies of all relevant medical information in the possession of the party or that is subsequently received by the party, but not previously provided.

(2) For the purpose of this regulation, medical information in the possession of, or received by, the party's agent or attorney is considered to be in possession of the party.

(3) The duty to disclose applies to all medical information including reports, evaluations, tests, and bills, and continues during the pendency of the claim.

B. Duty to Provide Medical Authorization.

(1) Unless the Commission orders otherwise for good cause shown, a party shall provide to any other party, on written request, a medical authorization or release.

(2) The parties shall, in good faith, attempt to resolve any issues concerning the scope of the requested medical authorization or release.

(3) Failure to comply with this regulation may result in sanctions including attorneys' fees and costs, delay, and the exclusion of any evidence not properly disclosed.

C. Motion to Compel Medical Authorization.

(1) Upon the failure of a party to provide an executed medical authorization, the party seeking the medical authorization may file a Motion to Compel Medical Authorization form.

(2) A Motion to Compel Medical Authorization shall:

(a) Be filed electronically;

(b) Be served by hand delivery or facsimile on all parties of record; and

(c) Contain the claimant's name, date of accident/disablement, the health care provider's name, and the body parts or medical conditions to which the authorization/release applies.

(3) A party may oppose the motion by filing a Response to Motion to Compel Medical Authorization form.

(4) A Response to Motion to Compel Medical Authorization shall:

(a) Be filed within 7 days after receipt of the motion;

(b) Be filed electronically;

(c) Be served by hand delivery or facsimile on all parties of record; and

(d) State with particularity the reasons for failing to provide the requested medical authorization;

(5) The motion shall be decided on the papers filed.

14.09.03.08

.08 Medical Examinations.

A. Medical Examinations Ordered by the Commission.

(1) The Commission may order that the claimant be examined, at the Commission's expense, by the Commission's medical examiner or by some other physician, psychologist, or psychiatrist selected by the Commission.

(2) The claimant shall report to the office of the examining physician at the time scheduled by the physician for the examination.

(3) If the claimant is physically unable to report to the physician's office, the examination may be conducted wherever the claimant is located or is physically able to report.

(4) When the examining physician's report is filed, the Commission shall serve on all parties:

(a) A copy of the report; and

(b) A notice that any written objection to the report shall be filed within 15 days after the date of the notice.

(5) A written objection may be made by written letter filed with the Commission and shall state clearly the reasons for objecting to the examining physician's report.

(6) If no written objection is timely filed, the Commission may consider the report, along with any other admissible evidence presented, in deciding the claim.

(7) If an objection is timely filed, the Commission shall schedule a hearing on the matter.

B. Medical Examination Requested by a Party.

(1) A party may schedule a medical examination of the claimant with a physician, psychologist, or psychiatrist chosen by the party, by providing to the claimant and claimant's counsel reasonable notice of the examination in writing.

(2) The party scheduling a medical examination of the claimant shall be responsible for all reasonable expenses associated with the examination.

(3) The parties shall, in good faith, attempt to resolve any differences in scheduling and scope of examination.

(4) A claimant shall appear for a scheduled medical examination.

(5) If a claimant fails to appear, refuses to submit, or fails to cooperate with the medical examination, the party requesting the examination may file an Issues form for a hearing to compel a medical examination and for reimbursement of reasonable expenses and costs.

(6) If a claimant fails to appear at, refuses to submit to, or fails to cooperate with the medical examination, without good cause, the Commission may order the claimant to attend a medical examination and order reimbursement of reasonable expenses and costs at a rate not to exceed $125 per missed examination.

C. Appearance by Examining Physician. A party requesting the appearance of an examining physician, psychologist, or psychiatrist at a hearing shall pay the appearance fee imposed by the provider.

14.09.03.09

.09 Hearing Exhibits and Witnesses.

A. Mandatory Exchange of Hearing Exhibits.

(1) At least 3 business days prior to the scheduled hearing date, each party shall send to the other parties, including the Subsequent Injury Fund and the Uninsured Employers' Fund, copies of all medical exhibits that the party intends to introduce at the time of hearing that were not previously produced to the other party in accordance with Regulation 14.09.03.07A.

(2) Failure to comply with this provision may result in sanctions.

B. Confidential Information.

(1) If sensitive material must be brought to the attention of a Commissioner for the proper adjudication of a matter in dispute, the party seeking the admission of the sensitive or restricted material may request to brief the Commissioner in-chambers regarding the subject matter only after providing notice to opposing counsel.

(2) A request to admit sensitive or restricted material shall be granted or denied at the Commissioner's discretion.

C. General Rules Concerning Hearings.

(1) On any genuine issue, each party is entitled to call witnesses, offer evidence, and cross-examine any witness who testifies.

(2) A hearing shall be called to order by the Commissioner. The Commissioner may allow the parties to present preliminary matters.

(3) Witnesses shall be sworn or put under affirmation to tell the truth.

(4) A Commissioner may admit evidence that reasonable and prudent individuals commonly accept in the conduct of their affairs, and give probative effect to that evidence.

D. Hearing Exhibits.

(1) Each party shall prepare an exhibit that:

(a) Includes all documents that have not been filed previously with the Commission that are relevant and necessary to decide the issue or issues to be heard;

(b) Is paginated; and

(c) Includes a table of contents that indicates the first page of each document contained in the exhibit, and the name of the health care provider, the date of the report, and date of treatments.

(1) Upon request by a party, the Commissioner may exclude witnesses other than parties from the hearing room, except when testifying.

(2) A party, representative, witness, or spectator may not disclose to a witness excluded under this section the nature, substance, or purpose of testimony, exhibits, or other evidence introduced during that witness's absence.

(3) A party that is not an individual may designate an employee or officer as its representative to remain in the hearing room, even though the employee or officer may be a witness.

(4) An expert witness who is to render an opinion based on testimony given at the hearing may remain during the testimony.

(5) The Commissioner may exclude the testimony of a witness who receives information in violation of this section, or take other appropriate action.

F. Stipulations.

(1) The parties may, in accordance with law, agree to any substantive or procedural matter.

(2) A stipulation may be filed in writing or entered on the record at the hearing.

(3) The Commissioner may require additional development of stipulated matters.

(4) The parties filing a stipulation shall attach to the stipulation, or submit to the Commissioner at the hearing, documentation supporting the stipulation.

G. Expert Testimony.

(1) If a party wishes to have an expert witness appear and testify, other than a vocational rehabilitation counselor, the party must seek prior approval from the Chairman.

(2) The party shall submit a letter stating why oral testimony is necessary in lieu of documentary evidence.

(3) The party producing the expert witness shall be responsible for any fees charged by the expert for appearing and testifying.

14.09.03.10

.10 Consequence of Nonappearance by Claimant.

A. When a claimant, without good cause, fails to appear at a hearing on issues contesting the compensability of a claim, the Commission may dismiss the claim.

B. When a claimant, without good cause, fails to appear at a hearing on issues in a compensable claim, the Commission may proceed ex parte and may decide the issues based on information on file with the Commission, together with any evidence presented at the hearing.

14.09.03.11

.11 Request for Emergency Hearing.

A. A party may request an emergency hearing by filing a Request for Emergency Hearing form.

B. A party may request an emergency hearing on the following bases:

(1) Continuing temporary total disability and exigent circumstances causing undue financial hardship;

(2) Proposed urgent medical treatment; or

(3) Other truly exigent circumstances causing undue hardship.

C. A request for an emergency hearing shall be accompanied by supporting medical documentation and other documentation that establishes the nature of the emergency condition or circumstance.

D. A Request for Emergency Hearing on temporary total disability shall contain a detailed statement showing that any delay will cause the claimant undue financial hardship.

E. Unless exceptional circumstances are demonstrated, the Commission shall deny a Request for Continuance made by the party upon whose request the emergency hearing was scheduled.

F. A Request for Emergency Hearing will be decided based on the papers filed.

14.09.03.12

.12 Request for Continuance.

A. Prior to filing a Request for Continuance of a scheduled hearing, the party seeking the continuance shall contact the other parties to the case and seek their consent.

B. A party seeking a continuance shall file a Request for Continuance form setting forth the reasons for the continuance at least 30 days prior to the scheduled hearing.

C. Requests for Continuance filed more than 30 days prior to a scheduled hearing, to which the parties have consented, shall routinely be granted.

D. A Request for Continuance filed less than 30 days before the hearing may be granted subject to the discretion of the Commissioner.

E. A Request for Continuance will be decided based on the papers filed.

14.09.03.13

.13 Motion for Modification.

A. A party seeking modification of a prior finding or order shall file the form captioned Motion for Modification and simultaneously file an Issues form identifying the issue to be resolved.

B. A party seeking modification must file a Motion for Modification within 5 years of the later of the date of the accident, the date of disablement, or the date of the last compensation payment.

C. The motion shall state specifically the finding or order that the party wishes modified and the facts and law upon which the party is relying as grounds for the modification.

D. When a party seeks an increase in a prior award for permanent partial disability, the parties shall comply with Regulation .07 of this chapter and COMAR 14.09.09.

14.09.03.14

.14 Motion for Rehearing.

A. Within 15 days after the date of decision, a party seeking reconsideration of a decision shall file a Motion for Rehearing form, available on the Commission’s website.

B. If the motion is based on an alleged error of law, the motion shall state specifically the error and the applicable case and statutory law.

C. If the motion is based on newly discovered evidence, the motion shall describe specifically the newly discovered evidence and the reasons why that evidence was not known and could not have been discovered by due diligence at the time of the prior hearing.

D. The motion shall be accompanied by copies of all documentary evidence upon which the motion is based.

E. An answer to a motion for rehearing may be filed with the Commission within 10 days after the motion is filed.

F. The Commission may decide the motion with or without a hearing.

14.09.03.15

.15 Miscellaneous Forms.

A. The Request for Action on Filed Issues Form shall be used:

(1) By the filing party, to withdraw issues previously filed;

(2) By the claimant, to request dismissal of the claim;

(3) By the filing party, to request that the issues raised on the issue form be set for hearing with the pending issues in related claims; and

(4) By any party, to request a change in venue.

B. The Request for Document Correction form may be used to correct an error when:

(1) There is an undisputed typographical error; or

(2) All parties agree that the factual error is undisputed.

C. The Request for Document Correction form may not be used to:

(1) Obtain reconsideration or rehearing of an issue;

(2) Correct a factual matter over which there is a dispute.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 04 Legal Representation and Fees

Authority: Labor and Employment Article, §§9-309, 9-721, and 9-731, Annotated Code of Maryland

14.09.04.01

.01 Legal Representation.

A. Representation.

(1) A party may be represented before the Commission by:

(a) An attorney admitted by the Court of Appeals to practice in this State;

(b) An out-of-State attorney specially admitted by order of the circuit court pursuant to the Business Occupations and Professions Article, §10-215, Annotated Code of Maryland; or

(c) A party, who is an individual, may appear on the individual's own behalf pursuant to Business Occupations and Professions Article, §10-102, Annotated Code of Maryland.

(2) All parties, other than an individual electing to represent him or herself, may be represented only by an attorney.

B. Attorney Registration with Commission.

(1) An attorney wishing to practice before the Commission shall:

(a) Complete and file an Attorney Registration form; and

(b) Submit the attorney registration fee.

(2) Following verification and completion of the registration, the Commission shall issue the attorney a multiple digit attorney code.

C. Entry of Appearance.

(1) An attorney representing a party in a claim shall complete and file an Entry of Appearance form with the Commission to establish an attorney of record.

(2) Within 10 days of the filing of issues by any party, an insurer shall have an attorney complete and file an Entry of Appearance form with the Commission to establish an attorney of record.

(3) After an Entry of Appearance has been filed by an attorney on behalf of the insurer, all papers filed on behalf of the insurer shall be filed by the attorney of record until the claim becomes undisputed.

D. Notices.

(1) If a party is represented by an attorney, notices to the party may be mailed to the attorney of record only.

(2) An employer may designate a person who shall receive a courtesy copy of each Notice of Employee's Claim filed against the employer.

E. Termination of Representation. An attorney whose appearance has been entered on behalf of a party to a claim remains the attorney of record for the party to that claim until:

(1) The attorney:

(a) Files a Request to Strike Appearance form;

(b) Certifies that a copy of the Request to Strike Appearance was mailed to all parties; and

(c) Certifies that notice of any pending hearing was mailed to the attorney's client; or

(2) The party requests that the Commission strike the appearance of the attorney.

14.09.04.02

.02 Attorney's Fee and Medical Evaluation Fee — Application or Petition for Approval.

A. Request for Fee Not in Excess of Schedule.

(1) An attorney seeking approval of an attorney's fee that does not exceed the maximum amount set forth in Regulation .03 of this chapter, may request approval of the fee by filing the Claimant's Consent to Pay Attorney and Doctor Fee form.

(2) A completed Claimant's Consent to Pay Attorney and Doctor Fee form shall:

(a) Be signed by the claimant;

(b) Include the amount of any medical evaluation fee requested to be approved;

(c) Include any amount of costs advanced by claimant's attorney for which the attorney is seeking payment; and

(d) Include any appeal fee requested under Regulation .03B(9) of this chapter.

(3) An attorney shall substantiate a request for medical evaluation fee, costs or a fee under Regulation .03B(9) of this chapter by:

(a) Submitting medical bills, receipts, or other evidence of costs;

(b) Submitting evidence establishing that:

(i) The prior compensation award was appealed to the circuit court and tried on appeal;

(ii) The prior compensation award was appealed to an appellate court, briefed and decided on the merits;

(iii) The prior compensation award was appealed to the circuit court but not resolved by trial;

(iv) The prior compensation award was appealed to an appellate court but not briefed and decided on the merits; or

(v) The prior order of the Commission on the issue of compensability of the claim was appealed to the circuit court and the claim was determined to be compensable by the circuit court or jury.

(4) The claimant's consent to the fee is not binding on the Commission.

(5) An award by the Commission approving an attorney's fee under this regulation shall be notice to the party responsible for payment to reserve in escrow the amount of fee approved.

(6) If an appeal is not filed within 30 days, the party responsible for payment shall remit the approved fee to the attorney immediately after the expiration of the 30-day appeal period.

(7) If an appeal is filed timely, the party responsible for payment shall continue to reserve in escrow the amount of the fee approved by the Commission pending final determination of the appeal.

(8) If the parties agree that an appeal will not be filed, the fee may be remitted to the attorney before expiration of the 30-day appeal period.

B. Petition for Fee in Excess of Schedule.

(1) An attorney seeking an attorney's fee exceeding the maximum amount set forth in Regulation .03 of this chapter, shall draft and file with the Commission a written petition.

(2) The petition shall contain the following:

(a) A clear and concise description of the legal services rendered to the claimant;

(b) The amount of attorney's fee requested to be approved;

(c) A detailed statement of the reasons for a fee in excess of the maximum amount set forth in Regulation .03 of this chapter;

(d) A detailed statement establishing the exceptional circumstances that warrant an excess fee;

(e) The claimant's signed acknowledgement of the fact that the attorney is requesting approval of an attorney's fee in excess of the schedule, in the amount specified and for the services described;

(f) The amount of any medical evaluation fee requested to be approved; and

(g) A certificate of service indicating that a copy of the petition has been served on the claimant, as well as the other parties to the case.

(3) A petition for approval of an attorney's fee ordinarily shall be considered by the Commissioner who issued the award of compensation.

C. Unreasonable Proceeding — Attorney Fee Award.

(1) Pursuant to Labor and Employment Article §9-734, Annotated Code of Maryland, the Commission may award to an opposing party a reasonable attorney's fee in any proceeding that the Commission determines not to have been brought on a reasonable ground.

(2) The Commission may make the attorney's fee award on its own initiative or at the request of any party.

(3) Unless the award of the fee is appealed, the fee allowed under this section is payable immediately.

14.09.04.03

.03 Schedule of Attorney's Fees.

A. The Commission shall approve attorney's fees in accordance with the schedule of fees established by the Commission and set forth in §B of this regulation.

B. Schedule of Fees.

(1) Definitions.

(a) In this section, the following terms have the meanings indicated.

(b) Terms Defined.

(i) "Final award" means the award of compensation determined by the Commission after exhaustion of all applicable appeals, regardless of whether the award is increased or decreased as a result of any appeal.

(ii) "Formal set-aside allocation" means a document reflecting a comprehensive analysis and projection of future injury-related medical needs and associated costs.

(iii) "State average weekly wage" means the State average weekly wage in effect on the date of the accident or date of disablement.

(2) Fee in Excess of Limits. The Commission may approve an attorney's fee in excess of the limits set forth in this section only if exceptional circumstances are shown.

(3) Permanent Partial Disability.

(a) General. Except as otherwise provided in §B(3)(b) of this regulation, in a case in which a final award of compensation is made for permanent partial disability, the Commission may approve an attorney's fee in a total amount not exceeding 20 times the State average weekly wage and computed as follows:

(i) Up to 20 percent of the amount due for the first 75 weeks of an award of compensation awarded;

(ii) Up to 15 percent of the amount due for the next 120 weeks of an award of compensation; and

(iii) Up to 10 percent of the amount due for an award of compensation in excess of 195 weeks.

(b) Disability Due to Amputation or Loss of Vision. In a case in which a final award of compensation is made for permanent partial disability due to the amputation of an arm, leg, hand, or foot, or total loss of vision in one eye, and the sole issue before the Commission is the nature and extent of disability, the Commission may approve an attorney's fee in an amount up to 5 percent of the compensation awarded, but not exceeding 6 times the State average weekly wage.

(4) Permanent Total Disability.

(a) General. Except as otherwise provided in §B(4)(b) of this regulation, in a case in which a final award of compensation is made for permanent total disability, the Commission may approve an attorney's fee in an amount not exceeding 20 times the State average weekly wage.

(b) Special Cases. The Commission may approve an attorney's fee in an amount not exceeding 13 times the State average weekly wage in a case in which compensability is not an issue and an award of compensation is made for permanent total disability established either pursuant to:

(i) Labor and Employment Article, §9-636(b), Annotated Code of Maryland, for the loss of two or more scheduled members; or

(ii) The stipulation on the extent of disability.

(5) Temporary Total and Temporary Partial Disability. The Commission may not approve an attorney's fee in a case in which final award of compensation is made for temporary total or temporary partial disability or temporary total disability paid while a claimant is receiving vocational rehabilitation services unless the claimant's right to the compensation is contested and the issue is resolved by evidentiary hearing or by stipulation. In such a contested case, the fee may be in an amount not exceeding 10 percent of the compensation that has accrued as of the date of the award.

(6) Dependency Claims.

(a) In a case involving a claim of dependency, if compensability is not contested, but the extent of dependency, partial or total, or the identity of a dependent, or both is contested, the Commission may approve a total attorney's fee for attorneys representing all dependents in an amount not exceeding five times the State average weekly wage in a case of partial dependency and not exceeding 12 times the State average weekly wage in a case of total dependency.

(b) In a case involving a claim of dependency, if neither compensability nor dependency is contested and a record is being made solely to determine to whom payments of compensation shall be made, the Commission may approve an attorney's fee in an amount not exceeding two times the State average weekly wage.

(c) In a case involving a claim of dependency, if compensability and dependency are contested, the Commission may approve an attorney's fee in an amount calculated under §B(3)(a) of this regulation, in a case of partial dependency and calculated under §B(4)(a) of this regulation, in a case of total dependency.

(7) Settlement Agreements.

(a) In a case in which an agreement of final compromise and settlement is approved, the Commission may approve an attorney's fee in accordance with this regulation.

(b) For a settlement amount that is less than or equal to 14 times the State average weekly wage, the attorney's fee shall be 20 percent of the amount of the settlement.

(c) For a settlement amount that is greater than 14 times the State average weekly wage but less than or equal to 35 times the State average weekly wage, the attorney's fee shall be:

(i) 20 percent of 14 times the State average weekly wage; plus

(ii) 15 percent of the difference between the settlement amount, and 14 times the State average weekly wage.

(d) For a settlement amount that is greater than 35 times the State average weekly wage, the attorney's fee shall be:

(i) 20 percent of 14 times the State average weekly wage; plus

(ii) 15 percent of 21 times the State average weekly wage; plus

(iii) 10 percent of the difference between the settlement amount and 35 times the State average weekly wage.

(e) The total amount of an attorney's fee in a case in which an agreement of final compromise and settlement is approved may not exceed 20 times the State average weekly wage.

(f) In calculating the attorney's fee, an attorney may not include as part of the settlement any amounts paid or payable in the case for medical services and prescription drugs including but not limited to:

(i) Any monies allocated to future medical expenses through a formal set-aside allocation;

(ii) Any monies apportioned to future medical benefits; and

(iii) Any monies already paid or owing for medical services and prescription drugs.

(g) The Commission may not regulate the attorney's fees charged for the administration of the formal set-aside allocation once a case is resolved by an agreement of final compromise and settlement.

(8) Increase in Last Award of Compensation for Permanent Partial Disability.

(a) Except as otherwise provided in §B(8)(b)—(c) of this regulation, if the claimant is entitled to additional compensation as a result of an increase in a permanent partial disability award, the Commission may approve an additional attorney's fee in an amount not exceeding the difference between the fee approved for all prior awards and the fee computed under §B(3) or (4)(a) of this regulation on the increased award.

(b) If the claimant is entitled to additional compensation as a result of a final compromise and settlement, and was previously awarded permanent partial disability, the Commission may approve an attorney's fee calculated using the methodology set forth in §B(7) of this regulation.

(c) If the claimant is entitled to additional compensation as a result of an increase in a permanent partial disability award or a final compromise and settlement, and the attorney previously was awarded the maximum fee authorized under §B(3) of this regulation, the Commission may approve an additional attorney's fee in an amount up to 5 percent of the difference between the prior awards of compensation and the increased award of compensation, but not to exceed five times the State average weekly wage.

(9) Additional Fees for Appeals of Compensation Awards.

(a) When a compensation award of the Commission is appealed to a circuit court and the case is tried on appeal, the Commission may approve an additional attorney's fee in an amount up to 5 percent of the first final indemnity award issued following the circuit court action, but not exceeding six times the State average weekly wage.

(b) When a decision of a circuit court on an appeal from a compensation award of the Commission is appealed to a higher appellate court and the appeal is briefed and decided on its merits, the Commission may approve an additional attorney's fee for each appeal in an amount up to 5 percent of the first final indemnity award issued following the appellate action, but not exceeding six times the State average weekly wage.

(c) When an appeal from a compensation award of the Commission to a circuit court is not tried, or an appeal to a higher appellate court is not briefed and decided on its merits, the Commission may approve an additional attorney's fee in an amount up to 2.5 percent of the first final indemnity award issued following the appellate action or circuit court action, but not exceeding three times the State average weekly wage.

(d) When a decision of the Commission on the issue of compensability of a claim is appealed to a circuit court, if the claim is determined on appeal to be compensable, the Commission, upon remand, may approve an additional attorney's fee in an amount up to 5 percent of the first final indemnity award issued following the remand, but not exceeding six times the State average weekly wage.

(e) An attorney may be awarded an appeal fee under only one subparagraph of this subsection for a circuit court action or appellate court action.

(f) Once an appeal fee has been awarded for a circuit court action or appellate action, the Commission may not award an additional appeal fee based on the same circuit court action or appellate action.

C. Attorney's Fee Not Allowed.

(1) Absent exceptional circumstances, the Commission may not approve an attorney's fee in a case in which it is determined that the claimant is not entitled to any compensation or benefits.

(2) Absent exceptional circumstances, the Commission may not approve an attorney's fee in a case involving issues such as medical care and treatment, or vocational rehabilitation, in which the claimant does not receive any monetary award.

14.09.04.04

.04 Attorneys' Fees for Multiple Counsel.

A. An attorney who no longer represents a claimant and wishes to pursue a fee lien shall draft and file a petition for attorneys' fees.

B. The petition for attorneys' fees shall include:

(1) A statement of the work performed and the basis of the fee; and

(2) A certificate of service.

C. The filing of the petition for attorneys' fee constitutes a fee lien that shall be noted and held until the permanency award or settlement.

D. Unless the parties have otherwise agreed, upon the issuance of a permanency award or settlement, any attorney's fee awarded shall be held in escrow until the distribution of the fee to be resolved by:

(1) A hearing; or

(2) Agreement of the attorneys on the division of the attorney's fee.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 05 Uninsured Employers' Fund Claims

Authority: Labor and Employment Article, §§9-309, 9-6A-04, 9-6A-07, and 9-1002, Annotated Code of Maryland

14.09.05.01

.01 Notification and Response of Uninsured Employer and Claimant.

A. If a workers' compensation claim is received by the Commission and the Commission's records indicate that the employer is uninsured, the Commission shall notify the employer of the claim by sending the employer:

(1) A Notice of the Claim form;

(2) An uninsured employer's questionnaire; and

(3) A request for verification of the employer's workers' compensation insurance policy.

B. The Commission shall send a copy of the Notice of the Claim form to all parties of record.

C. Within 21 days of the date the Notice of the Claim form was sent by the Commission:

(1) The uninsured employer shall:

(a) Begin paying temporary total benefits; or

(b) File a Response to Employee's Claim form (C-40), if the employer contests the claim; and

(2) File one of the following:

(a) The signed and completed uninsured employer's questionnaire; or

(b) The verification of the employer's workers' compensation insurance policy, if applicable.

D. Within 21 days of the date the Commission sends the Notice of the Claim form to the parties of record, the claimant shall complete and file the claimant's questionnaire in accordance with COMAR 14.09.02.

14.09.05.02

.02 Review of Claim Contested by Uninsured Employer.

A. The Commission shall set a hearing to review any claim contested by an uninsured employer pursuant to Regulation .01C of this chapter.

B. Upon completion of the hearing the Commission shall:

(1) Dismiss the claim; or

(2) Issue an award requiring that the appropriate compensation be paid by the uninsured employer to the claimant.

14.09.05.03

.03 Review of Uncontested Claims.

If an uninsured employer does not contest the claim by filing the Response to Employee's Claim form (C-30) within 21 days after the Commission served the Notice of the Claim form to the employer, the Commission may:

A. Review the claim for legal sufficiency; and

B. Either:

(1) Dismiss the claim; or

(2) Issue an automatic award finding the claim compensable.

14.09.05.04

.04 Notification and Payment of the Award.

The uninsured employer shall pay an award issued under Regulation .02 or .03 of this chapter within 30 days of the date the Commission serves notice of the award to the parties in accordance with Labor and Employment Article, §9-1002, Annotated Code of Maryland.

14.09.05.05

.05 Request for Payment by the Fund.

A. If the uninsured employer fails to pay an award and does not file for review of the award, the claimant may:

(1) Send a request for payment, and a copy of claimant's questionnaire to the UEF; and

(2) Contemporaneously file a copy of the request for payment and the claimant's questionnaire with the Commission.

B. No action will be taken against an employer or the UEF if the request for payment and the claimant's questionnaire are not filed with the Commission.

14.09.05.06

.06 Response of UEF and Impleader of Other Employer or Insurer.

A. Within 21 days after the date claimant filed a copy of the request for payment and claimant's questionnaire, the UEF shall respond by:

(1) Paying the award; or

(2) Filing issues.

B. If the UEF raises issues of statutory employment, or the existence of another employer or insurer, the UEF shall implead the employer and the insurer, if known.

14.09.05.07

.07 Notification and Response of Impleaded Employer or Insurer.

A. If the UEF impleads an employer or insurer the Commission shall serve the impleaded party a copy of the Notice of the Claim form.

B. The impleaded party shall respond within 21 days after the date of the notice referred to in §A of this regulation, by:

(1) Paying the award; or

(2) Filing issues.

14.09.05.08

.08 Review of Disputed Claim.

A. If the UEF or an impleaded party disputes a claim under Regulation .06 or .07 of this chapter, the Commission shall set a hearing to review the claims of all parties on all issues.

B. Upon completion of the hearing, the Commission shall:

(1) Dismiss the claim; or

(2) Issue an award.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 06 Payment of Awards and Assessments and Termination of Benefits

Authority: Labor and Employment Article, §§9-309, 9-605, 9-713, 9-727—9-731, Annotated Code of Maryland

14.09.06.01

.01 Payment Prior to Filing of Claim.

A. If a covered employee or dependent has not filed a claim with the Commission for the death or disability of the covered employee, an employer or insurer may not pay, in whole or in part, any compensation under Labor and Employment Article, Title 9, Annotated Code of Maryland.

B. If a covered employee or dependent has not filed a claim with the Commission for the death or disability of the covered employee, an employer or insurer may pay or contest charges for medical and other services under Labor and Employment Article, Title 9, Subtitle 6, Part IX or Part XIII, Annotated Code of Maryland.

C. An employer or insurer shall pay uncontested medical charges promptly after receipt.

14.09.06.02

.02 Claims for Medical Expenses; Notice; Penalty.

A. Notice. Within 5 days after receipt of an order of the Commission on a claim for payment for medical services, the claimant shall serve a copy of the order on the provider of the medical services for which payment was granted or denied.

B. Penalty for Late Payment for Treatment or Services.

(1) The Commission may assess against an employer or insurer a fine not to exceed 20 percent of any fee approved but not timely paid pursuant to Labor and Employment Article, 9-664, Annotated Code of Maryland.

(2) The Commission shall determine the amount of the fine on a case-by-case basis.

14.09.06.03

.03 Payment of Assessments.

A. Time for Payment. Assessments payable for the SIF and the UEF shall be paid within 30 days after the date of the award of compensation or approval of a settlement.

B. Assessments shall be paid in accordance with Labor and Employment Article, §§9-806, 9-1007, and 9-1008, Annotated Code of Maryland, as ordered by the Commission.

14.09.06.04

.04 Termination of Temporary Total Disability and Medical Benefits.

A. Termination of Monetary Benefits Requiring Notice.

(1) Prior to terminating payment of temporary total disability benefits, an insurer shall give written notice to the claimant by:

(a) Completing the Insurer's Termination of Temporary Total Disability Benefits form; and

(b) Sending a copy of the form to the claimant, counsel and to the Commission.

(2) The Insurer's Termination of Temporary Total Disability Benefits form may be used to provide notice to the claimant of the termination of disability benefits when:

(a) The employee is working for another employer other than the employer where the accident or occupational disease occurred;

(b) No medical evidence supports continued payment;

(c) The employee failed to appear for a medical evaluation requested by the employer/insurer;

(d) A physician other than the employee's chosen treating physician has determined that the employee has reached maximum medical improvement; or

(e) Otherwise supported by law.

B. Termination of Monetary Benefits — No Notice Required. An insurer may terminate payment of temporary total disability benefits without providing written notice, pursuant to Labor & Employment Article, §9-733(a), Annotated Code of Maryland, if:

(1) The employee has returned to his or her current employment;

(2) A treating physician chosen by the employee has advised that the employee has reached maximum medical improvement; or

(3) The termination is made after the termination date contained in an order of the Commission.

C. Termination of Medical Benefits.

(1) Prior to terminating the payment of medical benefits, an insurer shall give written notice to the claimant and the claimant's treating physician or health care provider of the date that benefits will be terminated.

(2) Written notice of the date that medical benefits will be terminated shall include a statement that the claimant has the right to request a hearing before the Commission on the issue of termination.

(3) A copy of the termination notice provided to the claimant shall be filed with the Commission.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 07 Vocational Rehabilitation Practitioners

Authority: Labor and Employment Article, §§9-309, 9-6A-04, and 9-6A-07, Annotated Code of Maryland

14.09.07.01

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Advisory Committee" means the Advisory Committee on the Registration of Rehabilitation Practitioners.

(2) "Case management functions" means the coordination and utilization of vocational rehabilitation services, either in person or telephonically, with respect to a specific injured worker, including the supervision of these duties performed by others.

(3) "Commission" means the Maryland Workers' Compensation Commission.

(4) "Director" means the Director of Rehabilitation of the Maryland Workers' Compensation Commission.

(5) "DORS" means Maryland State Department of Education Division of Rehabilitation Services.

(6) "Enrolled vocational rehabilitation organization" means an organization or company that:

(a) Employs, or has working on its behalf, at least one registered vocational rehabilitation practitioner; and

(b) Has enrolled with the Commission.

(7) "Functional Capacity Evaluation (FCE)" means the systematic process of assessing an individual's physical capacities and functional abilities and matching human performance levels to the demands of a specific job or work activity or occupation.

(8) "Job placement" means services provided to support the disabled covered employee's search for work including, but not limited to, identifying job leads, arranging interviews, teaching techniques for effective job searches, resume writing, interviewing and job application completion,

(9) "Nurse case manager" means a nurse who is certified by the State Board of Nursing to provide case management services, including but not limited to interviewing the worker for the purpose of implementing and coordinating services with health care providers and with the worker and the worker's family.

(10) "Office" means the Office of Vocational Rehabilitation of the Maryland Workers' Compensation Commission.

(11) Provider.

(a) "Provider" means the enrolled vocational rehabilitation organization that provides vocational rehabilitation services to a claimant through a registered vocational rehabilitation practitioner.

(b) "Provider" includes the Maryland State Department of Education Division of Rehabilitation Services ("DORS").

(12) "Rehabilitation counselor" means a qualified individual who is engaged in activities leading to vocational assessment or job placement, or both, of an injured worker.

(13) "Rehabilitation practitioner" means an individual who provides vocational rehabilitation services including:

(a) A nurse certified by the State Board of Nursing as a nurse case manager;

(b) A rehabilitation counselor; and

(c) A vocational evaluator.

(14) "Retraining plan" means a plan for providing the disabled covered employee with educational and vocational training and may include on-the job training.

(15) "Self-employment plan" means a business plan for self-employment that identifies the skills, experience and expertise necessary to manage the business, and may include a complete business description, an organization plan, owner/operator qualifications, a marketing plan supported by factual information concerning the demand for products or services, income projections, a sound start-up financial plan, financial resources needed to start the business, and a contingency plan in the event the self-employment plan targets are not met.

(16) "Suitable gainful employment" has the meaning stated in Labor and Employment Article, §9-670(c), Annotated Code of Maryland.

(17) "Vocational assessment" has the meaning stated in Labor and Employment Article, §9-670(d), Annotated Code of Maryland.

(18) "Vocational evaluator" means a qualified individual who utilizes a comprehensive process that systematically uses the simulated or actual work environment as the basis for vocational assessment and exploration.

(19) "Vocational rehabilitation services" has the meaning stated in Labor and Employment Article, §9-670(e), Annotated Code of Maryland.

(20) "Vocational testing" means standardized interest, aptitude, achievement, and other specific skills tests used to identify areas of interest and aptitudes for various types of work, and compatibilities with different work environments. The types of test may include but are not limited to the Wide Range Achievement Test (WRAT), the General Aptitude Test Battery (GATB), Strong Interest Inventory, the Myers-Briggs Type Indicator, and the Test of Nonverbal Intelligence.

14.09.07.02

.02 Application Procedures for Registration.

A. To apply for registration with the Commission, an applicant shall submit to the Commission:

(1) An application on the form prescribed by the Commission completed in accordance with the directions provided;

(2) Two letters attesting to the applicant's moral character;

(3) Appropriate documentation that the applicant satisfies the education and experience requirements of Labor and Employment Article, §9-6A-09, Annotated Code of Maryland; and

(4) A money order or check in the amount of the application fee established by the Commission.

B. Automatic Registration.

(1) Nurse Case Managers. A nurse case manager certified by the State Board of Nursing is automatically registered with the Commission upon:

(a) Completion of the Commission application form; and

(b) Payment of the fee established by the Commission.

(2) Other Health Practitioners. Any health care provider who is licensed or certified by the applicable State licensing board or commission and who provides vocational rehabilitation services is automatically registered with the Commission upon:

(a) Completion of the Commission application form; and

(b) Payment of the fee established by the Commission.

(3) If another State licensing board or commission's certification is valid for a period of time less than a provider's registration under Regulation .02 of this chapter, the provider shall submit a copy of the provider's certificate or renewal to the Director within 30 days after receiving the certificate or renewal.

C. Waiver of Registration.

(1) The Commission shall keep a list of providers who are not required to be registered with the Commission in accordance with §A or B of this regulation.

(2) A provider who is not required to be registered with the Commission shall file a request for waiver on a form prescribed by the Commission every 2 years.

D. Review of Application.

(1) The Commission shall review applications for registration and requests for waivers.

(2) The Commission may refer an application to the Advisory Committee for review, evaluation, and recommendations.

(3) If an application has been referred to the Advisory Committee for review, the Commission shall place the application under advisement until the Advisory Committee makes its recommendation regarding the applicant.

(4) After the Advisory Committee makes its recommendations, the Commission shall consider the application and recommendations at its regularly scheduled monthly meeting. The Commission need not accept the Advisory Committee's recommendations.

(5) If the application is approved, the Commission shall promptly register the applicant as a provider of vocational rehabilitation services.

E. Term and Renewal of Registration.

(1) A registration is valid for 3 years from the date of issuance.

(2) Notice of renewal and a renewal application shall be:

(a) Sent to each registered provider before the registration's expiration date; and

(b) Returned to the Director by the deadline for renewal.

(3) Requirements for Renewal of Registration.

(a) Continuing Education Requirements.

(i) In order to qualify for renewal of a provider's registration, the provider shall participate in a minimum of 12 hours of continuing education credits in workers' compensation related programs within the 3-year period preceding the application for renewal.

(ii) At least six of the credits specified in §E(3)(a)(i) of this regulation shall be in training or information classes given by the Commission.

(iii) The Commission shall accept credit hours for workers' compensation related programs approved by the Commission.

(b) Along with the renewal application, a provider shall submit appropriate documentation that the provider has satisfied the continuing education requirements specified in §E(3)(a) of this regulation.

(c) If a provider has not completed at least 12 hours of continuing education credits within the 3-year period preceding an application for renewal, the Commission has the sole discretion to determine the sufficiency of efforts by the provider in deciding whether to renew the provider's registration.

14.09.07.03

.03 Hearings on Denial of Application or Request for Waiver.

A. Denial of Application.

(1) If the Commission denies an application or request for waiver, the Commission shall issue an order advising the applicant of the Commission's action.

(2) The applicant may request a hearing by submitting the prescribed Commission form to the Director within 30 days after the date of the order.

B. Hearings and Final Orders.

(1) If a hearing is requested, the Commission shall conduct a hearing which is presided over by a panel of three Commissioners.

(2) After a hearing, the Commission shall promptly issue a final order which shall be decided by at least two of the three Commissioners.

(3) If an applicant fails to request a hearing within the time prescribed by §A(2) of this regulation, the Commission shall issue a final order denying the application.

C. The applicant may appeal a final decision of the Commission in accordance with Labor and Employment Article, §9-737, Annotated Code of Maryland.

14.09.07.04

.04 General Rules for Vocational Rehabilitation Service Practitioners.

A. A practitioner shall consider the best interests of a disabled covered employee in providing vocational rehabilitation services. Unrepresented disabled covered employees shall be treated in the same manner as represented disabled covered employees.

B. A practitioner may not misrepresent the practitioner's duties or responsibilities or the workers' compensation process to disabled covered employees.

C. The vocational rehabilitation practitioner shall exercise independent and professional judgment when performing an assessment or developing a vocational rehabilitation plan.

D. At the initial comprehensive assessment, a practitioner shall advise the disabled covered employee that:

(1) The practitioner's fees are paid by the employer/insurer; and

(2) The practitioner is an independent professional and shall render an opinion based solely on the facts and evidence in the case.

E. Subject to any applicable privilege, a practitioner shall notify all parties of any contact with or about the disabled covered employee, whether that contact was in person, in writing, or made electronically.

F. Unless the disabled covered employee consents in writing, a practitioner may not be present during a medical examination.

G. With the written consent of the disabled covered employee, a practitioner may seek a healthcare provider's opinion following examination.

H. A practitioner shall comply with:

(1) The Commissioner's orders and procedures; and

(2) Standards of practice adopted by the practitioner's State licensing board or commission, if applicable.

I. Penalties. Violation of this regulation may result in the Commission:

(1) Suspending or revoking the practitioner's registration;

(2) Placing the practitioner on probation; or

(3) Reprimanding the practitioner.

14.09.07.05

.05 Standards of Practice for Rehabilitation Counselors and Vocational Evaluators.

A. Scope. This regulation applies only to rehabilitation counselors and vocational evaluators.

B. Standards.

(1) Rehabilitation counselors and vocational evaluators shall use their professional skills to promote a disabled covered employee's active participation in plan development and the rehabilitation process within the disabled covered employee's physical and mental abilities.

(2) Rehabilitation counselors and vocational evaluators shall function within the limits of their defined roles, training, and professional competencies.

(3) Rehabilitation counselors and vocational evaluators may not engage in any activity which may compromise the health, safety, or welfare of the disabled covered employee, and shall avoid continuing a consulting or counseling relationship if it is reasonably expected that the relationship can be of no benefit to the client.

(4) Rehabilitation counselors and vocational evaluators shall demonstrate honesty and objectivity in:

(a) The administration, scoring, interpretation, and utilization of assessment instruments;

(b) The writing of reports; and

(c) Charges for professional services.

(5) Rehabilitation counselors and vocational evaluators may not engage in harassment or discrimination of disabled covered employees on the basis of age, race, creed, national origin, gender, disability, or religious affiliation.

(6) Rehabilitation counselors and vocational evaluators may not engage in any act or omission of a dishonest, deceitful, or fraudulent nature in the conduct of their professional activities.

(7) Rehabilitation counselors and vocational evaluators may not allow the pursuit of financial gain or other personal benefit to interfere with the exercise of sound professional judgment and skills.

(8) Rehabilitation counselors and vocational evaluators may not disparage the competency or ethics of other professionals or agencies in discussions with their clients.

(9) Rehabilitation counselors and vocational evaluators shall perform appropriate and objective vocational evaluations and vocational assessments promptly.

(10) Rehabilitation counselors and vocational evaluators shall work cooperatively in a multidisciplinary effort to provide services leading to suitable gainful employment for an injured worker.

C. Penalties. Violation of one or more of the standards in §B of this regulation may result in the Commission:

(1) Suspending or revoking the practitioner's registration;

(2) Placing the practitioner on probation; or

(3) Reprimanding the practitioner.

14.09.07.06

.06 Complaints Against Practitioners.

A. Complaints.

(1) A complaint concerning a practitioner shall be:

(a) In writing;

(b) On the form prescribed by the Commission; and

(c) Signed under oath by the complainant.

(2) The complaint as filed shall be confidential, unless introduced into evidence at a hearing before the Commission.

(3) All correspondence related to a complaint shall be:

(a) Addressed to the Director of Rehabilitation, Workers' Compensation Commission, 10 E. Baltimore Street, Baltimore, MD 21202; and

(b) Marked CONFIDENTIAL.

B. Preliminary Procedures.

(1) If the Director determines that the complaint may be meritorious, the Director shall:

(a) Promptly notify the practitioner in writing that a complaint has been filed against the practitioner; and

(b) Send the practitioner a copy of the complaint by registered mail.

(2) Within 21 days after receipt of the complaint, the practitioner may:

(a) Respond in writing to the complaint; and

(b) Submit to the Director any additional information that may be relevant to the Director's investigation.

(3) The Director shall ascertain whether the complaint is within the jurisdiction of the Commission or any other health licensing boards or commissions. If the complaint is within the jurisdiction of another licensing board or commission, the Director shall promptly send a copy of the complaint to the appropriate licensing board or commission.

(4) If the Director determines that there is insufficient information to make a fair determination of the conduct alleged in the complaint, the Director may request additional information from the complainant or others.

(5) If the Director requests additional information from the practitioner, the practitioner shall respond within the time specified by the Director. Failure to respond or to participate in the Director's investigation may result in a finding against the practitioner and a reprimand or suspension or revocation of the practitioner's registration.

C. Referral to Commission.

(1) If the Director determines that there is reasonable cause to believe that the practitioner has violated one or more of the Commission's regulations or standards of practice, the Director shall refer the complaint to the Commission for a decision. The Director shall promptly inform the practitioner by registered mail that the complaint has been referred to the Commission.

(2) The practitioner shall respond in writing within 21 days after receipt of notice of the referral. The response shall indicate whether the practitioner:

(a) Intends to defend against the allegations of the complaint; and

(b) Requests a hearing.

(3) If the practitioner does not request a hearing within the time limit specified in §C(2) of this regulation, the Commission may rule on the complaint with or without a hearing. Top of Form

14.09.07.07

.07 Procedures for Hearings on Complaints.

A. Notice of Hearing. The Commission shall send written notice of a hearing to all interested parties at least 30 days before the hearing. The notice shall state the:

(1) Date, time, and place of the hearing; and

(2) Issues or charges involved in the proceeding.

B. Conduct of Hearing.

(1) A hearing on a complaint against a practitioner shall be held before a panel of three Commissioners.

(2) Order of Procedure. The case on behalf of the Commission shall be presented first. The respondent shall then present the respondent's case. After that, rebuttal is permitted.

(3) All parties appearing at hearings have the right to appear in proper person, or by or with counsel.

(4) If a practitioner who has requested a hearing and been served with notice fails to appear for the hearing, the Commission may:

(a) Proceed with the hearing; and

(b) On the evidence presented, make its decision.

C. Records and Transcripts.

(1) The Commission shall prepare an official record which includes all:

(a) Pleadings;

(b) Testimony;

(c) Exhibits; and

(d) Other memoranda or material filed in the proceeding.

(2) A record of the proceeding shall be made at the expense of the Commission. This record need not be transcribed unless requested by a party or by the Commission. The cost of any typewritten transcripts of proceeding, or part of them, shall be paid by the party requesting the transcript.

D. Decision and Order.

(1) After the hearing, the Commission shall promptly issue an order which shall be decided by two out of the three Commissioners.

(2) A copy of the Commission's decision and order shall be delivered or mailed to:

(a) Each party; or

(b) The party's attorney of record.

E. Rehearing.

(1) A party aggrieved by the Commission's decision may move for a rehearing within 10 days after service of the decision and order.

(2) Unless otherwise ordered, a rehearing or a motion for rehearing does not stay the enforcement of the Commission's order, or excuse the persons affected by it for failure to comply with its terms.

(3) The Commission may decide the motion with or without a hearing.

F. Appeals. Either the practitioner or the Director may appeal the final decision of the Commission as provided by Labor and Employment Article, §9-737, Annotated Code of Maryland.

14.09.07.08

.08 Application Procedures for Enrollment of Providers.

A. To enroll with the Commission, the provider shall submit:

(1) An application on the form prescribed by the Commission completed in accordance with the directions provided; and

(2) A complete listing of all registered practitioners employed by the provider.

B. Upon approval of the application, the Commission shall promptly enroll the provider as an enrolled provider of vocational rehabilitation services.

C. Term, Conditions and Renewal of Enrollment.

(1) Enrollment is valid for 2 years from the date of issuance.

(2) The Commission shall provide each enrolled provider with a notice of renewal and a renewal application 30 days prior to the expiration date of the current enrollment.

(3) The enrolled provider shall return the application for renewal to the Rehabilitation Office by the specified deadline for renewal.

(4) The enrolled provider shall update the list of registered practitioners employed by the provider semi-annually.

(5) Unless a provider has enrolled with the Commission, a provider may not be eligible for referral under Regulation .09F of this chapter.

14.09.07.09

.09 Selection of Practitioner.

A. A rehabilitation practitioner shall register with the Commission in accordance with Regulation .02 of this chapter.

B. To be eligible for referral under §F of this regulation, a provider shall enroll with the Commission in accordance with Regulation .08 of this chapter.

C. The Commission website shall provide information regarding enrolled providers including the name, address, website address, and telephone number of the provider.

D. A disabled covered employee may obtain vocational rehabilitation services only in accordance with this regulation.

E. Referral by Agreement or Order.

(1) The parties shall attempt to reach agreement on:

(a) Whether vocational rehabilitation services are appropriate in the case; and

(b) The registered practitioner to provide the vocational rehabilitation services.

(2) If the parties reach agreement on both the propriety of the services and the practitioner, the parties shall complete the prescribed Commission form indicating their agreement and identifying the selected practitioner.

(3) The parties shall file the form with the Commission and send a copy of the form to the selected practitioner.

(4) Unless the practitioner has received a copy of form selecting the practitioner as the individual to provide services, the practitioner may not:

(a) Contact the disabled covered employee directly or through an agent; or

(b) Initiate vocational rehabilitation services.

(5) If the parties are unable to agree that vocational rehabilitation services are appropriate, the dispute shall be resolved in accordance with Regulation .12 of this chapter.

(6) If the Commission determines that vocational rehabilitation services are appropriate, the parties shall attempt to reach agreement on the identity of the registered practitioner to provide the vocational rehabilitation services in accordance with this section.

F. Referral Without Agreement.

(1) If the parties agree that vocational rehabilitation services are appropriate, or the Commission has determined that services are appropriate, but the parties cannot agree on a practitioner, each party has 5 business days from the date the parties were unable to reach agreement to:

(a) Notify the Commission of the dispute; and

(b) Identify three registered practitioners and the enrolled provider for whom the practitioner works, if applicable, for consideration.

(2) Notice of the dispute and identification of the three preferred practitioners and corresponding providers shall be made electronically on a form prescribed by the Commission.

(3) Within 5 days of filing the notice of dispute and identification of three preferred practitioners and corresponding providers, each party shall strike two of the practitioners/providers from the opposing party's list and submit those strikes, by close of business, to the opposing party and to the Director by hand-delivery or facsimile.

(4) The Commission shall select one of the two remaining preferred practitioners and corresponding providers and inform the parties of this selection. All parties are bound by this selection.

(5) If a party fails to submit three registered practitioners and corresponding providers or to submit two strikes, the Commission shall select a practitioner/provider from the opposing party's list.

14.09.07.10

.10 Assessment and Reporting.

A. Comprehensive Vocational Assessment.

(1) As soon as practicable, a practitioner shall meet with the disabled covered employee and conduct a comprehensive vocational assessment in compliance with Labor and Employment Article, §9-670(d), Annotated Code of Maryland.

(2) A nurse case manager providing telephonic medical case management may conduct an initial assessment by telephone.

(3) A comprehensive vocational assessment may include evaluation of the disabled covered employee's:

(a) Age;

(b) Education, including information about education level, courses or transcripts, licenses, and certifications or registrations obtained by the disabled covered employee in the past;

(c) Complete work history, addressing any gaps in employment;

(d) Transferable skills and experience, whether obtained from prior employment, prior courses and training, prior vocational rehabilitation services or plans, or non-work related activities such as hobbies and/or volunteer experience;

(e) Current physical and mental conditions caused by the injury or occupational disease, and the effect of those conditions on the disabled covered employee's ability to work;

(f) Pre-existing physical and mental conditions and the effect of those conditions on the disabled covered employee's ability to work;

(g) Post-injury physical and mental conditions and the effect of those nonrelated conditions on the disabled covered employee's ability to work;

(h) Wage and employment at the time of injury;

(i) Barriers to employment, including whether the barriers can be removed and what is needed to address the barriers;

(j) Current financial status; and

(k) Family supports/psychosocial aspects.

B. Reports.

(1) A practitioner shall:

(a) Prepare a written report within 30 days of the comprehensive vocational assessment;

(b) Prepare periodic progress reports every 30 days showing the activity and type of vocational rehabilitation services provided; and

(c) Submit copies of all reports to the Commission, the employer/insurer, and the disabled covered employee's attorney.

(2) A practitioner shall include the following information in a comprehensive assessment report:

(a) If the practitioner is unable to obtain the information set forth in §A(3) of this regulation, documentation of the practitioner's efforts to secure that information;

(b) A determination of whether the disabled covered employee is able to work and if so, in what capacity, including whether the disabled covered employee can return to work in any capacity with the former employer and whether the disabled covered employee can return to work in a new job based on transferrable skills;

(c) Recommendations for additional testing including, but not limited to, a Functional Capacity Evaluation, psychiatric evaluation, and vocational testing;

(d) If no additional testing is recommended, identification of the order of vocational services to be provided; and

(e) A job analysis, approved by the healthcare provider, for the job or jobs for which the disabled covered employee is able to work if applicable.

(3) A practitioner shall prepare periodic progress reports that contain the following information:

(a) A review of the disabled covered employee's compliance with the vocational rehabilitation plan, including any issues involving attendance, grades, and progression;

(b) A list of the dates the vocational rehabilitation counselor contacted the disabled covered employee and any training site, if applicable;

(c) A description of the work-related skills the disabled covered employee has acquired and a comparison with the vocational rehabilitation plan;

(d) A summary of all actions taken in the past 30 days, including progress on previously recommended actions;

(e) Identification of any barriers preventing completion of the plan and actions taken by the practitioner to address those barriers; and

(f) A statement of whether the disabled covered employee is progressing as expected and will complete the plan by the target end date.

(4) The parties shall provide the Rehabilitation Office with such medical information as the Rehabilitation Office may direct.

14.09.07.11

.11 Vocational Rehabilitation Services and Plans.

A. Hierarchy of Vocational Rehabilitation Services.

(1) In determining the appropriate vocational rehabilitation services reasonably necessary to return a disabled covered employee to suitable gainful employment, a practitioner shall consider each of the factors specified in Labor and Employment Article, §9-673(b), Annotated Code of Maryland.

(2) A practitioner shall document that each factor has been considered either in the vocational rehabilitation plan or in the initial assessment report.

(3) In providing vocational rehabilitation services, a practitioner shall attempt to return a disabled covered employee to suitable gainful employment in accordance with the following order of preference:

(a) Returning the disabled covered employee to the same job with the same employer;

(b) Modifying the same job with the same employer;

(c) Finding a new job with the same employer;

(d) Finding a job with a new employer;

(e) On the job training;

(f) Formally retraining the disabled covered employee for a period of time designed to lead to suitable gainful employment; and

(g) Self-employment.

B. Vocational Rehabilitation Plan—Components.

(1) Vocational rehabilitation plans shall follow the hierarchy of services set forth in §A of this regulation.

(2) If a disabled covered employee is unable to return to suitable gainful employment without the provision of vocational rehabilitation services, a practitioner shall prepare a proposed vocational rehabilitation plan.

(3) A practitioner shall prepare a proposed rehabilitation plan on the vocational rehabilitation plan form prescribed by the Commission and shall complete the form in accordance with the instructions provided.

(4) A practitioner shall document in the proposed rehabilitation plan that each level of the hierarchy of services set forth in §A of this regulation has been considered during plan development.

(5) If the vocational rehabilitation plan includes a job placement plan, the practitioner shall include the following items in the vocational rehabilitation plan:

(a) The specific vocational goals;

(b) The specific types of services to be provided;

(c) Any viable job leads;

(d) A specific timeline including starting and completion dates; and

(e) Any estimated costs necessary to meet the specific vocational goals.

(6) Retraining Plan.

(a) If the vocational rehabilitation plan includes a formal retraining plan, the practitioner shall include the following items in the vocational rehabilitation plan:

(i) The specific vocational retraining goal;

(ii) The estimated costs necessary to meet the specific goal;

(iii) Information about any formal course of study in the retraining plan including the name of the school, titles of classes, course length in weeks, attendance including beginning and ending dates, an itemized cost of tuition, books, and other necessary school charges; and

(iv) Any other required costs.

(b) The practitioner shall attach to the retraining plan the following items:

(i) A copy of the course syllabus;

(ii) The physical requirements of the work for which the retraining will prepare the disabled covered employee;

(iii) Medical documentation demonstrating that the proposed training and field of work are within the disabled covered employee's physical restrictions;

(iv) Reports of all vocational testing and evaluations; and

(v) A recent labor market survey of the field for which the training is proposed.

(c) In the proposed retraining plan, the practitioner shall explain why retraining is recommended, including a discussion of the other options considered and the likelihood that the proposed retraining plan will result in the employee's return to suitable gainful employment.

C. Vocational Rehabilitation Plan—Approval.

(1) The practitioner shall send copies of the proposed vocational rehabilitation plan to all parties.

(2) Within 15 days after receipt of a proposed rehabilitation plan, a party may sign the plan or submit the reason for disagreement, in writing, to all parties.

(3) Lack of response from a party is interpreted to mean that the party consents to the plan.

(4) If the parties agree to the proposed vocational rehabilitation plan, the parties shall submit the plan to the Commission for approval.

(5) The Commission may accept or reject the proposed plan, in whole or in part, and shall pass an order to that effect.

(6) The parties shall attempt to resolve any disagreement concerning the recommendations contained in the proposed vocational rehabilitation plan.

(7) If the parties are unable to reach agreement concerning the recommendations, the dispute shall be resolved in accordance with Regulation .12 of this chapter.

(8) If a hearing is necessary to resolve the dispute, the practitioner shall appear at the hearing to present the practitioner's recommendations.

(9) Expiration of Vocational Rehabilitation Plan.

(a) Fifteen (15) days prior to the expiration date of the Vocational Rehabilitation Plan, the practitioner shall contact all parties and make recommendations to:

(i) Discontinue services;

(ii) Extend services; or

(iii) Develop a new plan in accordance with §A of this regulation.

(b) If the parties are unable to reach agreement concerning the practitioner's recommendations, the dispute shall be resolved in accordance with Regulation .12 of this chapter.

14.09.07.12

.12 Disputes, Noncompliance and Termination.

A. Disputes.

(1) If a dispute or issue arises regarding vocational rehabilitation services, the parties shall file electronically a vocational rehabilitation dispute form, as prescribed by the Commission.

(2) Upon receipt of the vocational rehabilitation dispute form, the Duty Commissioner shall contact the parties by telephone.

(3) If the Duty Commissioner is unable to resolve the dispute, a hearing will be scheduled within 5 business days.

(4) The Commission may award reasonable attorney fees in disputes arising out of vocational rehabilitation issues when deemed necessary given the particular facts of a claim.

B. Noncompliance with Vocational Rehabilitation Plan. If a disabled covered employee is not meeting the employee's responsibilities or is not cooperating with vocational rehabilitation services, a practitioner shall:

(1) Document the factual basis for that determination and the practitioner's efforts to promote the disabled covered employee's participation; and

(2) Promptly notify all parties in writing.

C. Termination of Vocational Rehabilitation Services.

(1) Whenever a practitioner closes a case, the practitioner shall document the reasons for terminating vocational rehabilitation services.

(2) Upon termination of vocational rehabilitation services or case closure, a practitioner shall notify all parties within 5 working days of the:

(a) Reason for the termination or closure; and

(b) Current employment status of the disabled covered employee.

(3) A practitioner shall send a closure report to the Commission within 10 business days after notice of termination on the form prescribed by the Commission.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 08 Guide of Medical and Surgical Fees

Authority: Labor and Employment Article, §§9-309, 9-663, and 9-731, Annotated Code of Maryland

14.09.08.01

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) Ambulatory surgical center (ASC) means any center, service, office facility, or other entity that:

(a) Operates primarily for the purpose of providing surgical services to patients requiring a period of postoperative observation but not requiring overnight hospitalization; and

(b) Seeks reimbursement from payors as an ambulatory surgery center.

(2) "Authorized Provider" means:

(a) A licensed physician's assistant (P.A.), providing services on or after March 24, 2008;

(b) A licensed acupuncturist;

(c) A medical doctor (M.D.);

(d) A doctor of osteopathy (D.O.);

(e) A doctor of chiropractic (D.C.), for services provided within the scope of Health Occupations Article, Title 3, Annotated Code of Maryland;

(f) Podiatrist (D.P.M.);

(g) An optometrist (O.D.);

(h) A certified registered nurse anesthetist (C.R.N.A.);

(i) An occupational therapist (O.T.);

(j) A pharmacist (R. Ph.);

(k) A licensed physical therapist (P.T.);

(l) A psychologist (Ph.D.);

(m) A licensed clinical social worker (L.C.S.W.);

(n) A licensed audiologist;

(o) A licensed speech-language pathologist;

(p) A dentist (D.D.S./D.M.D.); and

(q) Any other health care provider as defined under Health-General Article, §4-301(g)(i), Annotated Code of Maryland.

(3) "Base Unit/Basic Value" means the value assigned by CMS to each anesthesia procedure code based on the difficulty of the anesthesia service and is used to determine a portion of the reimbursement amount of the anesthesia procedure.

(4) "CMS" means the Centers for Medicare and Medicaid Services, the federal agency that administers the nation's Medicare program and partners with the states to administer the Medicaid program.

(5) “CMS-1500” means the standard claim form, maintained by the National Uniform Claim Committee (NUCC), used by a non-institutional provider or supplier to bill Medicare carriers, Medicare administrative contractors, and Medicaid State agencies.

(6) “CPT” means the Physician’s Current Procedural Terminology, copyrighted and maintained by the American Medical Association.

(7) “CPT code” means the five digit numerical code obtained from the CPT in effect when a medical service or treatment is provided.

(8) “CPT modifier” means the numerical code used to indicate that a service or procedure was altered in some way from the stated CPT description.

(9) “Geographic Price Cost Index (GPCI)” means the resource cost difference of providing a service, by geographic region, reflected in the relative work (work), practice expense (PE), and malpractice costs (MP) of the service.

(10) “Healthcare Common Procedure Coding System (HCPCS) “ means one of two coding systems used by CMS: level I, consisting of CPT codes, and level II, used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies.

(11) “Maryland specific conversion factor (MSCF)” means a fixed dollar amount used as a multiplier in calculating the MRA for medical services and treatment, orthopedic and neurological surgical procedures, and anesthesiology services.

(12) “Maximum reimbursement allowable (MRA)” means the amount payable to an authorized provider, unless subject to a private agreement to the contrary, calculated pursuant to this chapter for the provision of medical services and treatment rendered to an individual whose injury or disease falls within the scope of Labor and Employment Article, Title 9, Annotated Code of Maryland.

(13) “Medicare economic index (MEI)” means a measure of the inflation faced by physicians with respect to their practice costs and wage levels as calculated by CMS.

(14) “Medicare Physician Fee Schedule” means the Medicare database, based on the RBRVS, from which the Medicare reimbursement rate is obtained.

(15) “Medicare reimbursement rate (MRR)” means the rate at which Medicare reimburses a services provider based on certain inputs including the CPT/HCPCS code, jurisdiction, year, any applicable CPT modifiers, any federal budget neutrality adjuster, and any Medicare conversion factor.

(16) “Resource based relative value scale (RBRVS)” means the system by which medical providers are reimbursed based on the resource costs needed to provide a given service. Under the RBRVS, CMS assigns each medical procedure a relative value quantifying the relative work (work), practice expense (PE), and malpractice costs (MP) for each service.

(17) “RBRVS relative value unit (RVU)” means the uniform value assigned by CMS to each medical procedure and service identified by CPT/HCPCS code quantifying the work (work), practice expense (PE), and malpractice costs (MP) for each service.

(18) “Time Unit” means a measure of each 15-minute interval, or fraction thereof, during which anesthesiology services are performed.

14.09.08.02

.02 Incorporation by Reference.

The “Official Maryland Workers’ Compensation Medical Fee Guide” (1995) is incorporated by reference.

14.09.08.03

.03 Calculation of the Maximum Reimbursement Allowable.

A. For medical services and treatment provided before August 31, 2001, the MRA shall be the fees set forth in the Official Maryland Workers’ Compensation Medical Fee Guide (1995). For anesthesiology services, the MRA is calculated by adding the Time Units and Base Units/Basic Value and multiplying that sum by a conversion factor: MRA = (Time Units + Base Units) × Conversion Factor.

B. For medical services and treatment provided between August 31, 2001, and August 31, 2004, the MRA shall be calculated by increasing the fees set forth in the Official Maryland Workers' Compensation Medical Fee Guide (1995) by 4 percent.

C. For medical services and treatment provided between September 1, 2004, and January 31, 2006, the MRA shall be calculated by multiplying the MRR by a percentage multiplier as follows:

(1) The MRR is obtained from the Medicare Physician Fee Schedule by utilizing 2004 for the year, Maryland for the state, Baltimore and Surrounding Counties for the locality, the applicable CPT code and any CPT modifier;

(2) The MRA is calculated by multiplying the MRR by 109 percent; and

(3) For anesthesiology services, the MRA is calculated by adding the Time Units and Base Units/Basic Value, multiplying that sum by the CMS 2004 conversion factor multiplied by 109 percent: MRA = (Time Units + Base Units) × CMS 2004 Conversion Factor × 109 percent.

D. For medical services and treatment provided between February 1, 2006, and March 24, 2008, the MRA shall be calculated by multiplying the MRR by a percentage multiplier as follows:

(1) The MRR is obtained from the Medicare Physician Fee Schedule by utilizing 2004 for the year, Maryland for the state, Baltimore and Surrounding Counties for the locality, the applicable CPT code and any CPT modifier; and

(2) The MRA is calculated by multiplying the MRR by the specified percentage multiplier:

(a) For anesthesiology services, the MRA is calculated by adding the Time Units and Base Units/Basic Value, multiplying that sum by the CMS 2004 conversion factor multiplied by 109 percent;

(b) For orthopedic and neurological surgical procedures, excluding minor procedures, the MRA is calculated by multiplying the MRR by 144 percent; and

(c) Except as otherwise provided, the MRA for all other medical services and treatment is calculated by multiplying the MRR by 109 percent.

E. After March 24, 2008.

(1) For medical services and treatment provided after March 24, 2008, the Commission shall utilize the current calendar year CMS Resource Based Relative Value Scale (RBRVS), exclusive of any Federal Budget Neutrality Adjustment Factor or CMS conversion factor, as the basis for calculating the MRA.

(2) The non-facility MRA shall be calculated by multiplying each RBRVS relative value unit (RVU) by each corresponding GPCI, adding those sums, and then multiplying that total by the Maryland specific conversion factor (MSCF) as follows: Non-facility MRA = ((Work RVU × Work GPCI) + (Transitioned Non-Facility PE RVU × PE GPCI) + (MP RVU × MP GPCI)) × MSCF.

(3) The facility MRA shall be calculated by multiplying each RBRVS RVU by each corresponding GPCI, adding those sums, and then multiplying that total by the MSCF as follows: Facility MRA = ((Work RVU × Work GPCI) + (Transitioned Facility PE RVU × PE GPCI) + (MP RVU × MP GPCI)) × MSCF.

(4) For anesthesiology services, the MRA shall be calculated by adding the Time Units and Base Units and multiplying that sum by the MSCF: MRA = (Time Units + Base Units) × MSCF.

(5) In calculating the MRA, the following MSCFs apply:

(a) For anesthesiology services, the MSCF is $19.39;

(b) For orthopedic and neurological surgical procedures, MSCF is $53.77; and

(c) For all other medical services and treatment, except as otherwise provided, the MSCF is $40.70.

F. Ambulatory Surgical Centers.

(1) For medical services and treatment provided at an ASC between September 1, 2004, and January 31, 2006, the MRA is calculated by multiplying the CMS 2004 ASC group payment rate by 109 percent.

(2) For medical services and treatment provided at an ASC between February 1, 2006, and March 24, 2008, the MRA is calculated by multiplying the 2004 CMS ASC group payment rate by 125 percent.

(3) For medical services and treatment provided at an ASC on, or after, March 24, 2008, the MRA is calculated by multiplying the current calendar year ASC MRR by 125 percent.

G. MSCF Annual Adjustment.

(1) Beginning January 1, 2009, an adjustment shall be made to the prior year's MSCFs and percentage multiplier (for ASCs).

(2) The MSCFs for the following year shall be calculated by multiplying the MSCFs in effect on November 1 of the current year by the percentage change in the first quarter MEI of the current year, as published on November 1 of the current year, and adding that amount to the current year's MSCFs.

(3) The percentage multiplier for the following year shall be calculated by multiplying the percentage multiplier in effect on November 1 of the current year by the percentage change in the first quarter MEI of the current year, as published on November 1 of the current year, and adding that amount to the current year's percentage multiplier.

(4) The resulting figures shall be utilized as the new MSCF and percentage multiplier for the following year for the purpose of calculating the MRA under §§E and F of this regulation.

(5) The Commission shall post the new MSCFs and percentage multiplier on its website by December 1.

(6) The resulting new MSCFs and percentage multiplier shall be effective January 1 of the following year.

(7) The Commission shall review the annual adjustment process every 5 years to assure that reimbursement rates are neither inadequate nor excessive.

14.09.08.04

.04 MRA or Fee Not Established.

A. The Commission has not established a medical fee schedule for dental services, durable medical equipment, and pharmaceuticals.

B. For products and services for which the Commission has not established an MRA or medical fee schedule, including dental services, durable medical equipment, and pharmaceuticals, the insurance carrier shall assign a relative value to the product or service.

C. An insurance carrier may base the assigned value on nationally recognized and published relative value studies, or on the values assigned for services involving similar work and resources.

D. Upon application of either party, the amount of reimbursement is subject to review by the Commission under the procedures set forth in Regulation .06 of this chapter.

E. Reimbursement.

(1) Except as provided in §E(2) of this regulation, reimbursement shall be the lesser of:

(a) The MRA amount as established by this regulation; or

(b) The authorized provider's usual and customary charge.

(2) If, in the opinion of a health care provider it is medically necessary to exceed the MRA, the authorized provider shall submit substantiating documentation to the payor with the Form CMS-1500.

F. For relevant CPT/HCPCS level I codes that are not valued by CMS, the Commission shall post MRAs for those codes on its website.

14.09.08.05

.05 Guidelines for Using Values and Codes.

A. The Maryland Workers' Compensation Act, implementing regulations, policies, and guidelines shall take precedence over any conflicting provision adopted or utilized by CMS in administering the CMS program.

B. For coding, billing, reporting, and reimbursement of medical treatment and services, authorized providers shall apply the CPT/HCPCS code and CPT modifier in effect on the date the treatment or service was provided.

C. The Commission shall post instructions for obtaining RVU and GPCI values on its website.

D. RVU and GPCI values shall be obtained utilizing the current year, the locality code for Baltimore and Surrounding Counties (0090101), the applicable CPT/HCPCS code and any CPT modifier.

E. The Commission shall post a link to the Medicare Physician Fee Schedule on its website.

F. The Commission shall post a link to the ASC payment rate instructions on its website.

G. Notwithstanding CMS payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

H. For procedures performed or services rendered after September 1, 2004, a multiple procedure discount is not permitted for physical medicine and rehabilitation services (CPT codes 97010—97799).

I. After September 1, 2004, only one code per session will be reimbursed for CPT codes 97012—97039.

14.09.08.06

.06 Reimbursement Procedures.

A. To obtain reimbursement under this chapter, an authorized provider shall:

(1) Complete Form CMS-1500 in accordance with the written instructions posted on the Commission's website; and

(2) Submit to the employer or insurer the completed Form CMS-1500, which shall include:

(a) An itemized list of each service;

(b) The diagnosis relative to each service;

(c) The medical records related to the service being billed;

(d) The appropriate CPT/HCPCS code with CPT modifiers, if any, for each service;

(e) The date of each service;

(f) The specific fee charged for each service;

(g) The tax ID number of the provider;

(h) The professional license number of the provider; and

(i) The National Provider Identifier (NPI) of the provider.

B. Modifiers.

(1) Modifying circumstances may be identified by use of the relevant CPT modifier in effect when the medical service or treatment was provided.

(2) The identification of modifying circumstances does not imply or guarantee that a provider will receive reimbursement as billed.

C. Time for Reimbursement. Reimbursement by the employer or insurer shall be made within 45 days of the date on which the Form CMS-1500 was received by the employer or insurer, unless the claim for treatment or services is denied in full or in part under §G of this regulation.

D. Untimely Reimbursement. If an employer or insurer does not pay the fee calculated under this chapter or file a notice of denial of reimbursement, within 45 days of receipt of the CMS-1500, the Commission may assess a fine against the employer or its insurer, and award interest to the provider in accordance with Labor and Employment Article, §§9-663 and 9-664, Annotated Code of Maryland, and COMAR 14.09.01.22.

E. Denial of Reimbursement.

(1) If an employer or insurer denies, in full or in part, a claim for treatment or services, the employer or insurer shall:

(a) Notify the provider of the reasons for the denial in writing; and

(b) Mail the notice of denial of reimbursement to the provider within 45 days of the date on which Form CMS-1500 was received.

(2) An employer or insurer who fails to file a notice of denial of reimbursement within 45 days of receipt of the CMS-1500 waives the right to deny reimbursement, and is subject to the provisions of Labor and Employment Article, §§9-663 and 9-664, Annotated Code of Maryland, and COMAR 14.09.01.22

F. Objection to Denial of Reimbursement.

(1) A provider may contest a partial or total denial of reimbursement, by submitting to the Commission the following items:

(a) A "Claim for Medical Services" on a form provided by the Commission;

(b) The Form CMS-1500 that relates to the unpaid claims; and

(c) All correspondence relating to the unpaid claim.

(2) The Commission shall review the items submitted, without hearing, and issue its decision in an Order Nisi.

G. Hearing on Objection to Commission's Order Nisi.

(1) The provider, employer, or insurer may contest the Commission's Order Nisi by filing with the Commission a controversion of medical claim, on a form provided by the Commission, within 30 days of the date of the Order Nisi.

(2) The Commission shall schedule a hearing on the matter and render a decision.

14.09.08.07

.07 Medical Records.

A. Medical records are the basis for determining whether a particular treatment or service is medically necessary and, therefore, reimbursable.

B. Each health care provider is responsible for creating and maintaining legible medical records documenting the employee's course of treatment.

C. Employee medical records shall include the:

(1) History of the patient;

(2) Results of a physical examination performed in conformity with the standard of practice of similar health care providers, with similar training, in the same or similar communities;

(3) Progress, clinical, or office notes that reflect:

(a) Subjective patient complaints;

(b) Objective findings of the provider;

(c) Assessment of the presenting problem;

(d) Any plan or plans of care or recommendations for treatment; and

(e) Updated assessments of patient's medical status and response to therapy;

(4) Copies of lab, x-ray, or other diagnostic tests, if any, that reflect the current progress of the patient and response to therapy; and

(5) Hospital inpatient and outpatient records, if any, including:

(a) Operation reports;

(b) Test results;

(c) Consultation reports;

(d) Discharge summaries; and

(e) Other dictated reports.

D. Writing, Maintaining, and Submitting Medical Records.

(1) Employee medical records shall be submitted to the employer or insurer, or, upon request, to the Commission.

(2) The cost of maintaining medical records is included in the treatment and service fees established by the Official Maryland Workers' Compensation Medical Fee Guide (1995) and this chapter. A provider may not submit a separate fee for writing or maintaining medical records.

(3) Additional Medical Report Fees.

(a) Upon the request of any party or the Commission, a provider shall promptly write and submit the requested additional medical reports.

(b) When additional medical reports are requested by the Commission, a provider may not charge a fee for writing or preparing the additional medical reports.

(c) When additional medical reports are requested by any party, the provider may seek reimbursement under Regulation .06 of this chapter.

(4) Copies of Medical Records and Additional Medical Reports.

(a) Requests for Copies of Medical Records.

(i) A party requesting medical records shall ensure that the request is reasonable and specific.

(ii) Health care providers shall respond promptly to requests for medical records and additional medical reports.

(iii) Health care providers may request clarification regarding which medical records and medical reports are the subject of the request.

(iv) Copies of medical records that were not specifically requested by the payor, are not subject to reimbursement under this chapter.

(b) Fees for Copying.

(i) When requested by the injured employee, injured employee's attorney, the employer, or insurer, copies of medical records and additional medical reports will be reimbursed pursuant to Health-General Article, §4-304(c), Annotated Code of Maryland, and other applicable law.

(ii) Medical record requests by the Commission will be furnished by the provider without charge.

14.09.08.08

.08 Deposition Witness Fee.

A. After March 24, 2008, the Commission no longer regulates the reimbursement of deposition fees through a medical fee schedule.

B. For witness depositions for which a bill has been submitted by the authorized provider before March 24, 2008, the authorized provider shall be allowed a witness fee if the provider submits a bill for the fee using the CPT code for the service.

C. Reimbursement for a deposition is limited to the amount published in the "Official Maryland Workers' Compensation Medical Fee Guide (1995)" for the appropriate CPT code.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 09 Guide for Evaluation of Permanent Disability

Authority: Labor and Employment Article, §§9-309, 9-701, 9-721, and 9-731, Annotated Code of Maryland

14.09.09.01

.01 Incorporation by Reference.

Guides to the Evaluation of Permanent Impairment (American Medical Association, Fourth Edition, 1993) is incorporated by reference.

14.09.09.02

.02 Filing Issues.

A. A claimant alleging permanent disability shall file with the Commission an Issues Form that:

(1) Explicitly claims permanent partial or permanent total disability;

(2) Identifies the body parts at issue; and

(3) Identifies any alleged psychiatric disability.

B. Prior to filing an Issues Form raising permanent disability, the party filing the issue shall have obtained a written evaluation of permanent impairment prepared by a physician, psychologist, or psychiatrist in accordance with Regulation .03 of this chapter.

14.09.09.03

.03 Evaluation of Permanent Impairment.

A. Written Evaluation Required. As evidence of permanent impairment, a party shall submit:

(1) A written evaluation of permanent impairment prepared by a physician; or

(2) In claims where the issue concerns psychiatric impairment, a written evaluation of permanent psychiatric impairment prepared by a licensed psychologist or psychiatrist.

B. When preparing an evaluation of permanent impairment, a physician, psychologist or psychiatrist shall:

(1) Generally conform the evaluation with the format set forth in §2.2 ("Reports") of the American Medical Association's "Guides to the Evaluation of Permanent Impairment";

(2) Use the numerical ratings for the impairment set forth in the American Medical Association's "Guides to the Evaluation of Permanent Impairment", provided that a physician, psychologist or psychiatrist is not required to use the inclinometer evaluation technique specified in §3.3, but instead may use the goniometer technique specified in the "Addendum to Chapter 3";

(3) Include the items listed under the heading "Comparison of the results of analysis with the impairment criteria . . ." in §2.2 ("Reports") of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"; and

(4) Include information on the items required by Labor and Employment Article, §9-721, Annotated Code of Maryland:

(a) Loss of function, endurance, and range of motion; and

(b) Pain, weakness, and atrophy.

C. Numerical Ratings.

(1) A physician, psychologist or psychiatrist preparing an evaluation of permanent impairment may include numerical ratings not set forth in the American Medical Association's "Guides to the Evaluation of Permanent Impairment" for the items listed in §B(4) of this regulation.

(2) If the physician, psychologist or psychiatrist uses other numerical ratings the physician shall include in the evaluation the detailed findings that support those numerical ratings.

D. When reviewing an evaluation for permanent impairment, the Commission shall consider all the items listed in §B of this regulation.

E. The Commission may not approve payment of a physician's, psychologist's or psychiatrist's fee for an evaluation that does not comply with this regulation.

F. This regulation shall apply to all evaluations prepared on or after July 1, 1990.

14.09.09.04

.04 Stipulation for Permanent Disability.

A. A written stipulation to an award for permanent disability shall be filed using the Stipulation of Parties and Award of Compensation form and contain the following information:

(1) The claimant's average weekly wage;

(2) The inclusive dates of any temporary total disability;

(3) The inclusive dates and rate of any temporary partial disability;

(4) A copy of any medical evaluation relied upon;

(5) The percentage of claimant's loss of use or industrial loss of use and the benefits weeks payable;

(6) Any medical expenses claimed;

(7) Any attorney's fees sought by claimant's attorney; and

(8) The signatures of all parties if a written stipulation is submitted.

B. If the claimant is not represented by an attorney, the stipulation shall be accompanied by the following:

(1) All medical information in the possession of other parties; and

(2) A statement signed by the claimant acknowledging that the claimant understands that the stipulation does not foreclose the claimant's future right to benefits under the Workers' Compensation Law, including the right to reopen and the right to continuing medical treatment.

C. The stipulation is not binding on the Commission.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 10 Settlements and Lump Sum Payments

Authority: Labor and Employment Article, §§9-309, 9-402, 9-403, 9-405, and 9-406, 9-701, and 9-722, Annotated Code of Maryland

14.09.10.01

.01 Lump Sum Payment.

A. A claimant seeking a lump sum payment shall file an application with the Commission that:

(1) States specifically the facts and circumstances that the claimant contends justify the lump sum payment; and

(2) Is accompanied by any documents upon which the claimant relies in support of the application.

B. The party who may be required to make the lump sum payment shall file with the Commission a statement showing the outstanding balance of payments due the claimant and indicating whether that party objects to the granting of the application.

C. A hearing on the application shall be scheduled if:

(1) The employer, insurer or other payor does not consent to the lump sum, or

(2) The Commission, upon review of the application, determines a hearing is warranted.

14.09.10.02

.02 Agreements for Final Compromise and Settlement.

A. General Requirements. An agreement for final compromise and settlement of a claim that is submitted to the Commission for approval as required by Labor and Employment Article, §9-722, Annotated Code of Maryland, shall contain the following:

(1) The total amount of settlement proposed;

(2) A payment allocation sheet including the amount of any deductions for attorney's fees, medical fees, and other costs;

(3) The inclusive dates of any temporary total disability;

(4) The date on which the payments under the agreement are to begin;

(5) If any compensation was previously awarded or paid, a statement indicating whether the settlement includes, is in addition to, or is in place of all or part of that compensation;

(6) A statement indicating the rate of payment and whether all or part of the settlement is to be paid in a lump sum;

(7) The claimant's average weekly wage;

(8) The claimant's date of birth and age in years and months;

(9) The total amount of all indemnity benefits paid to claimant;

(10) The gross total of all future payments to be paid pursuant to an annuity (not present value);

(11) If the insurer makes an assignment of any of its obligations to a third party, the settlement agreement shall contain affirmative language confirming that the employer/insurer shall resume its obligation for all remaining payments in the event of default by the third party;

(12) The date of disablement by accidental injury or occupational disease; and

(13) A completed copy of the Settlement Worksheet form, available on the Commission website, attached to the settlement.

B. Future Medical Expenses.

(1) A settlement involving future medical expenses, including future pharmaceutical expenses, may be approved by the Commission provided that the settlement agreement:

(a) Contains a detailed statement explaining how the interests of Medicare have been considered in reaching the settlement; and

(b) Identifies the amount of the proposed settlement:

(i) Apportioned to future medical expenses; or

(ii) Set aside for future medical expenses through a formal set-aside allocation.

(2) The apportionment of the amount of the settlement associated with future medical expenses shall be supported by medical evidence such as a medical opinion or evaluation.

(3) A formal set-aside allocation shall comply with the guidelines established by Medicare for set-aside allocations.

(4) In determining whether a set-aside allocation and settlement may be reviewed and approved by the Centers for Medicare and Medicaid Services (CMS), the Commission shall apply the most current Medicare review thresholds set forth in the memoranda or regulations available on the CMS website.

(5) A settlement within the Medicare review thresholds may be approved by the Commission provided that, in addition to the requirements set forth in §B(1) of this regulation, the settlement agreement contains a statement acknowledging:

(a) That the settlement is within the CMS review thresholds;

(b) That the parties voluntarily have elected not to submit the settlement and formal set-aside allocation to CMS for review and approval; and

(c) That the parties are aware that CMS may refuse to pay for services related to the injury and may assert a recovery claim against any entity, including a claimant, provider, supplier, physician, attorney, or private insurer.

(6) A settlement involving future medical expenses may not be approved if the proposed settlement contains contingency provisions from which the Commission cannot determine the amount of medical expenses, if any, subject to assessment under Labor and Employment Article, §§9-806(a)(2) and 9-1007(a)(2), Annotated Code of Maryland.

C. Special Requirements.

(1) Resolution of Third-Party Liability Claims. When a third-party liability claim has been resolved by settlement or judgment, the agreement settling the workers' compensation claim shall be submitted to the Commission for approval, comply with §§A and B of this regulation, and contain or be accompanied by the following:

(a) A statement of the full amount of compensation paid or to be paid by the employer and insurer;

(b) A statement of the total amount of compensation paid or payable, the amount the employer or insurer is waiving reimbursement from the third-party settlement, the amount of the third-party settlement, the amount of attorney's fee charged in the third-party case; and

(c) A copy of the executed release or judgment.

(2) Dependency Claims.

(a) When the settlement arises in connection with a claim involving a surviving dependent, the agreement submitted to the Commission for approval, in addition to complying with §§A and B, shall contain:

(i) A statement setting forth in factual detail the position of the parties on each issue involved in the claim; and

(ii) The name and address, if known, of any dependent for whom a claim has not been filed or a statement that no other dependents are known to the parties.

(b) The parties shall file with the agreement, if not previously filed in the case, certified copies of the following:

(i) The certificate of death of the deceased employee;

(ii) The autopsy report for the deceased employee, if applicable;

(iii) The certificate of marriage for the dependent and deceased employee, if the dependent is the surviving spouse of the employee; and

(iv) The birth certificate of the dependent, if the dependent is the surviving child of the employee.

(c) When a document or public record required by this chapter was created or issued in a foreign State, the party submitting the document shall comply with the authentication requirements for foreign documents set forth in COMAR 14.09.02.05.

D. Structured Settlements. Agreements for the structured settlement of a claim shall be determined on a case-by-case basis.

E. Medical Report.

(1) An agreement for final compromise and settlement shall be accompanied by all medical reports evaluating the nature and extent of the claimant's disability.

(2) On written request of the parties, the Commission may waive the requirement under §E(1) of this regulation if:

(a) The claim being settled is contested on an issue that denies the claimant's right to any benefits under Labor and Employment Article, Title 9;

(b) The claim has been disallowed by the Commission and is pending on appeal; or

(c) Good cause, that does not involve solely the question of the nature and extent of the claimant's disability, is shown for not requiring a medical report.

F. Hearing.

(1) The Commission may not approve an agreement for final compromise and settlement without a hearing unless the agreement is accompanied by the affidavit of the claimant, on the form prescribed by the Commission, waiving the hearing.

(2) The Commission may, at its discretion, require a hearing even when the affidavit is filed.

14.09.10.03

.03 Assessments on Third Party and Structured Settlements.

A. Third-Party Settlements. In a final compromise and settlement involving third-party liability under Labor and Employment Article, Title 9, Subtitle 9, Annotated Code of Maryland, the assessments for SIF and UEF shall be computed on the amount of compensation paid or to be paid by the employer or insurer for which the employer or insurer may not be reimbursed from the third-party settlement.

B. Structured Settlements.

(1) In case of a structured settlement of a claim, the assessments for SIF and UEF shall be computed on the premium payable by the employer or insurer for any annuity policy purchased on behalf of the employee.

(2) If the parties fail to disclose to the Commission the amount of premium payable by the employer or insurer, then the assessments shall be computed on the total amount of money guaranteed to be paid under the settlement agreement.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 11 Judicial Review Procedures

Authority: Labor and Employment Article, §§9-309, 9-701, 9-731(c) and (d), 9-737, and 9-739, Annotated Code of Maryland

14.09.11.01

.01 Petition for Judicial Review.

A. A party seeking judicial review of a decision of the Commission may file a petition for judicial review in the circuit court within 30 days after the date the Commission's order was mailed in accordance with Labor and Employment Article, §9-737, Annotated Code of Maryland, and the Maryland Rules, 7-201, et seq.

B. A party filing a petition for judicial review shall serve a copy of the petition on the Commission in accordance with Labor and Employment Article, §9-737, Annotated Code of Maryland, and Maryland Rule 7-202(d).

C. A party seeking judicial review of a decision granting or denying attorney's fees shall serve a copy of the petition for judicial review on the Assistant Attorney General assigned to represent the Commission at the Commission's principal office in Baltimore City.

14.09.11.02

.02 Transcript of Proceedings.

A. Unless the parties agree that a transcript is not necessary for review, or the court so orders, the first petitioner shall request and pay for a copy of the transcript of the proceedings before the Commission in accordance with Maryland Rule 7-206.

B. The first petitioner shall file with the Court Reporter Division a written request that the transcript be prepared containing:

(1) The Commission case number;

(2) The date and place of the Commission hearing;

(3) The circuit court case number if known;

(4) The name of the first petitioner; and

(5) An acknowledgement that the first petitioner shall pay the cost of transcription.

C. Upon receipt of the request, the court reporter who recorded the hearing shall advise the first petitioner in writing of the estimated cost of the transcript.

D. The first petitioner shall pay the cost of the transcription.

14.09.11.03

.03 Circuit Court Proceedings.

A. Following the disposition of a petition for judicial review by trial or motion, the prevailing party shall notify the Commission of the circuit court disposition within 30 days after disposition.

B. A Cover Sheet for Action on Claims on Appeal shall be used to notify the Commission of the circuit court disposition and shall be accompanied by:

(1) A true test copy of circuit court order or verdict; and

(2) A copy of docket entries.

C. If a hearing is required, the prevailing party shall file an Issues Form with the cover sheet.

14.09.11.04

.04 Appellate Proceedings.

A. Following the disposition of a case on appeal to the appellate courts, the prevailing party shall notify the Commission of the appellate court disposition.

B. A Cover Sheet for Action on Claims on Appeal shall be used to notify the Commission of the appellate court disposition and shall be accompanied by:

(1) The appellate court opinion and order; and

(2) The appellate court mandate.

C. If a hearing is required, the prevailing party shall file an Issues form with the cover sheet.

14.09.11.05

.05 Record of Subsequent Proceeding Where Case on Appeal.

A. If review of a decision of the Commission has been sought in the circuit or appellate courts, and the Commission exercises its continuing jurisdiction under Labor and Employment Article, §9-742, Annotated Code of Maryland, to decide an issue, the first petitioner/appellant shall file with the Commission a written letter within 5 days of disposition requesting that the Commission:

(1) Prepare a copy of the record of the proceeding in which the Commission exercised its continuing jurisdiction; and

(2) Transmit that record to the circuit or appellate court in which judicial review/appeal is pending within 60 days of the date of the Commission's order.

B. The written letter shall contain:

(1) The workers' compensation claim number;

(2) The claimant's name; and

(3) The caption of the case on appeal including the parties, the name of the court, and case number.

C. Any transcript of the proceeding that is required for inclusion in the record shall be requested by and paid for by the first petitioner or appellant.

D. The petitioner/appellant shall file the written request as soon as possible.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 12 Responsibilities of Insurers

Authority: Labor and Employment Article, §§9-309, 9-404, 9-405, 9-409, 9-410, and 9-744; Insurance Article, §19-406; Annotated Code of Maryland

14.09.12.01

.01 Definitions.

A. In this chapter, the following term has the meaning indicated.

B. Terms Defined.

(1) "Competent Individual" means an individual who has sufficient skill, knowledge, and experience to handle and adjust disputed claims and who has authority to resolve claims without having to routinely contact an out-of-State representative of the insurer.

(2) "Commission designee" means the National Council on Compensation Insurance or any other entity that the Commission, from time to time, may designate as its representative to receive notices required by this regulation.

(3) "Insurance policy" means a policy or binder for workers' compensation insurance under Labor and Employment Article, Title 9, Annotated Code of Maryland.

14.09.12.02

.02 Notices of Insurance, Cancellation, Reinstatement, and Election of Coverage.

A. Notice of Insurance. When an insurance policy is issued or renewed, the insurer issuing or renewing it shall file a Notice of Insurance with the Commission designee within 30 days after the effective date of the policy.

B. Notice of Cancellation.

(1) Required Filing. When an insurance policy is cancelled by the insurer or by the insured, the insurer shall file a Notice of Cancellation with the Commission designee.

(2) Time for Filing.

(a) Cancellation by Insurer.

(i) If the insurer cancels the insurance policy for nonpayment of premium, the Notice of Cancellation shall be filed at least 10 days before the effective date of the cancellation, in compliance with Insurance Article, §19-406(f), Annotated Code of Maryland.

(ii) If the insurer cancels the insurance policy for any other reason, the Notice of Cancellation shall be filed at least 30 days before the effective date of the cancellation, in compliance with Insurance Article, §19-406(a), Annotated Code of Maryland.

(b) Cancellation by Insured. When the cancellation is initiated by the insured, the Notice of Cancellation shall be filed by the insurer within 15 days after the effective date of the cancellation.

C. Notice of Reinstatement — Time of Filing. When an insurance policy is reinstated, the insurer shall file a Notice of Reinstatement with the Commission designee within 15 days after the effective date of the reinstatement.

D. Notice of Insurance, Cancellation, and Reinstatement—Form and Content. A notice of insurance, cancellation, or reinstatement shall contain all the following information:

(1) The employer's name;

(2) All names under which the employer trades;

(3) All nontemporary business addresses of the employer in Maryland;

(4) The employer's federal identification number or, if the employer is not required to have a federal identification number, the employer's social security number;

(5) The insurance policy number; and

(6) The policy period.

E. Notice of Election of Inclusion or Exemption of Coverage.

(1) A person may elect to be a covered employee by filing a Notice of Election with the Commission and with the insurer.

(2) The following types of persons may elect to be covered employees:

(a) Pursuant to Labor and Employment Article, §9-227(b), Annotated Code of Maryland, sole proprietors; and

(b) Pursuant to Labor and Employment Article, §9-219(b), Annotated Code of Maryland, partners.

(3) A person may elect to be exempt from coverage as an employee by filing a Notice of Election with the Commission and the insurer.

(4) The following types of persons may elect to be exempted from coverage:

(a) Pursuant to Labor and Employment Article §9-206(b)(1), officers of a closed corporation;

(b) Pursuant to Labor and Employment Article §9-206(b)(2) and (c), officers of a corporation, other than closed corporation;

(c) Pursuant to Labor and Employment Article §9-206(b)(3) and (4), officers of a farm corporation or professional services corporation; and

(d) Pursuant to Labor and Employment Article §9-206(b)(5), members of a limited liability company.

(5) If an employer changes insurers, a person must file a new Notice of Election with the Commission and with the new insurer.

14.09.12.03

.03 Handling and Adjusting Disputed Claims.

A. An insurer that provides workers' compensation insurance in Maryland shall have in the State competent individuals who:

(1) Handle and adjust each disputed workers' compensation claim for the insurer; and

(2) Possess the knowledge and experience to handle and adjust each disputed claim.

B. If an insurer files issues to dispute a claim, the filing shall be done in the State by competent individuals who:

(1) Handle and adjust each disputed workers' compensation claim for the insurer; and

(2) Possess the knowledge and experience and adjust each disputed claim.

C. Within 10 days of an insurer filing issues to dispute a claim, the insurer shall have an attorney complete and file an Entry of Appearance form in accordance with COMAR 14.09.04.01C(2).

D. Each insurer shall register with the Commission the name, address, telephone number, and email address of a designated representative who can identify the competent individual handling and adjusting each disputed claim.

E. Upon inquiry, the designated individual shall provide the name, address, telephone number, and email address of the competent individual handling and adjusting a claim within 2 business days.

F. If any of the information in §D of this regulation changes, the insurer shall notify the Commission immediately.

G. An insurer that provides workers' compensation insurance in Maryland shall establish a toll-free telephone number through which an insured or claimant, or a representative of an insured or claimant, may make direct telephone inquiries during regular business hours.

14.09.12.04

.04 Failure to Comply.

A. Fine.

(1) An insurer found in violation of Regulation .03 of this chapter may be fined up to $1,000 per offense.

(2) Each day a violation is continued after the first fine is a separate offense.

B. Revocation of Self-Insurance Approval. A violation of Regulation .03 of this chapter that jeopardizes prompt and fair compensation of a Maryland workers' compensation claim may be grounds for the revocation of an employer's self-insurance approval under Labor and Employment Article, §9-403(e)(1), Annotated Code of Maryland.

14.09.12.05

.05 Hearing Procedure.

A. Notice of Agency Action.

(1) If the Commission has reasonable cause to believe that an insurer has violated Regulation .03 of this chapter, the Commission shall give reasonable notice of the alleged violation and the action the Commission proposes to take.

(2) The notice shall state:

(a) The facts that are asserted;

(b) If the facts cannot be stated in detail when the notice is given, the issues that are involved;

(c) The potential penalty that could be imposed;

(d) That the recipient has a right to request a hearing;

(e) That any request for a hearing shall be in writing and received by the Commission within 20 days of the date of the notice; and

(f) That if a hearing is not requested within the time allowed, the Commission shall render its decision on the basis of its own investigation.

B. Notice of Hearing.

(1) If a hearing is requested, the Commission shall mail a notice of the hearing 20 days before the date set for the hearing.

(2) The notice shall state:

(a) The date, time, place, and nature of the hearing;

(b) That the insurer may submit a written statement 5 days before the hearing;

(c) That the insurer may present oral argument at the hearing;

(d) That the insurer may call witnesses and submit documents or other evidence relative to the issues contained in the notice; and

(e) That the insurer may agree to the evidence and waive its right to appear at the hearing.

C. Postponement.

(1) An insurer may request a postponement in writing 5 days before the hearing.

(2) If an insurer fails to appear at a hearing, and has not requested a postponement, the Commission may either:

(a) Proceed with the hearing; or

(b) Make its decision on the record before it.

D. Disposition. A hearing may not be adjourned or continued except upon order of the Commission.

14.09.12.06

.06 Penalty for Failure to Submit Required Case Payment Report.

A. The Commission may assess against an insurer a fine not to exceed $1,000 for any unexcused failure to file a case payment report as required under Labor and Employment Article, §9-313(b), Annotated Code of Maryland.

B. Schedule of Assessments. The schedule of assessments established by the Commission is as follows:

Date	*Amount Not To Exceed*	*Type Action*
41st day	$100	Initial Notice
51st day	250	2nd Notice
61st day	500	3rd Notice
91st day	1,000	Final Notice
120th day	1,000	Referral to Central Collection Unit and Insurance Commissioner

C. In calculating the imposition of an assessment on an insurer, each failure to submit a required report or the submission of an inaccurate or incomplete report is considered a separate violation subject to assessment.

14.09.12.07

.07 Appeal.

An appeal from a decision made under this chapter shall be made in accordance with Maryland Rules 7-200, et seq. and COMAR 14.09.11.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 13 Individual Employer Self-Insurer

Authority: Labor and Employment Article, §§9-309, 9-402, 9-403, 9-405, and 9-406, Annotated Code of Maryland

14.09.13.01

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Acceptable financial indicators" means indicators consistent with comparable industry financial health and performance criteria as reported in rating services such as RMA Annual Financial Statement Studies or equivalent recognized indices.

(2) "Act" means the Maryland Workers' Compensation Act, Labor and Employment Article, Title 9, Annotated Code of Maryland.

(3) "Actuarial report" means a report written by an actuary who is a member of the Casualty Actuarial Society or the American Academy of Actuaries.

(4) "Affiliate" means a member of a group of companies with common ownership but not the company having a direct ownership interest.

(5) "Commission" means the Maryland State Workers' Compensation Commission.

(6) "Investment grade securities" means federal or state bonds accepted by the circuit courts for investment of trust money.

(7) "Irrevocable trust, custodian, safekeeping, or book entry account" means a depository account of monies and investment grade securities held by a Federal Deposit Insurance Corporation bank that agrees to hold amounts ordered by the Commission for a self-insurer that can only be withdrawn by the Commission, or if a trust exists pursuant to the terms of the trust document.

(8) Self-Insurer.

(a) "Self-insurer" means an employer which has been granted the privilege to self-insure its liability and to maintain direct responsibility for the payment of this liability under the Act including any approved subsidiary of the self-insurer.

(b) "Self-insurer" does not include a parent company or affiliate that has guaranteed the payment of the self-insurer's liability.

(9) "State" means the State of Maryland.

14.09.13.02

.02 Application.

A. Requirements.

(1) An initial application for individual self-insurance shall be submitted to the Commission on forms prescribed by the Commission and shall include all required information and documentation required by the Commission.

(2) A nonrefundable fee in the amount established by the Commission shall accompany the application.

(3) The required information on the application shall be fully completed and particularly set forth under oath by the employer or an individual acting on the employer's behalf. The affidavit shall be made upon personal knowledge of the matters set forth in the application. The Commission may require the applicant to supplement or explain any of the matters set forth or to provide additional information that the Commission considers necessary.

(4) Upon receipt of a complete application and all required information and documentation, the Commission shall act upon the application for self-insurance within 60 days.

B. Parental Guarantees and Subsidiaries.

(1) When an employer applying to self-insure is a subsidiary company, the parent company shall provide, on forms prescribed by the Commission, a written agreement adopted by its board of directors which states that the parent company guarantees the payment of all claims incurred by the self-insurer and its affiliates and subsidiaries that are approved under the self-insurance program. The parent company shall further assume liability for the payment of an affiliate's or subsidiary's claims incurred during its period of self-insurance upon termination of the affiliate or parent-subsidiary relationship until formally released by the Commission.

(2) When a subsidiary company applies to self-insure under a parent company's existing self-insurance program, the subsidiary company shall file an application on forms prescribed by the Commission.

C. Approval.

(1) In determining whether an applicant is eligible for self-insurance and in establishing the amount of surety required, the Commission shall consider all relevant factors including the following:

(a) Established record of financial stability and solvency, including:

(i) Net worth or unrestricted net assets of not less than $10,000,000 and at least 20 times average annual incurred claims net of reimbursements for the past 3 years;

(ii) Profitable and positive cash flow from operations 3 out of the last 5 years;

(iii) Acceptable debt-equity ratio;

(iv) Acceptable current and quick ratio;

(v) Acceptable interest coverage ratio; and

(vi) Acceptable financial stability of surety, excess carrier, or letter of credit issuer;

(b) The proposed excess insurance policy limits and retention level;

(c) The experience of the organizational unit or service company processing and handling claims in the State;

(d) Workers' compensation loss history of the applicant; and

(e) The number of years in business, with a minimum of 3 consecutive years before application.

(2) Not-for-profit organizations need not be profitable if all other provisions are satisfied and there are significant investments or endowments and other resources to assure payment of workers' compensation claims.

14.09.13.03

.03 Revocation of Self-Insured Status.

A. Approval for self-insurance privileges shall be continuous unless and until revoked or withdrawn.

B. Deterioration in the financial strength of the self-insurer, which may affect the ability of the self-insurer to pay current and future claims when due, may result in modification or revocation of self-insurance privileges.

C. Failure of a self-insurer to satisfy the Commission of its financial ability to secure compensation to pay current and future claims includes the following conditions:

(1) 3 straight years of losses or negative cash flow from operations;

(2) Negative tangible net worth;

(3) 8 straight quarters of losses;

(4) Noncompliance with lender covenants;

(5) Financial instability of surety, excess carrier, or letter of credit issuer;

(6) Public disclosure of accounting irregularities;

(7) Potential insolvency or bankruptcy; or

(8) Any other issue that shows financial instability.

D. An employer whose self-insurance privileges have been revoked shall continue to provide competent administration of disputed claims. If it is determined by the Commission that the claims are not being competently administered or reported, the Commission shall notify the employer. If the problem is not resolved to the satisfaction of the Commission within a reasonable period of time, the Commission may require the designation of a new claims administrator and the costs shall be borne by the employer.

E. Whenever an employer voluntarily withdraws or is terminated or revoked from the self-insurance program, the Commission shall require the employer to provide all available information regarding case reserves and incurred but not reported estimates of remaining liability while self-insured.

14.09.13.04

.04 Voluntary Withdrawal From The Self-Insurance Program.

A. A self-insurer who voluntarily withdraws its privileges or the privileges of a self-insured subsidiary shall:

(1) Do so in writing to the Commission. The written notice shall be made to the Commission by personal delivery or by certified mail, return receipt requested; and

(2) Provide the date and time of the intended withdrawal and the carrier name, policy number, and effective date of coverage of the insurer assuming the risk.

B. All former self-insurers and their guarantors shall remain responsible for any and all workers' compensation liabilities incurred during the self-insurance period. The incurred liabilities of a subsidiary or division are not subject to transfer to another entity through a sale unless the liabilities are to be fully covered under a workers' compensation insurance policy or a qualified self-insurance program.

14.09.13.05

.05 Revoked and Terminated Self-Insurers.

A. Effective on the date of self-insurance revocation or termination, a revoked or terminated self-insurer shall provide the Commission with written evidence of workers' compensation insurance from an approved commercial carrier or the Maryland Injured Workers Insurance Fund, effective on the date of self-insurance termination.

B. A terminated or revoked self-insurer shall maintain the security, excess policy, and parental guarantee which were in effect for the period while self-insured until released by the Commission.

C. Each year, a terminated or revoked self-insurer shall provide to the Commission, an audited financial statement prepared by an independent certified public accountant. A self-insurer shall provide a separate report on a form prescribed by the Commission on the balance remaining in reserves, including incurred but not reported costs, for the period while self-insured. Any payments made during the year as well as the amount of adjustment made to the reserves from the prior year shall also be included in the prescribed report. The Commission may waive these requirements after 3 years from the date of termination.

D. When the security has been exhausted, the surety or administrator shall make a final accounting to the Commission. The Commission shall direct the transfer of the workers' compensation records associated with the period of self-insurance.

14.09.13.06

.06 Security.

A. Each self-insurer shall, as a condition for the approval and continuation of its self-insurance privilege, provide a qualifying security deposit to secure the payment of compensation. The security is not subject to assignment, execution, attachment, or any legal process whatsoever, except as necessary to guarantee compensation under this chapter. The Commission may waive security requirements for individually self-insured governmental entities.

B. Types of Qualifying Security.

(1) Surety Bond.

(a) A surety bond shall be on a form prescribed by the Commission and issued by a company authorized to transact surety business in this State by the Maryland Insurance Administration.

(b) The surety company shall possess a current A. M. Best Rating of A- or better or a comparable rating by another insurance company rating service acceptable to the Commission.

(2) Letter of Credit.

(a) Requirements.

(i) A letter of credit shall be issued by a Federal Deposit Insurance Corporation member bank on a form prescribed by the Commission and in accordance with the Act.

(ii) A letter of credit shall possess a current financial standing according to Weiss Ratings, Inc. or equivalent rating service of B- or better.

(iii) If the Commission executes a draw down against a letter of credit, the funds shall be wired to a Federal Deposit Insurance Corporation member bank account within the State.

(b) When a self-insurer, active or revoked, provides adequate security after the Commission drawing on the letter of credit, the funds shall be released back to the letter of credit issuer.

(3) Irrevocable Trust, Custodian, Safekeeping Agreement, or Book Entry Account.

(a) The Commission in its discretion may accept an irrevocable trust, custodian, safekeeping agreement, or book entry account for placement of securities issued by the federal government or by any state government in the United States, which is AA rated or better.

(b) Investment grade securities deposited in an irrevocable trust, custodian, safekeeping agreement, or book entry account shall be held for the benefit of the Commission and shall have a fair market value and be redeemable at or above the required security amount at all times.

(c) An irrevocable trust, custodian, safekeeping agreement, or book entry account that contains adequate securities as defined in §B(3)(a) and (b) of this regulation for the benefit of injured employees of the self-insurer may not be used for any other purpose or voided by order of owners, directors, or creditors of the self-insurer, or by order of any court, without specific written authorization of the Commission.

(d) When a self-insurer is revoked or withdraws from the self-insurance program, the securities remain pledged to the Commission to guarantee payment of any claim occurring during the self-insured period.

(e) At any time that the redeemable value falls below the security required, the self-insurer shall provide the additional security within 60 days of notification of deficit by the banking depository or the Commission. Any securities subject to rollover shall be replaced concurrently with the maturity and receipt of proceeds from the rollover.

(f) Any earnings received on these securities shall be returned to the self-insurer.

(g) A request for release of securities, or any part of the securities, shall be in writing to the Commission.

C. Security Deposit Determinations.

(1) Before approval of self-insurance status and periodically after that, the Commission, in establishing and adjusting security deposit amounts, shall consider, among other conditions or facts relevant to security and prompt payment of compensation, the following:

(a) Claims experience and reserves;

(b) Financial condition and performance;

(c) Safety record and program;

(d) Potential for catastrophic event;

(e) Compliance with law and regulations; and

(f) Reliability of audited financial statements, and reports of payroll, accident, claims, and reserve data.

(2) A self-insurer shall, after the third full year of an approved plan, or earlier if required by the Commission, and tri-annually after that, or at a time frequency determined by the Commission, provide an independent actuarial study prepared in accordance with actuarial standards of practice as a basis for security deposit determination. The Commission may use reported reserve amounts in addition to a factor for related administrative costs and the potential modifiers in this subsection to establish the security amount.

(3) The Commission may waive this requirement for security for individually self-insured governmental entities.

14.09.13.07

.07 Excess Insurance.

A. The applicant for self-insurance shall purchase excess insurance in an amount determined by the Commission.

B. Specific retention amounts as defined in the excess policy shall be no higher than 5 percent of net worth or unrestricted net assets. The specific excess limit shall be not less than 20 times the specific retention amount or as otherwise ordered by the Commission.

C. The applicant for self-insurance may request the intended specific retention amount and specific excess limit. The Commission shall order the approved amounts.

D. The applicant for self-insurance shall provide proof of excess insurance by filing a copy of the excess certificate with the Commission within 30 days of its issuance or renewal.

E. The Commission may waive this requirement for excess insurance for individually self-insured governmental entities.

14.09.13.08

.08 Reporting Requirements.

A. Financial Reports.

(1) A self-insurer shall file an annual audited financial report and 10K reports, if applicable, with the Commission within 120 days of the end of the reporting period. An extension may be granted upon written request of the Commission.

(2) The self-insurer shall submit interim reports as requested by the Commission.

B. Claims Reports.

(1) A self-insurer shall maintain true and accurate records of workers' compensation paid and incurred costs and case reserves on each claim in indemnity, medical, and allocated costs paid and reserves for each claim. This information shall be provided annually to the Commission or more frequently if requested by the Commission.

(2) Reports submitted by a service company or third-party administrator on behalf of the self-insurer shall be treated as if they were submitted by the self-insurer directly.

C. Penalty.

(1) After notice and opportunity for a hearing, the Commission may assess an individual employer self-insurer that the commission finds to be in violation of this regulation a fine not exceeding $1,000 for each violation.

(2) Failure to pay a fine assessed under this section may result in revocation of self-insurance status.

D. Reserves. A self-insurer shall evaluate and maintain adequate records of the past, present, and future liability of all claims incurred under its self-insurance program, including their closed and current claims in addition to reserves for future anticipated costs. Future anticipated costs shall represent the expected total cost of compensation over the life of each claim, based on all available information at the valuation date. Annually required reserves reports shall also include estimates of incurred but not reported costs applicable to both open claims, closed claims and claims which have occurred, but have not yet been reported.

E. Change In Ownership Or Financial Condition.

(1) A self-insurer shall notify the Commission within 30 days of a change in majority ownership. Existing parental guarantees may not be released until an acceptable replacement guarantee is received by the acquiring parent company.

(2) A self-insurer or parent guarantor that amends its organizational documents to change its identity, status, or business structure, including merger, acquisition, and disposition, shall promptly notify the Commission in writing. All legal agreements and instruments that obligate the self-insurer, guarantors, excess carrier, or security provider shall be updated by the provider within 30 days. The Commission may request copies of documents or information considered necessary to determine whether an action has affected the ability of the employer to self-insure.

F. Bankruptcy and Closure. A current or former self-insurer shall notify the Commission within 10 days by certified mail, return receipt requested, of a petition for bankruptcy or closure filing and shall provide an updated claims report as defined in Regulation .08B of this regulation.

14.09.13.09

.09 Proceedings.

A. An order of denial of an application for self-insurance or a change in terms or conditions of the self-insurance program shall be served upon the designated representative or representatives of the self-insurer by personal delivery or by certified mail, return receipt requested. The order shall include the reason or reasons for denial.

B. Upon receipt of the order of denial of an application for self-insurance or a change in terms or conditions of the self-insurance program, a party may request a hearing before the Commission within 15 days. A hearing shall be set as soon as practicable but no sooner than 20 days.

C. A show cause order for termination or revocation of the self-insurance program shall be served upon the designated representative or representatives of the self-insurer by personal delivery or by certified mail, return receipt requested. The order shall contain the reason or reasons for the termination or revocation and date, time, and place of the hearing.

D. A self-insurer who has been provided an order of denial or a show cause order may, at its option, submit a written statement before the date set for the hearing and, at the hearing, may appear and present oral argument or other evidence on the issues contained in the hearing notice. When a written statement is presented, 15 copies shall be served on the Commission at least 5 days before the date set for the hearing.

E. Under exigent circumstances, the Commission may set a hearing in a time period less than prescribed in §D of this regulation.

14.09.13.10

.10 Examinations.

The costs of examinations pursuant to Labor and Employment Article, §9-405(e), Annotated Code of Maryland, shall be paid by the Commission. If the self-insurer is in default, the expense of the examination shall be paid by the self-insurer.

14.09.13.11

.11 Access To Workers' Compensation Records of Self-Insurer.

A self-insurer or its designee shall immediately upon notification by the Commission, or upon discontinuance of workers' compensation payments for the period while self-insured, release all relevant records to the Commission or the agent for the surety responsible for the continuation of workers' compensation payments.

14.09.13.12

.12 Confidentiality of Information.

The Commission may not release to the public any information concerning a self-insurer other than confirmation that an employer is individually self-insured, its address, the effective date of the insurance program, and the name of the claims administrator, unless by order of a court, or as required by State or federal law.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 14 Governmental Group Self-Insurance

Authority: Labor and Employment Article, §§9-309, 9-402, and 9-404, Annotated Code of Maryland

14.09.14.01

.01 Definitions.

A. For the purposes of this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Actuarially calculated ultimate loss liability" means the sum of open claim reserves plus an estimate of incurred but not reported losses on open and closed claims through the cutoff date for the estimate in accordance with generally accepted actuarial principles.

(2) "Adequate consideration" has the meaning set forth in the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1108(17)(B).

(3) "Administrator" means a person or entity designated by the Board of Trustees for a purpose authorized by this regulation.

(4) "Board of Trustees" means the elected governing body of a governmental group self-insurance fund.

(5) "Elect" means either:

(a) Direct election by the members of the governmental group fund;

(b) Appointment by the Board of Directors of a governmental entity member organization; or

(c) Appointment by the Board of Directors of the governmental group or sponsoring organization.

(6) "Exchange traded fund" or "ETF" means an equity fund or bond fund designed to replicate the performance of a major broad market United States, international, or global index and publicly traded on an American Stock Exchange.

(7) "Fiduciary" means:

(a) An individual or group of individuals as defined in the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1102(21)(A);

(b) A member of the Board of Trustees;

(c) A member of an investment committee of the Board of Trustees; and

(d) An administrator.

(8) "Fiscal agent" means the entity employed by the Board of Trustees to hold the monies of the Fund.

(9) "Fund" means the governmental self-insurance group fund established pursuant to Labor and Employment Article, §9-404, Annotated Code of Maryland, and this chapter.

(10) "Party in interest" means:

(a) An administrator;

(b) A fiduciary;

(c) A member of the Fund, any of whose employees are covered by the Fund;

(d) A service company;

(e) A trustee;

(f) A fiscal agent;

(g) A spouse, ancestor, lineal descendent, or spouse of a lineal descendent of a person set forth in §B(10)(a) — (f) of this regulation;

(h) A corporation, partnership, trust or estate of which 50 percent is owned directly or indirectly by a person set forth in §B(9)(a) — (f) of this regulation;

(i) An employee, officer, director or 10 percent or more shareholder of an entity or person set forth in §B(10)(a) — (f) of this regulation; and

(j) A 10 percent or more partner or joint venturer of an entity or person set forth in §B(10)(a) — (f) of this regulation.

(11) "SEC" means the United States Securities and Exchange Commission.

(12) "Service company" means an organization, company, or person hired to perform a function of the Fund's day-to-day operations including, but not limited to:

(a) Adjusting claims;

(b) Performing safety engineering;

(c) Compiling statistics and preparing premium, loss, and tax reports;

(d) Preparing other required fund reports;

(e) Developing members' premiums and fees;

(f) Managing the investment of all or part of the Fund's assets; and

(g) Providing advisory services, including advice on investment objectives, asset allocation, manager search, and performance monitoring.

(13) "Sponsoring organization" means the governmental group that has been approved for joint self-insurance coverage under Labor and Employment Article, §9-404, Annotated Code of Maryland.

(14) "Surplus monies not needed to meet current obligations (surplus monies)" means monies not needed to pay current Fund:

(a) Expenses;

(b) Obligations;

(c) Open claim reserves; and

(d) Incurred, but not reported, claim reserves.

14.09.14.01-1

.01-1 Application.

A. Application for governmental group coverage for the express purpose of establishing a group self-insurers' fund, to be administered under the direction of an elected board of trustees, and to provide workers' compensation coverage for a group of public employers of the same type of unit, shall be made to the Workers' Compensation Commission.

B. The application shall be made on a prescribed form and shall contain answers to all questions and shall be accompanied by the application fee in the amount as may be approved by the Commission from time to time.

C. Additional Requirements. The application, as submitted by the initial board of trustees of self-insurers' fund, shall be accompanied by all of the following:

(1) A copy of the bylaws of the proposed group self-insurers' fund.

(2) An individual application of each member of the group applying for coverage in the fund.

(3) A current financial statement and a budget report that shows planned expenditures are funded.

(4) Evidence of the financial ability of the group to meet its obligations under the Workers' Compensation Law.

(5) A composite listing of the estimated standard premium to be developed by each member of the group individually and in total as a group.

(6) Proof of payment by each member of not less than 25 percent of the estimated annual standard premium into a designated depository. For governmental entities, a letter of intent signed by the responsible financial officer pledging payment within 10 days of the approval of the fund by the Commission may constitute proof of payment.

(7) A confirmation of excess insurance by an authorized carrier in an acceptable amount and which complies with the requirements in Regulation .08 of this chapter.

(8) Designation of a qualified employee or administrator of the association or group, or a qualified service company with a copy of the signed service agreement.

(9) Designation of the initial board of trustees.

(10) Proof of a fidelity bond and errors and omissions policy in a form and amount acceptable to the Commission.

(11) If required, a surety bond written by an authorized carrier in an amount acceptable or other acceptable security.

(12) A copy of a trust and indemnity agreement which shall be subject to approval by the Commission. The agreement shall contain a provision jointly and severally binding the group and each member of it to comply with the provision of the Workers' Compensation Law.

(13) A breakdown of all projected administrative expenses for the fund year in an amount and as a percentage of the annual standard premium collected.

(14) Proof, satisfactory to the Commission, that the annual gross premiums of the fund will not be less than $500,000. The premium collected from each member shall be computed by applying the appropriate manual rates per payroll code classification and multiplying the manual rate by an experience modification factor, if the modification factor is applicable.

(15) Proof that the fund has within its own organization ample facilities and competent personnel to service its own program with respect to underwriting matters and industrial safety engineering or shall contract with a qualified service company or employer adjusters to provide these services. A qualifiedservice company shall be used to handle claims adjusting and reporting of loss data.

14.09.14.02

.02 Approval and Review.

A. After considering the application and all supportive data, the Commission shall either grant approval or advise the trustees of the governmental self-insurers' group of the requirements to be met before approval is granted. The group shall be given 30 days from the receipt of the notice in which to comply with the requirements. The self-insured authority may not become effective until there is proof that all requirements for self-insured approval have been met.

B. The group may, at the discretion of the Commission, be granted additional time to meet the requirements for the self-insured program. A request for an extension of time shall be made in writing by the group within the 30-day compliance period. If the Commission does not receive proof that all requirements for the self-insured program have been met within the time prescribed, the application shall be considered withdrawn.

C. Upon meeting the requirements, the group shall receive a formal certificate approving its status as a self-insurer. The privilege shall be extended until denied.

14.09.14.03

.03 Members Admission and Termination.

A. After the inception date of the fund, prospective new members of the fund shall submit an application for membership to the board of trustees, or its administrator. The trustees or administrator may approve the application for membership pursuant to the bylaws of the governmental group self-insurers' fund. The application for membership shall then be filed with the Commission, and membership shall take effect on the date approval is granted by the Commission.

B. Individual members may elect to terminate their participation in a governmental group self-insurers' program or be subject to cancellation by the governmental group fund pursuant to the bylaws of the fund. However, termination or cancellation may not take place for at least 30 days after notice of the Commission of the termination or cancellation from the governmental group fund.

14.09.14.04

.04 Reports to the Commission.

A. Reports as to financial standing, payroll records, insurance coverage, accident experience, compensation payments, and such other reports as are required to be filed shall be made at the following times and in the following manner:

(1) Each fund shall file a statement of financial condition annually prepared by a certified public accounting firm. The financial statement shall show evidence that the fund has surplus sufficient to pay 1 year of estimated claim payments.

(2) Summary loss data shall be filed on each fund member within 60 days after the annual evaluation date of the losses being reported, in a manner as prescribed. Full actuarial reports and loss runs shall be provided annually. The Commission may request these reports more frequently.

(3) Classified, audited, and properly limited payrolls on each fund member shall be submitted on an annual basis or upon special request on forms prescribed.

(4) A certified copy of the minutes of all trustee meetings shall be submitted by the fund administrator within 30 days of approval but not less than 45 days after the meeting date.

(5) Members of a governmental self-insurers' group shall be subject to an experience rating plan for the purpose of determining the modified insurance rate to develop compensation premiums. The experience rating formula promulgated by the National Council on Compensation Insurance or other formula approved by the group and the Commission shall be used in determining the modified premium. Annually, or as otherwise prescribed, the modified premium for each member shall be approved by the trustees.

(6) The trustees of any governmental group fund may apply a penalty rate in excess of the normal premium to any risk with an unfavorable loss experience, provided the members and the Commission are notified in writing before the effective date of the change in rates.

B. Any fund which fails or refuses to file the above reports within the time limits prescribed in these regulations or whose filed reports indicate the fund is not operating in accordance with these regulations shall be notified that its authority to be self-insured shall be terminated and the grounds for the termination. The fund may request a hearing in accordance with the regulation.

14.09.14.05

.05 Trustee Responsibilities.

A. Trustee Election.

(1) Trustees shall be elected or appointed for a stated term of office.

(2) A trustee may not be an owner, officer, or employee of a service company with which the Board of Trustees contracts for a purpose authorized by this chapter, except that a Trustee may be an employee of the governmental group or sponsoring organization.

B. Delegation of Authority to Administrator.

(1) Subject to final approval by the Commission, the Board of Trustees may delegate authority to perform specific functions to an Administrator including, but not limited to, the authority to:

(a) Contract with a service company and other providers;

(b) Determine the premium charged to and refunds payable to members subject to the restrictions of the Commission;

(c) Invest surplus monies subject to the restrictions set forth in this regulation; and

(d) Approve applications for membership.

(2) The Board of Trustees shall include in the written minutes of trustee meetings the specific authority delegated to an administrator pursuant to this section.

(3) The Board of Trustees shall submit a copy of the minutes under §B(2) of this regulation to the Commission for approval.

(4) An Administrator designated by the Board of Trustees:

(a) May not be an owner, officer, or employee of a service company with which the Board of Trustees has contracted for a purpose authorized by this chapter, except that the Administrator may be an employee of the governmental group or sponsoring organization; and

(b) Shall furnish a fidelity bond, with the Fund as obligee, in an amount, as determined by the Commission, sufficient to protect the Fund against misappropriation or misuse of any monies or securities.

C. Authority of Board of Trustees.

(1) The Board of Trustees may not:

(a) Extend credit to individual members for payment of premiums other than normal premium payment plans;

(b) Utilize any of the monies collected as premiums for any purpose unrelated to the Fund's workers' compensation program; or

(c) Borrow any monies from the Fund or in the name of the Fund:

(i) Without obtaining the prior approval of the Commission; or

(ii) For the purpose of engaging in an investment activity pursuant to this chapter.

(2) The Board of Trustees may:

(a) Direct the administration of the Fund;

(b) Approve applications for membership in the Fund;

(c) Invest surplus monies subject to the restrictions set forth in Labor and Employment Article, §9-404(a), Annotated Code of Maryland, and this chapter; and

(d) Contract with a service company or other provider for a purpose authorized by this chapter.

(3) The Board of Trustees shall:

(a) Retain control of monies collected or disbursed from the Fund;

(b) Establish a claims fund sufficient to cover payment of the entire aggregate loss fund as defined in any aggregate excess policy required by the Commission;

(c) Establish a trustee fund sufficient to pay the administrative costs of the Fund and from which all administrative costs and other disbursements shall be made;

(d) Establish a revolving fund, to be replenished from time to time from the claims fund, for use by the Fund's staff or an authorized service company;

(e) Arrange for the annual audit of the accounts and records of the Fund by an independent certified public accountant, copies of which shall be filed with the Commission no later than 5 months after the close of the Fund fiscal year; and

(f) Determine the premiums charged to and refunds payable to members.

D. Use of Service Company.

(1) The Board of Trustees may contract with a service company to perform any function not specifically reserved to the Board of Trustees.

(2) Prior to entering into a contract with a service company or other provider for a purpose authorized by this chapter, the Board of Trustees or Administrator shall provide to the Commission satisfactory proof that the service company or provider:

(a) Is covered by a fidelity bond, with the Fund as obligee, in an amount sufficient to protect monies over which the service company or provider exercises control;

(b) Maintains fiduciary liability insurance, and if not, how the Fund's interests are protected;

(c) Possesses experience and expertise relevant to the activity that the service company or provider has been contracted to provide;

(d) Holds the qualifications required by the state or federal agency responsible for regulating the activity that the service company or provider has been contracted to provide; and

(e) Is licensed, registered, or exempt from licensing or registration, with the state or federal agency responsible for regulating the activity that the service company or provider has been contracted to provide.

E. Prohibited Transactions.

(1) Except as provided in §E(3), a fiduciary with respect to the Fund may not cause the Fund to engage in a transaction, if the fiduciary knows or should know that such transaction constitutes direct or indirect:

(a) Sale, exchange, or leasing of property between the Fund and a party in interest;

(b) Lending of money or other extension of credit between the Fund and a party in interest;

(c) Furnishing of goods, services, or facilities between the Fund and a party in interest;

(d) Transfer to, or use by or for the benefit of, a party in interest, of an asset of the Fund; or

(e) Engaging in investment, or other activity not provided for in the approved annual investment plan, this chapter, or Labor and Employment Article, §9-404(a), Annotated Code of Maryland.

(2) Except as provided in §E(3) of this regulation, a fiduciary may not:

(a) Deal with Fund assets in the fiduciary's own interest or for the fiduciary's own account;

(b) Act in a transaction involving the Fund on behalf of a party whose interests are adverse to the interest of the Fund or its members; or

(c) Receive any consideration for the fiduciary's own personal account from a person dealing with the Fund in connection with a transaction involving the assets of the Fund.

(3) The prohibitions in §E(1) and (2) of this regulation do not apply to the following transactions:

(a) Contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the Fund and its workers' compensation insurance program, if not more than reasonable compensation is paid for those services; or

(b) Transactions described in §E(1) and (2) of this regulation between the Fund and a person that is a party in interest, other than a fiduciary, who has or exercises any discretionary authority or control with respect to the investment of the Fund assets involved in the transaction, or who renders investment advice, within the meaning of Regulation .01B(7)(a) of this chapter, with respect to those assets, solely by reason of providing services to the plan or solely by reason of a relationship to such a service provider, but only if in connection with such transaction the Fund receives no less, or pays no more, than adequate consideration as defined in Regulation .01A(2) of this chapter.

(4) Upon application, the Commission may authorize other exemptions for fiduciaries or transactions.

14.09.14.06

.06 Funds, Advance Premium Discounts, Surplus Distribution, Deficits.

A. The trustees of any group self-insurers' fund may not allow advance premium discounts to any member in excess of that allowed by the excess insurance underwriter, subject, however, to a maximum of 15 percent of their standard premium.

B. Any surplus monies for a fund year in excess of the amount necessary to fulfill all obligations under the Workers' Compensation Law for that fund year, including a provision for claims incurred but not reported, may be declared to be refundable by the trustees at any time, and the amount of the declaration shall be a fixed liability of the fund at the time of the declaration.

C. The date of payment shall be as agreed by the trustees except that surplus monies not needed to satisfy the loss fund requirements, that is, trustees' funds, may be refunded immediately after the end of the fund year with the approval of the Commission. The intent of this section is to ensure that sufficient monies are retained to assure that total assets are greater than total liabilities for each fund year.

D. In the event of a deficit in any fund year, the deficit shall be made up immediately from any of the following:

(1) Unencumbered surplus from a fund year other than the current fund year;

(2) Trustees' funds;

(3) By assessment of the membership of the deficit fund year if ordered; or

(4) By such alternative method as the Commission may approve.

E. The Commission shall be notified before any transfer of unencumbered surplus funds.

14.09.14.07

.07 Excess Insurance.

A contract or policy of aggregate or specific excess insurance may not be recognized in considering the ability of an applicant to fulfill its financial obligations under the Workers' Compensation Law, unless the contract or policy complies with all of the following:

A. Is issued by a casualty insurance company authorized to transact this business in this State and is rated A- or above by AM Best or equivalent.

B. Is not cancelable or nonrenewable unless written notice by registered or certified mail is given to the other party to the policy and to the Commission not less than 30 days before termination by the party desiring to cancel or not renew the policy.

C. Any contract or policy containing any type of commutation clause shall provide that any commutation effected thereunder does not relieve the underwriter of further liability in respect to claims and expenses unknown at the time of the commutation or in regard to any claim apparently closed at the time of initial commutation which is subsequently reopened by or through a competent authority. If the underwriter proposes to settle their liability for future payments payable as compensation for accidents occurring during the term of the policy by the payment of a lump sum to the employer, to be fixed as provided in the commutation clause of the policy, then not less than 30 days prior notice of the commutation shall be given by the underwriters or their agent by registered or certified mail. If any commutation is effected, then the Commission shall have the right to direct that the sum be placed in trust for the benefit of the injured employee entitled to the future payments of compensation.

D. If a governmental group self-insured employer becomes insolvent or is unable to make compensation payments, the excess carrier shall make, directly to claimants or their authorized representatives, such payments as would have been made by the excess carrier to the employer after it has been determined that the retention level has been reached on the excess contract.

E. All of the following shall be applied toward the reaching of the retention level in the aggregate excess contract:

(1) Payments made by the employer;

(2) Payments due and owing to claimants of the employer;

(3) Payments made on behalf of the employer by any surety bond under a bond required by the Commission.

F. Copies of the complete policies of excess insurance shall be filed with the Commission, together with a certification that these policies fully comply with the regulations of the Workers' Compensation Law.

14.09.14.08

.08 Investments Authorized.

A. Conditions to Investing.

(1) Prior to engaging in an investment activity under this chapter, the Board of Trustees shall:

(a) Fully fund the actuarially calculated ultimate loss liability of the Fund; and

(b) Submit to the Commission for approval an Annual Investment Plan that satisfies the requirements of this regulation.

(2) The Annual Investment Plan submitted to the Commission shall include:

(a) A statement of investment policy and current year objectives;

(b) A complete asset allocation study;

(c) Projected investment activity for the coming year by asset allocation group; and

(d) A signed acknowledgement from any fiduciary acknowledging his or her fiduciary responsibilities and the prohibited transactions set forth in Regulation .06E of this chapter.

B. Investing of Surplus Monies in Insured and Government Obligations.

(1) The Board of Trustees may invest all surplus monies not needed to meet current obligations in:

(a) Investments authorized by State Finance and Procurement Article, §6-222, Annotated Code of Maryland;

(b) United States Government Bonds or Treasury Notes;

(c) Investment shares accounts in any savings and loan association whose deposits are insured by a federal agency; and

(d) Certificates of deposit issued by a duly chartered commercial bank.

(2) Except as provided in §B(3) of this regulation, the Board of Trustees:

(a) Shall limit deposits in savings and loan associations and commercial banks to institutions in this State; and

(b) May not deposit more than the federally insured amount in any one account.

(3) Notwithstanding §B(2) of this regulation, the Board of Trustees may deposit more than the federally insured amount in any one account if the amount does not exceed:

(a) 5 percent of the combination of surplus and undivided profits and reserves as currently reported for each bank in this State in the banking division annual report of the Financial Institution Bureau of the Department of Commerce (banking control); or

(b) $500,000 per institution.

C. Investing of Surplus Monies in Equities.

(1) The Board of Trustees may, subject to the requirements of this chapter, invest a maximum of 30 percent of surplus monies not needed to meet current obligations in equities.

(2) Of the monies that may be invested in equities pursuant to §C(1) of this regulation, the Board of Trustees may not invest more than:

(a) 33-1/3 percent, at cost, or 50 percent at market value, in any single equity fund, bond fund, or ETF, including any single country, commodity, or sector fund; and

(b) 5 percent, at cost, or 8 percent at market value, in any single listed equity, right, depositary receipt, or convertible security.

(3) Notwithstanding the investment allocation restrictions in §C(2) of this regulation, in the case of an equity investment whose weighting is greater than 5 percent of the applicable benchmark index, the Board of Trustees may

be permitted to equal-weight the equity investment at cost and hold a market value weighting not to exceed 1-1/2 times the equity investment's index weighting.

(4) The Board of Trustees may invest in only the following equities:

(a) Preferred stock of a solvent institution that is:

(i) Not in default of dividend, principal, or interest payments on any preferred stock or debt instrument; and

(ii) Created or existing under the laws of the United States, Canada, a state, or a province of Canada;

(b) Common stock of a solvent corporation created or existing under the laws of the United States, Canada, a state, or a province of Canada that is:

(i) Not in default of dividend, principal, or interest payments on any preferred stock or debt instrument;

(ii) Publicly traded on an American stock exchange; and

(iii) Subject to the rules and regulation of the SEC;

(c) Common Stock Mutual Funds and Bond Mutual Funds created by investment managers that are formed and operated under the laws of the United States, Canada, a state, or a province of Canada that are:

(i) Publicly traded and readily marketable;

(ii) Offered for purchase and redemption to the public; and

(iii) Are subject to the rules and regulation of the SEC and the existing laws and regulations of a State, province, or nation in which they reside; and

(d) An ETF that is formed and operated under the laws of the United States, Canada, a state, or a province of Canada and that is:

(i) Readily marketable;

(ii) Offered for purchase and redemption to the public; and

(iii) Subject to the rules and regulation of the SEC and the existing laws and regulations of the state, province, or nation in which it resides.

14.09.14.09

.09 Reporting Requirements and Corrective Action Plans.

A. The Board of Trustees shall:

(1) Submit quarterly reports regarding the status or condition of investments made pursuant to this chapter, including quarterly investment statements; and

(2) Submit any additional information requested by the Commission under §B of this regulation.

B. The Commission may direct the Board of Trustees to submit to the Commission:

(1) A written explanation of its investment strategy and performance;

(2) A written proposed corrective action plan; and

(3) Any additional information concerning these investments that the Commission deems relevant.

C. The Commission may order the Board of Trustees to implement a corrective action plan, to convert its investments to the investments authorized in Regulation .07B of this chapter, and to take any other action the Commission deems necessary.

D. The Commission shall serve an order issued under §C of this regulation on the Board of Trustees by certified and regular mail.

E. If aggrieved by a decision of the Commission under this regulation, the Board of Trustees may request a hearing before the Commission in accordance with Regulation .10 of this chapter.

F. The Commission may terminate a fund from participation in the governmental group self-insurance program for failing to comply with an order of the Commission under this chapter.

14.09.14.10

.10 Request for Hearing Before the Commission.

A. A Board of Trustees aggrieved by a decision of the Commission under this chapter may request a hearing before the Commission within 15 days of the date the decision is mailed.

B. A hearing shall be set as soon as practicable but no sooner than 20 days after the request is received by the Commission.

C. The Board of Trustees may:

(1) Submit a written statement, 15 copies of which shall be served on the Commission at least 5 days before the hearing; and

(2) Appear and present oral argument and evidence on the issues contained in the hearing notice.

D. The Board of Trustees bears the burden of persuasion in a hearing held under §A(1) of this regulation.

E. The Commission shall issue a decision, which shall be served on the Board of Trustees by certified mail, return receipt requested.

14.09.14.11

.11 Appeals to Circuit Court.

The Board of Trustees may appeal an adverse decision pursuant to Labor and Employment Article, §9-409, Annotated Code of Maryland.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 15 Open Meetings

Authority: Labor and Employment Article, §9-309(a); State Government Article, §10-507(b); Annotated Code of Maryland

14.09.15.01

.01 Scope.

This chapter applies to open meetings of the Workers' Compensation Commission.

14.09.15.02

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Commission" means the Workers' Compensation Commission.

(2) "Open Meeting" means any meeting of the Commission required to be open to the public by State Government Article, §§10-501—10-512, Annotated Code of Maryland.

(3) "Public body" has the meaning stated in State Government Article, §10-502(h), Annotated Code of Maryland.

14.09.15.03

.03 Public Attendance.

A. At any open meeting of the Commission, the public is invited to listen and observe.

B. Unless the Commission expressly invites public testimony, questions, comments, or other forms of public participation, or public participation is authorized by law, a member of the public attending an open meeting may not actively participate in the meeting.

14.09.15.04

.04 Prohibited Conduct or Activity.

A. An individual attending an open meeting of the Commission may not engage in conduct, including visual demonstrations such as the waving of placards, signs, or banners, that disrupts the session or interferes with the opportunity of members of the public to attend and observe.

B. The presiding officer may:

(1) Order an individual who persists in conduct prohibited in §A of this regulation, or who violates another regulation concerning conduct of the open meeting, to be removed from the meeting;

(2) Request police or other assistance to restore order; and

(3) Recess the meeting while order is restored.

14.09.15.05

.05 Recording, Photographing, and Broadcasting of Open Meetings.

A. A member of the public, including a representative of the news media, may record discussions of the Commission at an open meeting by means of tape recorder or another recording device, if the device:

(1) Does not create excessive noise that disturbs a member of the Commission or any individual attending the meeting;

(2) Does not otherwise interfere with an individual's observation or participation in the meeting; and

(3) Is operated openly so that it is obvious to those in attendance that the meeting is being recorded.

B. A member of the public, including a representative of the news media, may photograph or videotape the proceedings of the Commission at an open meeting with any type of camera, if the camera:

(1) Is operated without excessively bright artificial light that disturbs members of the Commission or other individuals attending the open meeting;

(2) Does not create excessive noise that disturbs members of the Commission or any individual attending the meeting;

(3) Does not otherwise interfere with an individual's observation or participation in the meeting; and

(4) Is operated openly so that it is obvious to those in attendance that the meeting is being photographed or videotaped.

C. A representative of the news media may broadcast or televise the proceedings of the Commission at an open meeting if the equipment used:

(1) Is operated without excessively bright artificial light that disturbs members of the Commission or other individuals attending the open meeting;

(2) Does not create excessive noise that disturbs members of the Commission or any individual attending the meeting;

(3) Does not otherwise interfere with an individual's observation of or participation in the meeting; and

(4) Is operated openly so that it is obvious to those in attendance that the meeting is being broadcast or televised.

D. The presiding officer may restrict movement of a person who is using a recording device, camera, or broadcasting or television equipment if the restriction is necessary to maintain the orderly conduct of the open meeting.

E. A public body of the Commission may require that an individual who intends to record, photograph, videotape, broadcast, or televise an open meeting register before the beginning of the meeting.

14.09.15.06

.06 Recordings, Photographs, Videotapes — Not Part of Record.

A recording, photograph, or videotape of an open session made by a member of the public, or any transcript or copy derived from a recording, photograph, or videotape is not part of the record of any proceeding of the Commission.

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 16 Public Information Act Requests

Authority: Labor and Employment Article, §9-309(a); State Government Article, §§10-611—10-628; Annotated Code of Maryland

14.09.16.01

.01 Scope.

This chapter sets out procedures under the Public Information Act for filing and processing requests to the Workers' Compensation Commission for the inspection and copying of public records of the Commission.

14.09.16.02

.02 Policy.

It is the policy of the Commission to facilitate access to the public records of the Commission, if access is allowed by law, by minimizing costs and time delays to applicants.

14.09.16.03

.03 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Act" means the Public Information Act, State Government Article, §§10-611—10-628, Annotated Code of Maryland.

(2) "Applicant" means a person or governmental unit that asks to inspect a public record.

(3) "Chairman" means the Chairman of the Workers' Compensation Commission.

(4) "Commission" means the Workers' Compensation Commission.

(5) "Custodian" means an authorized individual who has physical custody and control of a public record of the Commission.

(6) "Official custodian" means an officer or employee of the State or of a political subdivision who, regardless of whether the officer or employee has physical custody and control of a public record, is responsible for keeping the public record.

(7) Public Record.

(a) "Public record" means all papers, correspondence, forms, books, photographs, photostats, films, microfilms, sound recordings, maps, drawings, or other written documents, regardless of physical form or characteristics.

(b) "Public record" includes all copies that have been made by the Commission or received by the Commission in connection with the transaction of public business and includes the salaries of all employees of the Commission.

(8) "Working day" means a day other than Saturday, Sunday, or a State holiday.

(9) "Written documents" means all books, papers, maps, photographs, cards, tapes, recordings, computerized records, and other documentary materials, regardless of physical form or characteristics.

14.09.16.04

.04 Chairman as Official Custodian.

Unless otherwise provided by law, the Chairman is the official custodian of the public records of the Commission.

14.09.16.05

.05 Request for Public Records.

Any person may request to inspect or copy public records of the Commission.

14.09.16.06

.06 Necessity for Written Request.

A. Inspection.

(1) Except as otherwise provided in this chapter, the custodian shall make public records of the Commission available for inspection by an applicant without demanding a written request.

(2) The custodian shall require a written request if the custodian reasonably believes that:

(a) The Act or any other law may prevent the disclosure of the public record to the applicant; or

(b) A written request will materially assist the Commission in responding.

B. Copies. If the applicant requests one or more copies of any public record of the Commission, the custodian may require a written request.

14.09.16.07

.07 Contents of Written Request.

A written request shall:

A. Contain the applicant's name and address;

B. Be signed by the applicant; and

C. Reasonably identify, by brief description, the public record sought.

14.09.16.08

.08 Addressee.

A request to inspect or copy a public record of the Commission shall be addressed to the custodian of the record. If the custodian is unknown, the request may be addressed to the Chairman.

14.09.16.09

.09 Response to Request.

A. If the custodian decides to grant a request for inspection, the custodian shall produce the public record for inspection:

(1) Immediately; or

(2) Within a reasonable time period, not to exceed 30 days after the date of the request, if that period is needed to retrieve the public record and conduct any necessary review.

B. Denial of Request.

(1) If the custodian decides to deny a request for inspection, the custodian shall:

(a) Do so within 30 days after the request; and

(b) Immediately notify the applicant of the denial.

(2) If a request is denied, the custodian shall provide the applicant, at the time of the denial or within 10 working days, a written statement that gives:

(a) The reasons for the denial;

(b) The legal authority for the denial; and

(c) Notice of the remedies available for review of the denial.

C. If a requested public record is not in the custody or control of the person to whom application is made, that person shall, within 10 working days after receipt of the request, notify the applicant:

(1) That the person does not have custody or control of the requested public record; and

(2) If the person knows:

(a) The name of the custodian of the public record; and

(b) The location or possible location of the public record.

D. With the consent of the applicant, any time limit imposed by §§A—C of this regulation may be extended for an additional period of up to 30 days.

14.09.16.10

.10 Notice to Person Potentially Affected by Disclosure.

A. Unless prohibited by law, the custodian may provide notice of a request for inspection or copying of any public record of the Commission to any person who, in the judgment of the custodian, could be adversely affected by disclosure of that public record.

B. The custodian may consider the views of the potentially affected person before deciding whether to disclose the public record to an applicant.

14.09.16.11

.11 Public Record Temporarily Unavailable.

If a requested public record of the Commission is in the custody and control of the person to whom application is made but is not immediately available for inspection or copying, the custodian shall promptly:

A. Notify the applicant that the public record is not immediately available; and

B. Schedule a date within a reasonable time for inspection or copying.

14.09.16.12

.12 Public Record Destroyed or Lost.

If the person to whom application is made knows that a requested public record of the Commission has been destroyed or lost, that person shall promptly:

A. Notify the applicant that the public record is not available; and

B. Explain the reasons why the public record cannot be produced.

14.09.16.13

.13 Review of Denial.

If the custodian denies a request to inspect or copy a public record of the Commission, the applicant, within 30 days after receipt of the notice of denial, may file an appropriate action in the circuit court under State Government Article, §10-623, Annotated Code of Maryland.

14.09.16.14

.14 Disclosure Against Public Interest.

A. Denial Pending Court Order.

(1) If, in the opinion of the Chairman, disclosure of a public record of the Commission otherwise subject to disclosure under the Act would do substantial injury to the public interest, the Chairman may temporarily deny the request to obtain a court order allowing nondisclosure.

(2) The temporary denial shall be in writing.

B. Circuit Court Review.

(1) Within 10 working days after the denial, the Chairman shall apply to the appropriate circuit court for an order permitting continued denial or restriction of access.

(2) Notice of the Chairman's complaint shall be served on the applicant in the manner provided for service of process by the Maryland Rules of Procedure.

14.09.16.15

.15 Fees.

A. The fee schedule for copying and certifying copies of public records of the Commission is provided in §§B and C of this regulation.

B. Copies.

(1) The fee for each copy made by a photocopying machine within the Commission is 50 cents per page.

(2) The fee for each copy made otherwise shall be based on the actual cost of reproduction.

C. Certification of Copies. If a person requests that a copy of a public record be certified as a true copy, an additional fee of $1 per page (or if appropriate, per item) shall be charged.

D. Notwithstanding §§A—C of this regulation, if the fee for copies or certified copies of any public record of the Commission is specifically set by a law other than the Act or this regulation, the custodian shall charge the prescribed fee.

E. If the custodian cannot copy a public record within the Commission, the custodian shall make arrangements for the prompt reproduction of the record at public or private facilities outside the Commission. The custodian shall:

(1) Collect from the applicant a fee to cover the actual cost of reproduction; or

(2) Direct the applicant to pay the cost of reproduction directly to the facility making the copy.

F. Before copying a public record of the Commission, the custodian shall estimate the cost of reproduction and either:

(1) Obtain the agreement of the applicant to pay the cost; or

(2) Demand prepayment of the cost.

G. Except as provided in §H of this regulation, the custodian may charge a reasonable fee for time that an official or employee of the Commission spends:

(1) To search for requested public records; or

(2) To prepare public records for inspection and copying.

H. The custodian may not charge a search or preparation fee for the first 2 hours that an official or employee of the Commission spends to respond to a request for public records.

I. Waiver or Reduction of Fee.

(1) The official custodian may waive or reduce any fee set under this regulation if:

(a) The applicant requests a waiver; and

(b) The custodian determines that the waiver or reduction is in the public interest.

(2) The official custodian shall consider, among other relevant factors, the ability of the applicant to pay the fee.

J. If the applicant requests that copies of a public record be mailed or delivered to the applicant or to a third party, the custodian may charge the applicant for the cost of postage or delivery.

14.09.16.16

.16 Time and Place of Inspection.

A. An applicant may inspect any public record of the Commission that the applicant is entitled to inspect during the normal working hours of the Commission.

B. The inspection shall occur where the public record is located, unless the custodian, after taking into account the applicant's expressed wish, determines that another place is more suitable and convenient.