



James J. Campbell
Commissioner

The Commonwealth of Massachusetts

Department of Industrial Accidents

*600 Washington Street
Boston, Mass. 02111*

CIRCULAR LETTER NO. 276

TO: ALL INTERESTED PERSONS

FROM: JAMES J. CAMPBELL, COMMISSIONER *JJC*

RE: CLAIMS AND REQUESTS FOR REIMBURSEMENT UNDER §§37,37A

DATE: JUNE 15, 1994

Please be advised as to the following departmental policies relative to the processing of claims and requests for reimbursement under the provisions of G.L. c. 152, §§37,37A:

- * Parties seeking reimbursement from the Workers' Compensation Trust Fund (WCTF) should be aware of certain previously issued guidelines relative to voluntary adjustment of such reimbursement requests by the WCTF. These guidelines also set forth criteria under which the WCTF will agree to participate in alternative dispute resolution processes to settle outstanding claims. These guidelines are attached to this letter.
- * Parties seeking to have claims adjudicated by the Department through its division of dispute resolution should be advised that all such claims proceedings will be scheduled to be held at the Department's Boston office.
- * All parties seeking reimbursement from the WCTF for §37 or §37A petitions already filed or to be filed, must now procure an Affidavit from a supervisor, manager or officer of the employer, signed under the penalties of perjury, which will provide information as to:
 - a. whether the employer had actual knowledge of the employee's physical impairment(s),
 - b. the duties, physical requirements and job description for the employee's job at date of hire, and at the time of the "Second Injury."

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- c. whether the employee was able to perform the regular job duties during his/her employment,
 - d. what accommodations, if any, were made to the employee's job with respect to the employee's physical impairment?
 - e. if accommodations were made, whether they were temporary or permanent and the relevant dates the accommodations were made.
- * All relevant documents or personnel records which reflect that accommodations were made, and a copy of the employees's job application and resume must be attached to the Affidavit.
 - * This Affidavit must be included in all future §§37/37A petitions. The Affidavit must also be filed as a supplement to previously filed petitions. However, parties who have already filed will not suffer further delay, as the WCTF will only require the Affidavit for those petitions which are likely to be evaluated by Trust Counsel within 120 days of issuance of this Circular Letter. Written notice and a request for the Affidavit will be sent to Counsel on those petitions to be affected. The faster this Affidavit is received by the WCTF, the faster the claims may be resolved. The Affidavit must be in the form as attached.

Finally, to better direct inquiries regarding WCTF payment of reimbursements, please refer to the directory attached to this circular letter. All correspondence including notices of Lump Sum Conference should be sent to the WCTF.



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*600 Washington Street
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Workers' Compensation Trust Fund Directory (617) 727-4900

Priscilla Conant, Director	Extension 300
Mary Jean Henderson, Administrative Assistant	Extension 217
Paul Ingraham, WCTF Counsel	Extension 485
John Keefe, WCTF Counsel	Extension 498
Donna Sullivan, WCTF Counsel	Extension 236



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§§37/37A GUIDELINES

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\$37/37A PETITION GUIDELINES

INTRODUCTION

The Workers' Compensation Trust Fund (WCTF) has developed the enclosed guidelines as an aid both to furnish clear instruction as to the documentation necessary to support claims and to provide uniformity in the format of petitions submitted.

These guidelines will serve to expedite the review process and serve to avoid delays experienced when a claim for reimbursement is not sufficiently supported by the proper records.

In an effort to expedite the resolution of §§37/37A disputes, the WCTF has also established and enclosed the criteria by which it will participate in Alternative Dispute Resolution (ADR). Through ADR, the petitioner is afforded a more expedient means by which to contest a decision of the WCTF.

The WCTF encourages both the use of the enclosed guidelines to avoid unnecessary delays in the processing of petitions submitted and the employment of ADR whenever possible, in order to achieve the prompt resolution of all claims.

If you have any questions about the enclosed information, please feel free to call Mary Jean Henderson at (617)727-4900 extension 217.

Petition for Reimbursement under M.G.L. c. 152, §37

Employee: _____
Employer: _____
Insurer: _____
Insurer Federal Tax I.D. Number: _____
DIA Board Number: _____
Date of Subsequent Injury: _____

1. Nature of employee's work and work history:

Describe the nature of the work performed by the employee prior to not only the "subsequent injury," but also to the known impairment. If there were some change(s) in occupations or in job duties or functions precipitated by the pre-existing impairment, please explain those changes in detail and document them whenever possible. Give the employee's employment history, educational background and/or vocational training as well as a complete job description for the position occupied at the time of the "pre-existing injury." Additionally, identify all periods of light duty with modification in job description. (Also, please attach a copy of the job application, resume and a pre or post-employment physical report).

2. Pre-existing physical impairment:

Provide a short narrative describing the employee's pre-existing physical impairment, including dates of diagnosis, treatment for such condition, dates and nature of any relevant objective tests and dates and nature of any relevant surgical procedures. Attach copies of dated and signed and/or certified (prior to subsequent injury) medical records or physicians' reports which evidence that the employee had a "known physical impairment" prior to commencement or retention in employment with the insured. The records should not simply reflect a diagnosis of a medical condition, but should indicate that the condition was productive of a physical impairment.

3. Impairment was likely to be a hindrance or obstacle to employment:

Submit a medical report from an attending physician or an IME addressing the relationship of the previous known impairment to employment.

4. Employer's knowledge:

If the insured knew of the employee's pre-existing impairment prior to or within thirty days of hire, indicate the insured's

source of information in this regard. Attach personnel records or other documentation substantiating this knowledge.

OR

If the insured did not have personal knowledge of such impairment, and if the date of the employee's alleged subsequent injury is between 12/10/85 and 12/23/91, attach copies of medical records or reports which pre-date the employee's commencement of work with the insured or with retention of employment of the employee and which reflect that the employee underwent treatment with a medical provider for a physical condition or complaint. (Actual personal knowledge is required for claims governed by §37 as amended by St. 1991, c. 398, effective 12/23/91).

If a hospital record, attach a certified copy. If the offered document is a physician's report or office note, it should be signed by the health care provider.

You should submit questionnaires (filled out by the employee at the time of hire), application forms or results from pre-employment physical.

5. Personal injury sustained while employed by the insured:

Provide all of the following information and/or documents:

- Employer's form 101 (Employer's First Report)
- Agreements, Orders to Pay, and/or Hearing Decisions
- Suspension or Discontinuance of Benefits
- Notice of Lump Sum
- Proof of Payments
- Employee's Average Weekly Wage
- Dates of disability and total compensation paid in the first 104 weeks of disability
- Computer print-out identifying claimant, check number, date and amount paid after the 104th week
- Copy of Lump Sum Agreement
- Nature of injury and body part(s) for which insured accepted liability or was found liable for treatment
- Copies of medical bills incurred and paid

- All medical records reflecting treatment for subsequent disability, including complete discharge summary if same exists (placed in chronological order, last date of treatment to first)
- Submit reports from ALL Independent Medical Examinations performed and an Affidavit from the filing attorney that all reports have been submitted.
- If the employee died as a result of the personal injury, list name of any surviving spouse and names and birthdates of any dependents within the meaning of §31.
- Itemization of Reimbursement calculations

Note: Statute effective 11/1/86 provides reimbursement only under §§30, 30A, 31, 32, 33, 34, 34A, 35, 35A, 36 and 36A.

Statute effective 12/23/91 provides reimbursement only under §§31, 32, 33, 34A and 36A.

When figuring itemization, please include all reimburseable and non-reimburseable calculations.

6. Resulting disability substantially greater:

Attach a physician's report which addresses the relationship of the previous known impairment to the subsequent disability. The physician must set forth the medically substantiated basis for his/her opinion.

**Requirements for
Petition for Reimbursement under M.G.L. c. 152, §37A
Compensation for Disabled War Veterans**

Employee: _____

Employer: _____

Insurer: _____

Insurer Federal Tax I.D. Number: _____

DIA Board Number: _____

Date of Subsequent Injury: _____

1. Documentation from the Veterans Administration that certifies that the employee is a war veteran disabled as a result of military or naval service.
2. Medical report(s) from attending physician(s) or an IME indicating that the current injury is aggravated or prolonged by service related disability. The physician(s) should set forth the bases for his/her opinion in this regard.
3. Medical records reflecting treatment for this injury from date of injury to present. If the case has been lump summed, provide medical evidence through the lump sum date. Medical records should be supplied every six (6) months to show that the employee has remained disabled.
4. Provide the following information on the personal injury sustained while employed by the insured:
 - a. Date of Injury
 - b. Name of Employer/Insured
 - c. Board Number
 - d. Nature of injury and bodily part(s) for which the insurer accepted liability
 - e. If employee died as a result of the personal injury, list name of surviving spouse and names and birthdates of any dependents within the meaning of Section 31.

f. Notice of Lump Sum Proceedings

5. A breakdown of monies requested:

- Average Weekly Wage
- Compensation Rate
- First Day of Disability
- Dates of the first 104 weeks (reimbursement not to exceed 50%)
- Dates of reimbursement requested after 104 weeks (reimbursement not to exceed 100%)
- Copies of bills for which the insurer is requesting reimbursement. These must include: provider name, dates of service and monies billed/paid.
- Completed form 123 (proposed) Agreement Under §37A

Section 37 Payment Breakdown

Name: _____

Time Period of 104 weeks: _____

Compensation Rate: _____ Lump Sum: _____

Date: _____

Compensation paid after 104th week:

_____ to _____ = _____ weeks; \$ _____

_____ to _____ = _____ weeks; \$ _____

_____ to _____ = _____ weeks; \$ _____

Lump Sum: \$ _____

Medical bills for services after 104th week \$ _____
(Please attach documentation)

Other: _____ \$ _____

Total Payments: \$ _____

Reimbursed at _____%

TOTAL SECTION 37 DUE: \$ _____

Comments: _____

Prepared by: _____

SECTION 37A PAYMENT BREAKDOWN

Name: _____

Time Period of 104 Weeks: _____

Compensation Rate: \$ _____ Weekly Benefits
Initial 104 Weeks: \$ _____

Medical Bills Paid Initial 104 Weeks: \$ _____

Other Paid Initial 104 Weeks: \$ _____

Total Compensation Paid Initial 104 Weeks: \$ _____

Reimbursement at 50%: \$ _____

Compensation Paid after 104th Week:

_____ to _____ = _____ weeks \$ _____

_____ to _____ = _____ weeks \$ _____

_____ to _____ = _____ weeks \$ _____

Lump Sum: \$ _____

Medical Bills Paid after _____: \$ _____

Other: _____: \$ _____

Total Payments Reimbursed at 100%: \$ _____

Plus Reimbursement at 50%: \$ _____

TOTAL SECTION 37A DUE: \$ _____

Comments: _____

Prepared by: _____

ADR PROPOSAL COVER SHEET

EMPLOYEE:

EMPLOYER:

INSURER:

BOARD #:

DATE OF SUBSEQUENT INJURY:

REIMBURSEMENT SOUGHT (\$ amount):

§30:

§30A:

§31:

§32:

§33:

§34:

§34A:

§35:

§35A:

§36:

§36A:

ISSUES TO BE ARBITRATED/MEDIATED(QUESTIONS OF FACT):

PROPOSED ARBITRATION/MEDIATION FIRM:

ADDRESS:

FIRM HISTORY (*ATTACH BROCHURE):

PROPOSED ARBITRATOR(S) (*ATTACH RESUMES):

REFERENCES:

CONTACT PERSON:

PROPOSED SITE OF ADR:

*If not sent with previous proposals

CRITERIA BY WHICH THE WORKERS' COMPENSATION TRUST FUND
WILL PARTICIPATE IN ALTERNATIVE DISPUTE RESOLUTION
WITH RESPECT TO M.G.L. C. 152, §§37/37A PETITIONS

Listed below are conditions under which the Workers' Compensation Trust Fund (WCTF) will currently participate in some form of alternative dispute resolution (ADR) in cases involving claims for reimbursement pursuant to G.L. c. 152, §§37 and 37A:

1. All expenses attendant to the alternative dispute resolution, including, but not limited to, fees to the ADR provider, fees for the use of a facility to conduct the ADR, and any and all administrative fees, shall be borne by the insurer.
2. The site and time of all ADR proceedings must be agreeable to the WCTF Director (i.e. during normal business hours, Monday through Friday, 9:00 a.m. to 5:00 p.m., at a site easily accessible from downtown Boston by public transportation).
3. The ADR provider is subject to the approval of the WCTF Director.
 - a. The WCTF Director will approve only those ADR providers with demonstrated experience and/or knowledge of the provisions of workers' compensation (to the greatest extent possible, WCTF participation will be allocated among all such qualified providers).
 - b. All ADR proposals must be accompanied by an information packet on the ADR provider, including firm history, resumes, etc..
4. Claims must be withdrawn from the division of dispute resolution as a condition to referral to ADR.
5. Currently, no case involving any of the following issues of law shall be referred to ADR:
 - a. Cases involving reimbursement for second injuries occurring before December 10, 1985
 - b. Cases involving requests for reimbursement for subsequent injuries occurring on or after 1/1/91 where the request exceeds two years from when the reimburseable payment was made
 - c. Cases involving requests for reimbursement of any of the following benefits:
 1. attorneys fees
 2. vocational rehabilitation

3. specific compensation owed, prior to week 105
 4. weekly benefits owed, prior to week 105
 5. medical bills for services that were or should have been rendered prior to week 105
 6. inchoate rights of relatives of the employee
- d. Cases involving questions of law which require the interpretation of the meaning or applicability of any of the provisions of Sections 37 and 37A which have precedential impact including, but not limited to, questions concerning:
1. the necessity of the employer's prior knowledge
 2. What constitutes knowledge on the part of the employer
 3. Whether the requirements in paragraph one of subsection (1) of G.L. c. 152, §37 (as amended 12/10/85), particularly in respect to employer knowledge, apply to paragraph (2)
 4. What constitutes notice and opportunity to be heard by the Trust Fund or attorney general in respect to requests for reimbursement, claims for reimbursement and lump sum settlement proceedings
- e. Cases involving reimbursement requests of employers or self-insurance groups who have opted-out from participation in the trust fund pursuant to the provisions of G.L. c. 152, §65.
6. The decision of the ADR provider will be binding upon all participants. (Proposals for non-binding mediation may be entertained at a later date).

The WCTF strongly encourages the submission of ADR proposals by all parties who wish to seek redress for denial of petitions submitted, where the nature of the claim conforms with the criteria outlined above. The WCTF is hopeful that as regulatory and judicial interpretation is provided, with regard to the issues outlined above, a greater number of such petitions will be appropriate for resolution through ADR or other expedient means.

If you have any questions with regard to the availability of ADR in a particular claim, please contact Mary Jean Henderson, Administrative Assistant, WCTF at (617)727-4900 extension 217.



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Department of Industrial Accidents

*600 Washington Street
Boston, Mass. 02111*

FROM:

MAIL TO:

Section 37/37A Processing
Workers' Compensation Trust Fund
Department of Industrial Accidents
600 Washington Street, 7th floor
Boston, MA 02111

Dear Sir/Madam:

Attached please find a request, pursuant to Section 65 (as amended by Chapter 572 of the Acts of 1985), for Section 37/37A Second Injury Quarterly Reimbursement. This request is made for monies paid on behalf of _____ (claimant) by _____ (insurer), totalling \$_____.

I hereby certify under the penalties of perjury that all laws of the Commonwealth governing assessments and regulations thereof have been complied with and observed, and that all information is, to the best of my knowledge, correct.

SIGNED: _____

NAME: _____

TITLE: _____

PHONE #: _____

DATE: _____

Massachusetts Department of Industrial Accidents
M.G.L. c. 152 §§37, 37A Quarterly Reimbursement Petition

Claimant:

Address:

Insurer:

Address:

Federal ID#:

Board #:

104th week of disability:

Please check one (1) category:

§37 12/10/85 - 10/31/86___; §37 11/1/86 - 12/23/91___; §37 post 12/23/91___; §37A post 12/10/85___.

(1) Payment Quarter	(2) Weekly Benefits	(3) # of Weeks	(4) Total Benefits	*(5) Medical Bills for the Quarter	(6) Total of Columns 4 & 5	(7) Agreed % Reimb.	(8) Total Reimbursement Requested
(_____ to _____)							
(_____ to _____)							
(_____ to _____)							
(_____ to _____)							

Instructions: Calculations:

- a. #2 x #3 = #4.
- b. #4 + #5 = #6.
- c. #6 x #7 = #8.

*Attach medical bills and supporting documentation.

AFFIDAVIT

I, _____, am employed
by _____, and have
been employed there since _____. My title is
that of _____.

I, _____, hereby swear
under the pains and penalties of perjury that the information and
statements contained in this affidavit are true and correct.

1. I, _____, was
_____ to the
employee, _____, when he or
she was employed by _____.

2. I was/was not aware that _____
had a physical impairment.

3. The job description of the employee's job is as follows:
(Attach a written job description for the employee's job,
preferably one in existence prior to the employee's last
industrial accident).

4. The physical requirements or demands of the employee's job
were as follows:

(a) Lifting:

- Maximum weight _____ lbs.
- Percentage of job _____ %
- Average weight lifted _____ lbs.
- Frequently or not frequently _____

Affidavit

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(b) Carrying:

- Weight carried _____ lbs.
- Percentage of job _____ %
- Frequently or not frequently _____

(c) Sitting:

- Maximum duration sitting at one time _____ min./hrs.
- Percentage of job _____ %
- Frequently or not frequently _____

(d) Standing:

- Maximum duration of standing _____ min./hrs.
- Percentage of job _____ %

(e) Walking:

- Maximum duration of walking _____ min./hrs.
- Percentage of job walking _____ %
- Frequently or not frequently _____

(f) Stair Climbing:

- Maximum duration of walking _____ min./hrs.
- Percentage of job walking _____ %
- Frequently or not frequently _____

(g) Kneeling:

- Maximum duration of walking _____ min./hrs.
- Percentage of job walking _____ %
- Frequently or not frequently _____

(h) Bending:

- Maximum duration of walking _____ min./hrs.
- Percentage of job walking _____ %
- Frequently or not frequently _____

(i) Reaching:

- Maximum duration of walking _____ min./hrs.
- Percentage of job walking _____ %
- Frequently or not frequently _____

(j) Pulling:

- Maximum duration of walking _____ min./hrs.
- Percentage of job walking _____ %
- Frequently or not frequently _____

(k) Pushing:

- Maximum duration of walking _____ min./hrs.
- Percentage of job walking _____ %
- Frequently or not frequently _____

5. The employee's physical impairment did/did not interfere with or hinder his ability to do his/her regular job functions?
6. What physical requirements, if any, was the employee not able to perform because of his/her physical impairment? If so, when and for what time period?
7. What accommodations, if any, were made by the employer for the employee's physical impairment?

Affidavit

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8. Were these accommodations for a temporary period or were the accommodations ongoing at the time of the employee's last industrial accident?

Accommodations were made from: _____ to

9. I have attached the following records which reflect that accommodations were made for the employee's physical impairment (these records must pre-date the subsequent personal injury):

1. _____

2. _____

3. _____

4. _____

10. I have/have not attached a copy of the employee's job application and resume which were kept as business records in the employee's personnel file.

Signed under the pains and penalties of perjury, this
of _____ 199 .

day
