Georgia State Board of Workers' Compensation

Managed Care & Rehabilitation

Procedure Manual

The Procedure Manual is to be used as reference tool in conjunction with and as an adjunct to Title 34, Chapter 9 of the Official Code of Georgia Annotated and the Rules and Regulations of the State Board of Workers' Compensation (SBWC). The Procedure Manuals are updated annually to reflect any changes in the workers' compensation law or rules. Copies of the Procedure Manual may be obtained online at the SBWC's website at www.sbwc.georgia.gov.

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MANAGED CARE AND REHABILITATION
PROCEDURE MANUAL

Table of Contents

MANAGED CARE AND REHABILITATION

INTRODUCTION

This comprehensive manual provides guidance for navigating the complexities of catastrophic and non-catastrophic workers' compensation cases in Georgia. It is a valuable resource for Rehabilitation Suppliers, Case Managers, Qualified Medical Case Managers and Managed Care Organizations (MCOs), offering clarity on roles, responsibilities and procedures. This manual is to be used in conjunction with and as an adjunct to O.C.G.A. § 34-9-200.1 and § 34- 9-208 and accompanying Board Rules 200.1, 200.2, and 208. These laws and rules are subject to change on July 1 of every year. It is the responsibility of every Rehabilitation Supplier, Case Manager, Qualified Medical Case Manager, and Certified Managed Care Organization (MCO) to maintain knowledge of changing laws and rules regarding rehabilitation, case management, and certified MCOs.

A. 200.2 Case Management Services

Navigating the intricacies of non-catastrophic workers' compensation cases in Georgia requires a comprehensive understanding of your role and responsibilities. It is important to remember that the responsibility to stay abreast of changing laws and rules falls on everyone involved in the system, including Rehabilitation Suppliers, Case Managers, Qualified Medical Case Managers, and Certified Managed Care Organizations (MCOs). This applies to all parties, regardless of their specific role within the system. Whether a case consultant, a Field Case Manager, or a Telephonic Case Manager, understanding the relevant regulations is paramount.

Direct employees vs. Independent Case Managers: While this guide primarily focuses on Independent Case Managers, direct employees of insurers, third-party administrators, or employers, all are encouraged to familiarize themselves with the procedures and rules outlined in Rule 200.2. This understanding fosters collaborative working relationships and ensures compliance within the system.

The following chapter specifically focuses on Case Managers operating **exclusively in non-catastrophic injury cases** and **voluntarily utilized by employers or insurers** for telephonic or field medical case management services. It delves into the specific roles and responsibilities associated with each category, outlining appropriate activities and limitations for each. Additionally, the following addresses the unique nuances of cases where the employer/insurer has contracted with a certified workers' compensation MCO, ensuring your compliance with the Georgia Workers' Compensation Act and State Board of Workers' Compensation (SBWC) rules.

This guide will delve into the following key areas:

- **Understanding your role:** We will explore consent and communication protocols, approved activities and limitations, and working within a WC-MCO.
- **The value of case management:** Discover how Case Managers benefit employers, insurers, and injured workers alike.
- **Qualifications and registration:** Learn about the required qualifications and registration process for Case Managers.
- **Case management roles under Rule 200.2:** We will define the roles and responsibilities for different types of Case Managers, including Field Case Managers, Telephonic Case Managers, and Consultants.
- **Case management activities and limitations:** Understand what you can and cannot do as a Case Manager, including details on communication, documentation, job descriptions, and medical record procurement.
- **Certified WC-MCO case management:** Dive deeper into the intricacies of this specific role and its responsibilities.
- **Independent Medical Examinations (IMEs) and second opinions:** Clarify your involvement in these processes. See Independent Medical Exam (IME) and Second Opinion section (page 18).

B. Case Management Services and Board Rule 200.2

Under Georgia State Board of Workers' Compensation Board Rule 200.2, employers and insurers handling claims related to non-catastrophic injuries have the option to proactively employ Qualified Medical Case Managers for the provision of telephonic or field case management services. These case management services can be effectively utilized by the parties involved to facilitate medical care coordination and communication in accordance with the guidelines outlined in Board Rule 200.2. Moreover, Rule 200.2 permits Qualified Medical Case Managers, who are not direct employees of the employer or insurer, to engage in appropriate activities within the ethical boundaries defined by Rule 200.1(IV) for the purpose of assessing, planning, implementing, and evaluating options and services necessary to effect a cure or provide relief.

Understanding the Value of Case Management in Workers' Compensation

In Georgia's workers' compensation system, medical case management can significantly benefit employers, insurers, and injured workers alike. Let's explore specifically how:

For Employers and Insurers:

- **Enhanced Efficiency:** When multi-disciplinary care is required, a Case Manager coordinates and streamlines the process, saving time and resources. They can also navigate complex situations, like potential surgeries or open wounds, ensuring optimal care and minimizing disruption.

- **Improved Communication:** Case Managers facilitate clear communication between healthcare providers, injured workers, and stakeholders, reducing misunderstandings and delays. They can also address challenges with obtaining information from physicians or ensure treatment compliance, promoting efficient claim resolution.
- **Cost-Effectiveness:** By ensuring appropriate and timely care, Case Managers help avoid unnecessary costs and expedite the injured worker's return to work, reducing disability duration. They can also identify cost-effective treatment options and utilization of resources.

For Injured Workers:

- **Clear Guidance:** Case Managers act as a trusted resource, providing clarity and support throughout the recovery process. They can explain complex medical information, answer questions, and address concerns, reducing stress and anxiety.
- **Advocacy and Support:** Case Managers advocate for the injured worker's needs and ensure they receive the necessary care and services, promoting optimal recovery and quality of life. This includes assisting with understanding treatment options, facilitating communication with providers, and navigating potential challenges.

- **Return to Work:** A key focus of the Georgia Workers' Compensation system is facilitating a smooth and successful return to work. Case Managers collaborate with all parties involved to identify suitable work options, address job-related concerns, and ensure a safe and productive reintegration into the workforce. If not in collaboration with all parties, the Qualified Medical Case Manager may assist with job description approvals only as consistent O.C.G.A. § 34-9-240 and Board Rule 240.

C. Beyond Benefits: The Case Manager's Role

While the benefits outlined above showcase the value of case management, their role goes beyond. Through assessment, planning, implementation, coordination, monitoring, and evaluation, Case Managers facilitate provision of necessary services to achieve optimal recovery and return to work. This collaborative process guides the selection and timely delivery of services aimed at achieving a cure or providing relief, with both quality and cost-effectiveness in mind. By strategically utilizing resources and communication channels, Case Managers strive to optimize outcomes for all stakeholders.

Ethical considerations are paramount. Case Managers must adhere to the standards set by their professional certifying body, ensuring their actions are always guided by integrity and best practices. Case management activities that are outside the standards of the certifying entity are not allowed, regardless of any Board rule.

D. Qualifications and Registration

Qualified Medical Case Managers must possess certification or licensure of at least one certifying or licensing agency contained in Board Rule 200.1(I)(A) and must be registered with the Board.

Qualified Case Managers must be certified or licensed as one of the following:

- Certified Rehabilitation Counselor (CRC)
- Certified Disability Management Specialist (CDMS)
- Certified Rehabilitation Registered Nurse (CRRN)
- Certified Vocational Evaluation Specialist (CVE administered by CRCC)
- Licensed Professional Counselor (LPC)
- Certified Case Manager (CCM)
- Certified Occupational Health Nurse (COHN or COHN-S).

Case Managers providing services pursuant to O.C.G.A. §34-9-208, 34-9-201(b)(2), and Board Rule 208 are exempt from this registration requirement, as they are approved through the certification process of the Managed Care Organization.

E. Case Management Roles under Rule 200.2

The following outlines the roles and responsibilities for Qualified Medical Case Managers, who are **not** direct employees of the insurer or employer, operating under the provisions of Board Rule 200.2. Medical Case Managers employed by the employer or insured for non-catastrophic injury cases for telephonic or field case management will facilitate communication among all parties, keep all parties updated promptly as information is received and act as an advocate and resource of the injured worker.

Field Case Managers are those that possess the required qualifications as outlined in Board Rule 200.1((I)(A) who assess, plan, implement, coordinate, monitor, and evaluate the appropriate options and services required to meet an individual's health needs **in person**. Case Managers functioning in this capacity promote quality, cost effective outcomes with the goal of return to work and/or return to the highest level of physical functioning and level of independence comparable to the individual's pre-injury state.

Telephonic Case Managers are those that possess the required qualifications as outlined in Board Rule 200.1(I)(A) who assess, plan, implement, coordinate, monitor and evaluate the appropriate options and services required to meet an individual's health needs **without in person contact.**

Consultant – A Case Manager or Rehabilitation Supplier may be contracted with an employer/insurer, defense or injured worker's attorney to provide recommendations regarding case management, safety, and

rehabilitation issues, and to perform job analyses of employment positions. Case Managers and Rehabilitation Suppliers retained for consultant purposes shall not communicate, in person or in writing, with the injured worker, the injured worker's attorney (unless the Case Manager was retained by the injured worker's attorney), or the injured worker's authorized treating physician(s).

F. Case Management Activities and Limitations under Rule 200.2

Notice of Assignment - Advanced notification of medical case management assignment for medical management is required under 200.2. Prior to initially contacting an injured worker's treating physician, the Qualified Medical Case Manager working without the consent of the injured worker must give all parties and the injured worker's attorney written notification of being retained by the employer/insurer. Notification should take place as early as possible in the interest of transparency.

Communication

Direct Contact with Injured Worker – Verbal or written consent from the injured worker is required for the Case Manager to work directly with the injured worker and should be documented in the file. As a best practice, Case Managers should provide the injured worker with written confirmation of consent provided and notification that consent may be refused or withdrawn at any time. In all cases, the injured worker must be advised that he/she has the right to a private examination by the medical provider outside the presence of the Qualified Medical Case Manager. Attendance at an examination is only permissible upon written consent from the injured worker and/or his/her attorney and can be revoked at any time.

Direct Contact with Treating Physician(s) – Consent of the injured worker is not required for Qualified Medical Case Managers to contact the treating physician(s) for purposes of assessing, planning, implementing, and evaluating the options and services required to effect a cure or provide relief. However, 10 days advance notice is required to the injured worker, attorney, and medical provider for private meetings. Professional identification, retaining party, and explanation of the Qualified Medical Case Manager's role **shall** be provided to the physician at initial contact as well as information regarding the medical treatment and condition of the injured worker. **As a best practice, the proposed agenda should also be included with the 10-day advanced notice outlining items to be discussed with the treating physician.** Qualified Medical Case Managers shall simultaneously provide copies of all correspondence, written communication, and documentation of oral communications with the employee's treating physicians to all parties and their attorneys. The correspondence and written communication referenced herein includes, but is not limited to, medical records, medical reports, office notes, test results, and all other written documents received from the employee's treating physician. See Appendix B for Best Practices for Contact/Meeting with Physicians (page 29).

Private Meetings - If a planned, in-person meeting with the authorized treating physician is required for the above purposes, the Qualified Medical Case Manager must reserve with the physician sufficient appointment

time for the conference and give the injured worker and his/her attorney at least 10-day advanced notice of their option to attend the conference. If the injured worker or the treating physician does not consent to a joint conference, the Qualified Medical Case Manager should note this in his/her report and may in those instances communicate directly with the physician.

See Board Rule 200.1(II)(D)(1)-(4) for a more detailed explanation of suppliers' responsibilities and communications.

Case Management Activities

The following provides examples of general job duties for which a Qualified Medical Case Manager may be engaged by an employer/insurer in a non-catastrophic case. The following is not an all-inclusive list of activities or responsibilities, and Qualified Medical Case Manager conduct must be consistent with the professional standards established by his/her professional designation set forth by the certifying body for that designation, regardless of employer.

- **Care coordination-** Qualified Medical Case Managers may aid in scheduling medical care under the direction of the claim adjuster and assist the injured worker with procurement of necessary treatment and services. The Qualified Medical Case Manager may monitor medical care by reviewing proposed treatment plans and medical reports of authorized treating physicians and assist in coordinating referrals. **Qualified Medical Case Managers shall not advocate for a particular source for treatment or change in treatment.**
- **Monitoring Treatment Progress-** Qualified Medical Case Managers may monitor the injured worker's treatment progress and communicate updates to all parties. However, Qualified Medical Case Managers may not direct or influence treatment decisions.
- **Provide education and resources-** Qualified Medical Case Managers may educate injured workers on their rights and responsibilities under workers' compensation and provide information and resources available to them.
- **Authorizations-** Qualified Medical Case Managers may convey authorization for treatment from claim adjusters to medical providers but must refrain from making authorization decisions. Qualified Medical Case Managers may not perform utilization review.
- **Documentation-** The Qualified Medical Case Manager should clearly document all case management activities. All written communication with the medical providers, correspondence and case management reports shall be simultaneously provided to the injured worker and his/her attorney (if represented). If a private in-person conference is held with the treating physician(s) without the presence of the injured worker, the substance of the communication with the physician shall be provided to all parties. When drafting reports, it is important to keep in mind that this information is discoverable, and the injured worker is entitled to a copy of these reports. See Appendix C - Appointment Summary Best Practices Checklist for Qualified Medical Case Managers (page 32).

- **Medical Record Procurement-** Qualified Medical Case Managers shall ensure the confidentiality of the injured worker's medical records and shall not disclose the medical records to non-parties without the written consent of the injured worker or otherwise legally required to do so.

    - **Waiver of Confidentiality:** O.C.G.A. § 34-9-207 and Board Form 207 addresses the injured worker's waiver of confidentiality of communications with physicians and release of medical records. See Appendix D - Privileged and Confidential Communication (page 33). When an injured worker submits a claim for workers' compensation benefits, is receiving benefits and/or the employer has paid medical expenses, the employee waives privilege or confidentiality of records regarding treatment related to the injury. The waiver further applies to the employee's medical history relevant to the claimed condition. Upon request, the employee must provide a signed release for medical records related to the claim or history or treatment reasonably related to the condition for which the employee claims compensation, including but not limited to communication with psychiatrists or psychologists (O.C.G.A. § 34-9-207(A). If the injured worker declines to sign the waiver, the Qualified Medical Case Manager should inform the relevant parties of the refusal, including the reasons provided by the injured worker.
    - **Obtaining Medical Records:** The Qualified Medical Case Manager is frequently the first recipient of medical records, medical reports, office notes, test results and other written documents received from the worker's treating physician. These reports are to be provided to all parties to the case, including their attorneys.

- **Direct Employees of Employer/Insurer:** Upon request, the authorized treating physician must provide all relevant medical records related to the examination, treatment, testing, or consultation concerning the employee to the employer/insurer within a reasonable timeframe and for a reasonable fee.
- **Qualified Medical Case Managers:** While O.C.G.A. § 34-9-207 implies a waiver of confidentiality for parties directly involved in the claim (employer/insurer and their employees), the application to Qualified Medical Case Managers is less clear. Rule 200.2 allows Qualified Medical Case Managers to contact the treating physician for the purposes of assessing, planning, implementing, and evaluating options required to effect a cure and provide relief, but it **does not address** obtaining medical records or extending the waiver of confidentiality to them.

Therefore:

- Qualified Medical Case Managers should **not** assume medical records access based solely on Rule 200.2.
- They should prioritize obtaining the injured worker's **written consent** for record retrieval.
- If the injured worker is represented, obtaining the medical release should be done in coordination with the injured worker's attorney.

- Qualified Medical Case Managers shall simultaneously provide copies of all correspondence, written communication, and documentation of oral communications with the employee's treating physicians to all parties and their attorneys. The correspondence and written communication referenced herein includes, but is not limited to, medical records, medical reports, office notes, test results, and all other written documents received from the employee's treating physician.

Psychiatric Records

- O.C.G.A. § 34-9-207 provides for a waiver of confidentiality following submission of a claim for workers' compensation benefits, when the employee is receiving payment of weekly income benefits, or the employer has paid any medical expenses to include communications with psychiatrists and psychologists. The employee must also, upon request, provide the employer with a signed release for medical records and information related to the claim or history of relevant treatment including information related to the treatment for any mental condition or drug or alcohol abuse that is reasonable related to the condition for which they claim compensation benefits.
- Due to the additional protections afforded by psychiatric records under O.C.G.A. § 24-5-501, obtaining these records may require stricter consent procedures. Case Managers are encouraged to review and understand these protections prior to procurement and release of these records.
- Psychiatrists and psychologists will often include a standard warning in their reports regarding release to the individual examined as the information may be detrimental to the patient's emotional health. Case Managers should advocate for the injured worker to return to the psychiatrist or psychologist to review the findings of the report.
- The Case Manager should not interpret these records nor use their personal opinions to create or modify the next steps in medical management plans.

Dissemination of Medical Records:

- Medical records obtained for Workers' Compensation claims may only be shared with authorized parties directly involved in the claim or their representatives, such as:
    - The employer/insurer
    - Authorized medical professionals
    - The State Board of Workers' Compensation (if necessary)
    - Injured worker and his/her attorney
- Sharing records with unauthorized parties is a violation of patient confidentiality laws and can result in legal repercussions.

- **O.C.G.A. § 24-5-501 -** privileged communication and O.C.G.A. § 34-9-207 See Appendix D - Privileged and Confidential Communication (page 33).

- **Job Descriptions/Analysis (Involvement in WC-240 Process) –** A Qualified Medical Case Manager may present a written job description/analysis to the authorized treating physician(s) which shall be simultaneously provided to all parties. Providing job descriptions/analysis simultaneously to all parties is paramount as not doing so could damage the case, invalidate the job description/job analysis, and create unnecessary conflict among claim stakeholders. Consistent with the announced agenda for any private medical meeting, the Case Manager should provide any job description/analysis to the injured worker or their representative prior to presentation to the authorized treating physician.
- The Medical Case Manager may assist with approval of job descriptions only as consistent with O.C.G.A. § 34-9-240 and Board Rule 240.

G. Prohibited Case Management Activities under Rule 200.2

Utilization Review- Utilization review involves assessing the necessity, appropriateness, and efficiency of medical services provided in workers' compensation cases. Per Board Rule 200.2, Qualified Medical Case Managers may not perform utilization review.

Additional Activities Prohibited for Qualified Medical Case Managers:

- **Claim Adjustment:** Qualified Medical Case Managers **cannot** make any decisions regarding claim benefits, payments, or settlements. Claim adjusters may not outsource claim adjustment functions to Case Managers including but not limited to claim investigations, compensability decisions, surveillance, or settlement negotiations.
- **Denying or Directing Care:** Qualified Medical Case Managers **cannot** deny the injured worker necessary medical care authorized by the treating physician or dictate treatment choices, diagnoses, or work status to authorized physicians.
- **Pressuring the Injured Worker:** Qualified Medical Case Managers **cannot** pressure the injured worker to return to work prematurely or accept a settlement offer.
- **Legal Advice:** Qualified Medical Case Managers **cannot** offer legal advice or represent the injured worker in any legal proceedings.
- **Attending Appointments without consent:** Qualified Medical Case Managers **cannot** attend medical appointments with the injured worker without their written consent.
- **Withholding Information:** Qualified Medical Case Managers **cannot** withhold information required to be disseminated by Rule 200.2.
- **Claim Correspondence:** Qualified Medical Case Managers **cannot** handle claim correspondence directly with the injured worker or other parties. All official claim correspondence must come from the claim adjuster.

Ethical considerations are paramount. Qualified Medical Case Managers must adhere to the standards set by their professional certifying body, ensuring their actions are always guided by integrity and best practices.

Any activity that is outside the standards of the certifying body is not allowed regardless of any Board rule.

H. Certified WC-MCO Case Management (O.C.G.A. §34-9-208 and Board Rule 208)

This section delves into the essential duties and responsibilities of a Case Manager within Georgia's Workers' Compensation Managed Care Organization (WC/MCO) system, as outlined by O.C.G.A. §34-9-208 and Board Rule 208. As a Case Manager, you play a vital role in managing all aspects of an injured worker's care, ensuring they receive high-quality medical treatment efficiently and cost-effectively.

Your primary objective is to optimize the injured worker's recovery. You will achieve this by coordinating care, minimizing recovery times, and mitigating the impact of injuries through ongoing assessments. Keeping all parties informed with updated medical information is another crucial aspect of your role. Ultimately, your efforts pave the way for a smooth and timely return to work for injured workers.

By familiarizing yourself with the different case types you will encounter, the specific responsibilities associated with each, and the key distinctions between MCO Case Managers and registered Rehabilitation Suppliers, you will gain the confidence to navigate complex situations effectively and ensure the best possible outcomes for injured workers.

Qualifications:

Per Board Rule 208(h)(2), Medical Case Managers will have one of the following:
1. Certified Rehabilitation Registered Nurse (CRRN), or
2. Certified Case Manager (CCM), or
3. Certified Occupational Health Nurse (COHN) or Certified Occupational Health Nurse Specialist (COHN-S), or
4. Certified Disability Management Specialist (CDMS), or
5. Certified Rehabilitation Counselor (CRC), or
6 Licensed Professional Counselor (LPC)

I. Case Management Roles under Rule 208

The following outlines the roles and responsibilities for Medical Case Managers operating under the provisions of Board Rule 208. Medical Case Managers employed by the employer or insured for non-catastrophic injury cases for the provision of telephonic or field case management will facilitate communication among all parties, keep all parties updated promptly as information is received and act as an advocate and resource of the injured worker.

Telephonic Medical Case Management: The Telephonic Medical Case Manager advocates for the injured worker and ensures high quality, cost-effective, and timely provision of medical care. In addition to the core case management responsibilities listed below, Telephonic Medical Case Managers conduct initial phone assessments with all parties involved, gathering crucial information like injury details, treatment plans, return-to-work possibilities, and transitional duty options. They then coordinate medical care through referrals, answer questions, and facilitate communication between stakeholders. This ensures injured workers receive proper care and a smooth transition back to work.

On-Site Medical Case Management: In very limited circumstances, on-site medical case management services may be used. However, early engagement of on-site medical case management is essential in cases involving a catastrophic injury to facilitate initial emergency treatment, ensuring prompt medical care. On-site Medical Case Manager's objectives and duties may include consistent involvement, communication, presence, and face-to-face meetings. On-site case management services may be needed when communication barriers (i.e., language, hearing, education) hinder progress, treatment plans are disputed, or an injured worker requests their direct involvement.

Core Medical Case Management Responsibilities:

Initial Assessment: Upon notice of injury by the employer/insurer, the Medical Case Manager assesses and identifies those cases that will benefit from intervention. The level of medical case management intervention is determined by the degree of severity and nature of injury.

- **Collaborate & Communicate:** The Medical Case Manager may contact the medical provider to ascertain the nature of injury, coordinate medical care and return to work activities. Throughout the injured worker's recovery, the Medical Case Manager monitors and coordinates care with the treating physician and injured worker and facilitates clear communication between parties. After notification of attorney representation, the Medical Case Manager initiates direct contact with the attorney of the represented injured worker in a timely manner and makes follow up contact with the injured worker as needed. As stated in Board Rule 208 "The unreasonable refusal to cooperate with or the unreasonable interference with medical case management services by any party or its representative may subject that party or its representative to civil penalties pursuant to O.C.G.A. Section 34-9-18".
- **Assess & Manage:** Conduct ongoing assessments, adjust treatment plans as needed, and manage care throughout the recovery process. The Medical Case Manager monitors and coordinates high quality, cost-effective medical care for the injured worker and promotes adherence to the treatment plan. If there are inexplicable deviations from the treatment plan, the Medical Case Manager may conference with the Medical Director for the applicable WC-MCO for further appropriate action. Medical treatment disputes may be further addressed through the utilization review process. See Appendix E Utilization Review and Dispute Resolution (page 34).

- **Coordinate Return to Work:** MCO Case Managers play a crucial role in coordinating safe and swift return to work for injured workers. They act as advocates, working alongside the injured worker's supervisor, human resources, and treating physician to design temporary job modifications ("transitional duty" or "light duty") that accommodate medical restrictions. This collaboration extends throughout the recovery process, with the Case Manager monitoring progress and ensuring a smooth transition back to full duty or a permanent modified position. By providing post-return to work support and fostering communication between employer and treating physicians, MCO Case Managers help injured workers reintegrate into the workplace successfully. It is important to note that their focus is on returning injured workers to their current employer, while broader rehabilitation plans involving extended evaluation or training fall under the purview of registered Rehabilitation Suppliers. See Appendix F WC/MCO Return to Work Program and Board Rule 208 (page 35).

General Job Duties of WC/MCO Medical Case Manager

- Acts as an advocate for injured worker concerns.
- Obtains basic demographic and injury-related data.
- Inform the injured worker of his/her right to choose from network medical provider directory.
- Inform the injured worker that a list of medical providers within their 60-mile radius and/or GSA is available and assist the injured worker in obtaining the list if necessary. If the WC/MCO network is exhausted, direction of care can be made outside of the WC/MCO by enlisting assistance of provider locator services or other resources as appropriate.
- Contacts the network provider's office staff to provide demographic and type of injury information and schedule the injured worker for an initial evaluation within 24 hours after the injured worker's request for treatment.
- Facilitates prompt flow of information between the physician and the parties to the case. Seeks objective medical findings from the provider, projected number of days needed for recovery, release to return to work, and/or maximum medical improvement (MMI).
- In cases where the injured worker has received treatment by non-network provider, schedules injured worker to be seen by network provider for initial evaluation or treatment within five (5) working days of the injured worker's request for referral to the managed care plan.
- Monitors medical care by reviewing proposed treatment plans and medical reports of authorized treating physicians.
- Coordinates all referrals within the MCO network.
- Initiates inpatient/outpatient prospective/concurrent/ retrospective utilization review as indicated.
- Initiates utilization review as indicated.
- Documents medical case management activities.
- Conducts limited on-going assessment to determine the ability of injured worker to return to pre-injury position, transitional duty, or alternative job with same employer.
- Is accountable for adherence to all applicable laws and regulations governing the provision of managed

care services.

Medical Case Managers may employ these additional managed care services, as appropriate:

- Arranges for discounted durable medical equipment utilizing contracted network vendors, when available.
- Evaluates injured worker's adjustment to injury and acceptance of medical treatment plan.
- Communicates with medical provider(s) to address treatment options, diagnosis, prognosis, and work capacity when there is documented lack of case progress.
- Under limited circumstances, may utilize on-site Medical Case Managers for medical management when indicated (*e.g.*, injured worker has verbal communication barriers).

Important Note: Medical Case Managers do not perform job duties of claims adjusters or handle comprehensive rehabilitation plans beyond return to work within the current employment.

Additional Resources: Refer to Board Rule 208 (h)(1) for detailed information.

J. Important Distinctions and Limitations for WC/MCO Medical Case Managers:

The Medical Case Manager shall monitor, evaluate, and coordinate the delivery of high quality, timely, cost-effective medical treatment and other health services as needed by an injured worker, and shall promote an appropriate, prompt return-to-work, when medically indicated. Medical Case Managers must facilitate communication between the injured worker, injured worker's representative, employer's representative, insurer, health care provider, WC/MCO and, when authorized, any qualified rehabilitation consultant to achieve these goals. See Board Rule 208 (h)(1). The employer/insurers' choice of WC/MCO contains contractual obligations specific to that Employer/Insurers' needs.

Medical Case Managers operating under a certified Managed Care Organization pursuant to O.C.G.A. §34-9-208 and Board Rule 208 are **not** subject to Board Rule 200.1 if the Medical Case Manager provides services for an employer with a posted WC-P3 WC/MCO panel (§34-9-201(b)(3)) unless the claim is designated catastrophic.

While WC/MCO Medical Case Managers play a crucial role in worker recovery and return-to-work, it's essential to understand their limitations and distinct responsibilities compared to registered Rehabilitation Suppliers.

Key Distinction:

- **MCO Case Managers:** Focus on medical case management and early return-to-work planning within the injured worker's current employment.

- **Registered Rehabilitation Suppliers:** Provide comprehensive rehabilitation plans encompassing broader areas like extended evaluation, independent living, return-to-work with another employer, training, and self-employment. In mandatory catastrophic cases, these rehabilitation functions are provided by SBWC registered Rehabilitation Suppliers.

Responsibilities Beyond Your Scope:

- **Rehabilitation plans for:**
  - Extended evaluation
  - Independent living
  - Return-to-work with a different employer
  - Training
  - Self-employment

K. Independent Medical Exams (IME) and Second Opinions

This section clarifies the role of Case Managers in handling Independent Medical Examinations (IMEs) and second opinions within the Georgia workers' compensation system.

Independent Medical Examinations (IMEs):

Employers/insurers have the right to request that the injured worker submit to an independent medical examination (IME), performed by a duly qualified examining physician. While these evaluations may be to confirm the appropriateness of recommended treatment, they are considered to be a claims or legal tool to be used by the employer/insurer to challenge recommended treatment, impairment ratings, causation, relationship of other complaints and/or clarify other issues. The injured worker and/or their attorney may request an IME to show alternatives to the authorized treating physician's opinion, to challenge impairment ratings, to clarify causation, or relationship of other complaints and/or to clarify other issues. The examining physician does not consider the injured worker as a patient and is to remain totally independent. Because of the nature of the IME, the Case Manager should **decline** to be directly involved in the process including:

- Procuring or curating medical records to be provided to the treating physician.
- Scheduling IMEs, sending records to IME physicians, or obtaining IME reports.
- Presenting or sending IME reports to the Authorized Treating Physician (ATP) or other approved providers prior to all parties having accepted the report and agreed to proceed.
- Composing the IME letter.
- Attending the IME appointment.
- Discussing IME with the injured worker.

Second Opinions: Second opinion consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific medical condition is requested by another physician or appropriate source that may include the parties to the case, injured worker, and/or Case Manager. At times, the Case Manager or injured worker may question the adequacy of treatment provided by the authorized treating physician. In those instances, the Case Manager has a responsibility to explain how a second opinion may be beneficial.

- Case Managers can be involved in second opinions if **all parties agree** to it.
- This agreement must be **confirmed in writing**, specifying the chosen physician and the Case Manager's role (attending, sending records, etc.).
- If any party disagrees with the second opinion or chosen physician, the Case Manager must refrain from involvement.

Important Note:

- Rule 200.2 of the SBWC rules does not directly address the selection, scheduling, or conduct of IMEs as defined by O.C.G.A. § 34-9-202.

Remember, as a Case Manager, your primary role is to facilitate communication and manage the medical treatment process within the established guidelines. Adhering to these guidelines ensures a smooth and compliant claims process for all parties involved.

L. Voluntary and Catastrophic Rehabilitation Under Board Rule 200.1

- **Voluntary vs. Catastrophic Rehab:** Clarifies the differences between voluntary and catastrophic rehabilitation services.
- **Catastrophic Designation and Appointment of Supplier:** Explains how a case gets designated as catastrophic and the process for assigning a Rehabilitation Supplier.
- **Duties of a Catastrophic Rehabilitation Supplier:** Details your core responsibilities, including as an advocate for the injured worker, conducting an initial interview, developing and filing a rehab plan, submitting progress reports, and requesting case closure when appropriate.
- **Assessment:** Guides you through the initial evaluation process, emphasizing the importance of a thorough medical record review and in-person interview with the injured worker. This section further outlines the information to be included in the initial report submitted with the initial Board form.
- **Plan Development and Approval Process:** Explains the process for developing and filing a rehab plan (WC-R2A) with the Board.
- **Types of Rehab Plans:** This section provides an overview of different rehab plan types, including extended evaluation, return-to-work, job search, training, self-employment, medical care coordination, and independent living plans.

- **Status Reports:** Explains the requirement to submit regular status reports (WC-R2) with updated medical records every 90 days.
- **Rehab Closure:** Outlines the process for requesting case closure (WC-R3) when you believe rehab is no longer needed.
- **Change in Rehabilitation Supplier:** Explains how a party to the case can request a change in Rehabilitation Supplier and the approval process involved.

M. Voluntary vs. Catastrophic Rehabilitation

200.1 Voluntary Rehabilitation

A Rehabilitation Supplier may provide voluntary rehabilitation services in non-catastrophic claims by agreement of the employer/insurer and the injured worker. Voluntary Rehabilitation Suppliers collaborate with these parties on a personalized rehabilitation plan to facilitate the injured worker's recovery. Within this framework, both the Rehabilitation Supplier and the injured worker participate voluntarily, with greater flexibility in choosing a plan and overseeing progress. Consent from the injured worker must be in writing and consent may be revoked at any time. If the injured worker is represented by an attorney, a discussion with the attorney should be initiated prior to pursuing the consent of the injured worker and the discussion should be documented. See Appendix G for Voluntary Rehabilitation Consent Form (page 37).

The services provided in voluntary rehabilitation cases are pursuant to Board Rule 200.1. Unlike catastrophic rehabilitation, the Rehabilitation Supplier performing voluntary rehabilitation duties is not required to complete board forms and submit them to the MCR Division. However, the Rehabilitation Supplier is required to communicate simultaneously with all parties involved in the case. This includes providing copies of received medical records, completed rehabilitation reports, notification of any coordinated appointments or services, and a copy of written or verbal communications with the treating physician. Understanding these distinctions ensures you operate within the appropriate framework for each case.

200.1 Catastrophic Rehabilitation

In contrast to voluntary rehabilitation, catastrophic rehabilitation applies to severe injuries as defined by the Workers' Compensation Act (O.C.G.A. § 34-9-200.1(g)) and involves a more structured approach. Only Board approved Catastrophic Rehabilitation Suppliers can be involved, and they are required to complete specific Board forms for submission to the MCR Division. These forms track progress and ensure adherence to mandated protocols. Catastrophic rehabilitation prioritizes intensive care and a comprehensive approach to maximize the worker's recovery potential.

The employer/insurer is required to provide rehabilitation services that are reasonable and necessary for catastrophically injured workers. This applies to cases with date of injury after July 1, 1992. A catastrophic injury is defined as below:

1. Spinal cord injury involving severe paralysis of an arm, a leg or trunk.
2. Amputation of an arm, hand, foot, or leg involving the effective loss of use of that appendage.
3. Severe brain or closed head injury as evidenced by
   a. Severe sensory or motor disturbances
   b. Severe communication disturbances
   c. Severe complex integrated disturbances of cerebral function.
   d. Severe disturbances of consciousness.
   e. Severe episodic neurological disorders.
   f. Other conditions at least as severe in nature as any condition provided in subparagraph (a) through (e) preceding this paragraph.
4. Second or third degree burns over 25% of the body as a whole or third degree burns to 5% or more of the face or hands.
5. Total or industrial blindness
6. Any other injury of nature and severity that prevents the injured worker from being able to perform his/her prior work and any work available in substantial numbers within the national economy.

N. Catastrophic Designation and Appointment of Supplier

1. The employer/insurer shall designate a catastrophic Rehabilitation Supplier by filing WC-R1.
2. If the employer/insurer does not file the WC-R1, the injured worker or injured worker's attorney can request designation by filing form WC-R1CATEE.
3. Once board determination is made and the case is deemed catastrophic, the employer/insurer have 20 days to request assignment of a Rehabilitation Supplier.
4. When a catastrophic designation is disputed, the injured worker or injured worker's attorney shall file a WC-R1CATEE to request catastrophic designation and appointment of a registered catastrophic Rehabilitation Supplier. Filing of the WC-R1CATEE is not the responsibility of the Case Manager or Rehabilitation Supplier.
5. Rehabilitation Suppliers and Case Managers are not considered to be parties to the case.
6. Reporting to the MCR Division is required in all cases designated as catastrophic.
7. Only registered Rehabilitation Suppliers who meet additional educational and experience criteria and complete catastrophic training as outlined in See Appendix H Catastrophic Rehabilitation Registration Criteria and Requirements (page 39) are given designation as "Catastrophic Rehabilitation Suppliers." Only Catastrophic Rehabilitation Suppliers are assigned to cases deemed catastrophic.

Rehabilitation Supplier Role and Catastrophic Designation

1. O.C.G.A. § 34-9-200.1 provides the definitions for what is considered a catastrophic injury. In some respects, the question of whether a given injury is catastrophic is patently clear such as the amputation of a limb. However, there is some ambiguity and room for discussion or argument. The Rehabilitation Supplier should not put himself/herself in the position of deciding what is or is not catastrophic but should leave that to the parties to the claim or to the State Board of Worker's Compensation. The Rehabilitation Supplier should, however, provide his/her independent professional judgement to discuss and advise the employer/insurer when they feel that a particular injury is, should be or might be considered catastrophic. The Rehabilitation Supplier/Medical Case Manager should, consistent with their independent professional judgment, advise the parties when the injury is beyond their qualifications or certifications such that a more appropriate Rehabilitation Supplier/Medical Case Manager can be appointed.

O. Duties of Catastrophic Rehabilitation Supplier

1. The Rehabilitation Supplier duties are found in Rule 200.1(II)(B)(1-12).
2. The assigned Rehabilitation Supplier has sole responsibility for each case assigned.
3. The Rehabilitation Supplier is considered an advocate for the injured worker.
4. Initial evaluation/interview with the injured worker should take place within 30 days of appointment.
5. A rehabilitation plan should be formulated and discussed with the injured worker. Although the supplier should consult with the parties and invite input into the rehabilitation plan, ultimately the WC-R2a individualized rehabilitation plan is the supplier's plan for what rehabilitation activities need to happen in the case. WC-R2a forms outlining the rehabilitation plan should be filed within 90 days of appointment. WC-R2a forms along with corresponding medical records or reports are sent to all parties and the SBWC simultaneously.
6. If after the initial evaluation the Rehabilitation Supplier believes there is no need for rehabilitation services, they may request the case be closed. A WC-R3 closure form must be filed and approved by the MCR Division of SBWC.
7. For all active catastrophic cases, the Rehabilitation Supplier should provide ongoing medical and rehabilitation updates to all parties in real time.
8. The Rehabilitation Supplier shall file a status report to the SBWC by way of a WC-R2 form every 90 days. The WC-R2 can be completed more frequently if needed. WC-R2 forms should also include medical records or rehabilitation reports completed since last submission. Copies of the submission and form are sent to all parties simultaneously.
9. All rehabilitation forms should be completed online in ICMS. See Appendix I ICMS II Access/Registration for Form Submission (page 40).
10. If the Rehabilitation Supplier requires assistance of the assigned MCR Rehabilitation Coordinator on a case, the supplier can file anWC-R5 request for rehabilitation conference. Copies of the WC-R5 form are sent to all parties and SBWC simultaneously.

P. Injured Workers Residing Out of State

Should an injured worker reside out of state or relocate to another state, the designated Catastrophic Rehabilitation Supplier maintains the case. Initial patient evaluation and annual in-person evaluation is required by the designated Catastrophic Rehabilitation Supplier and rehabilitation report submission throughout the case must be maintained by the designated supplier. However, collaboration with local Rehabilitation Supplier(s) is allowable for purposes of attending appointments and other care coordination activities as appropriate. See Appendix J Assigning a Catastrophic Case to an Out of State Supplier (page 40).

Q. Assessment

The assigned Catastrophic Rehabilitation Supplier should complete an in depth and detailed initial evaluation. This is an in-person interview between the injured worker and Rehabilitation Supplier. A thorough review of medical records is vital for a comprehensive understanding of the past and current medical status of the case. If able, an in-home safety and accessibility assessment should also be completed for purposes of identifying any areas of need. Once all information has been gathered and the record review completed, the Rehabilitation Supplier should produce a written initial rehabilitation report. This report should be submitted with the first board form filed with the rehabilitation division, whether that is a WC-R2 or WC-R2a.

R. Initial Report

The initial report written shall include the following information:

a. Summary of current medical status
b. Identification of secondary conditions affecting recovery
c. List of current medications
d. Current treatment
e. Prognosis
f. Employer contact, specific name, and title
g. Work status
h. Social history
i. Educational background
j. Employment history
k. Average weekly wage at time of injury
l. Transportation availability
m. Equipment Status/Needs
n. Current monthly work comp benefits received and SSDI status
o. Statement of supplier's conclusion regarding the injured worker's need for rehabilitation services.
p. Plan of action

S. Plan Development and Approval Process:

Every catastrophic injury claim with an assigned Catastrophic Rehabilitation Supplier must have a current, approved rehabilitation plan, filed with the Board on Form WC-R2a. The initial plan must be filed within 90 days of appointment and is in place for no longer than one year. An amended or extended plan must be filed 30 days before the expiration of the current plan. An amended plan can also be filed sooner and is recommended when there is a change in medical status and/or medical treatment which affects the current plan in place.

The WC-R2a individualized rehabilitation plan is *your* proposed plan. Although you are expected to consult with the parties and invite input and participation, *if all parties do not agree on how to proceed, the plan should reflect what you believe is appropriate, based on your expertise.* Claim adjusters, injured workers, and attorneys are not in charge of rehabilitation plans. **"The registered Catastrophic Rehabilitation Supplier shall have sole responsibility for the rehabilitation aspects of each individual case." Board Rule 200.1(II)(B)**

When an individualized rehabilitation plan is filed, the parties have 20 days to object to it. If there is no objection, the plan is considered approved as filed. If a party objects to any part of a plan, or if the SBWC (through a rehabilitation coordinator) takes issue with a plan, then the rehabilitation coordinator will issue an Administrative Decision (with or without a conference) that will do one of three things:

1) Approve the plan as submitted.
2) Amend the plan; or
3) Direct the Rehabilitation Supplier to submit a revised plan.

The proposed plan shall include goals, justification for goals, objectives to achieve goals, dates for completion of objectives, delineation of responsibilities of the parties involved and estimated rehabilitation costs of the supplier services to complete the plan. The objectives shall be stated in measurable terms and shall be related to the established goal.

After the initial plan is approved, the Catastrophic Rehabilitation Supplier shall submit progress or status reports with updated medical records and supporting documentation every 90 days under cover of a Form WC-R2.

T. Types of Rehabilitation Plans

Extended Evaluation Plan: For the purpose of ascertaining if vocational rehabilitation is feasible, and if so, to identify specific job goals. Often labor market surveys, vocational evaluations and functional capacity evaluations are services proposed in this type of plan.

Return-To-Work Plan: All return-to-work scenarios are covered under this plan. Whether return-to-work to same employer or new employer. This plan should be accompanied by a current release to return-to-work from the authorized treating physician(s) and an approved job description or analysis of the job to which the injured worker is returning. The type of return-to-work plan should be indicated. These are:

A. Return-to-work with the same employer
B. Return to different job with the same employer
C. Return-to-work with new employer
D. Short-term training
E. Long term training
F. Self-employment

Job Search Plan: These plans should be accompanied by documentation of labor market surveys or other information which documents a reasonable possibility of suitable employment in the job objectives listed in the plan. The plan must be submitted with current release to return-to-work from the authorized treating physician(s).

Training Plan: Should be submitted only when direct placement with an employer of injury or with another employer is not possible, or unless all parties agree to training. The rationale for the plan should be clearly documented in the proposed training plan. All training plans should include documentation of the proposed training program, length of study and total cost. A provision should be considered that the injured worker must maintain passing grades for the proposed plan to continue.

Self-Employment Plan: Should be submitted only when direct placement with an employer of injury or another employer is not possible. This plan must further document that the proposed type of self-employment is likely to be successful. An extended evaluation plan may assist in determining the success of proposed self-employment.

Medical Care Coordination Plan: This plan can only be submitted in cases of catastrophic injury. This plan must address the injured workers comprehensive medical needs.

Independent Living Plan: This plan can only be submitted in cases of catastrophic injury. This plan must address the injured workers comprehensive rehabilitation needs, including suitable housing and transportation.

Status Reports: As stated above, a status report or WC-R2 is submitted in each case every 90 days. These can be done sooner if case activities require more frequent update. When filing the WC-R2, you should include all rehabilitation reports, medical records and any other pertinent documentation that has taken place since your last submission. A copy of the submission is sent to all parties simultaneously.

Rehabilitation Closure

The Rehabilitation Supplier is responsible for requesting closure of rehabilitation whenever his/her professional opinion is that rehabilitation is no longer needed or feasible. Closure must be requested by filing a WC-R3 to the MCR Division. There can be various reasons for requesting closure:

1. The supplier believes that rehabilitation is no longer needed or feasible.
2. The injured worker has successfully returned to full-time work for at least 60 days and is no longer in need of the supplier's services. (rehabilitation can remain open after the 60 days of RTW if the injured worker would benefit from further medical care coordination)
3. A stipulated settlement which does not include further rehabilitation services has been approved.
4. SBWC has issued a decision closing rehabilitation.

Any party to the case can file an objection to case closure within 20 days of WC-R3 receipt. A case party can also file their own request for rehabilitation closure by filing a WC-R3. In all cases of request, the SBWC's rehabilitation coordinator will decide and issue an administrative decision.

U. Change in Rehabilitation Supplier

Only a party to the case can request a change in Rehabilitation Supplier (see the next section outlining parties to the case). This request requires approval of the Board. When a party requests this, a WC-R1 should be filed requesting a change and include a proposed supplier's name and information. The party must also list the reason for the change. This WC-R1 should be copied to both suppliers. Any case party may file a written objection to the request for change by filing Form WC-Rehab Objection [online Form MC-NFN-12 Rehab Objection]. [NOTE: By rule, objections to change requests must be filed within 15 days of the certificate of service on the WC-R1 request. [See Rule 200.1 (II)(H)(3)] If the MCR Division determines that a Rehabilitation Supplier should be removed from the case and rehabilitation is still needed, the MCR Division may direct a change of supplier and will notify all parties and involved Rehabilitation Suppliers of the administrative decision. The replaced supplier should close their file and complete a WC-R3. Please note that the assigned Rehabilitation Supplier must maintain responsibility for providing rehabilitation services, unless excused by the SBWC, until all appeals have been exhausted.

V. Parties to the Case

The SBWC recognizes the following as parties to the case or party representatives: injured worker, employer, insurer, claim adjuster, third-party administrator (TPA), TPA adjuster, injured worker's attorney, defense attorney, Subsequent Injury Trust Fund (SITF), SITF representative, and SITF attorney if involved in the claim. A party to the claim could also be the injured worker in a death case, or a conservator bringing a claim

for a minor or legally incapacitated adult. Generally, in addition to getting notice of all proceedings in the claim, parties to the claim or their attorneys have access to ICMS and may obtain copies of the claim file.

The Case Manager/Rehabilitation Supplier is not considered to be a party to the case, nor is the authorized treating physician and other practitioners who may be providing care to the injured worker.

Parties of Interest:

A group insurance company or other health care provider who covers the costs of medical treatment for an injured worker may file a Form 206 request to be a party at interest in a claim during the pendency of the claim. However, parties at interest cannot request hearings and do not have access to the claim file, including obtaining copies of the claim file, even if they are represented by attorneys registered in ICMS. Parties at interest do get notices of hearings and may participate in the hearings, and their claims must be resolved at the time of settlement of workers' compensation liability claims.

APPENDICES

A. Definitions for Case Managers/Rehabilitation Suppliers and Related Roles in Georgia Workers' Compensation

Medical Case Manager or Case Manager

A professional who evaluates, plans, implements, coordinates, and monitors services to the injured worker within Georgia's Workers' Compensation system. Case Managers ensure efficient and cost-effective delivery of high-quality medical treatment, coordinate care, facilitate communication, and support the recovery process. While sometimes used interchangeably, the services may vary as follows:

Field Case Manager

Provides in-person services, visiting injured workers with consent of the injured worker and/or their counsel, medical providers, and employers to coordinate care and facilitate recovery.

Telephonic Case Manager

Coordinates care remotely through telephone, email, video conferencing, and other digital communication methods with injured workers, medical providers, employers, and other stakeholders.

Independent Case Manager

Operates independently, providing case management services without direct affiliation to a specific employer or insurer, but is rather self-employed or employed by a company that provides case management services.

In-house/Direct Employee Case Manager

This type of case manager works directly for an employer or insurer, managing cases internally within the organization. Unlike contracted case management services, which involve external providers, in-house case managers are considered direct employees of the organization. As such, Rule 200.2, which governs certain aspects of case management, does not apply to in-house or direct employee case managers provided that their specific role is identified.

Vocational Case Manager

Case manager who is trained and qualified to provide vocational services including vocational evaluations and vocational counseling.

Qualified Medical Case Manager

A Qualified Medical Case Manager is a professional who meets the specific criteria as outlined in Rule 200.2 and possesses certification and/or licensure of at least one certifying or licensing agency contained in Board Rule 200.1(I)(A).

Voluntary Rehabilitation Suppliers

A voluntary rehabilitation supplier provides rehabilitation services for non-catastrophic claims through mutual agreement with the employer/insurer and the injured worker, focusing on a personalized rehabilitation plan to aid recovery. Unlike catastrophic cases, these suppliers operate with greater flexibility and are not required to submit board forms, but must ensure simultaneous communication with all parties involved, including sharing medical records and rehabilitation reports.

Catastrophic Rehabilitation Supplier

A catastrophic rehabilitation supplier is a professional approved by the Board to manage rehabilitation for workers with severe injuries as defined by the Workers' Compensation Act (O.C.G.A. § 34-9-200.1(g)), ensuring comprehensive care and adherence to mandated protocols. They are responsible for completing specific Board forms to track progress and must meet additional educational and experience criteria to qualify for this role. Unlike voluntary rehabilitation, catastrophic rehabilitation involves a structured approach to maximize recovery potential for injuries such as paralysis, amputations, or severe brain injuries.

Eligibility and Case Handling for Case Managers and Rehabilitation Suppliers

Telephonic Case Managers, Field Case Managers, Independent Case Managers, and Vocational Case Managers can handle all types of cases (200.1 voluntary rehabilitation and 200.2 case management) if they meet the appropriate requirements as outlined in Board Rule 200.1(I)(A) and are registered with the State Board of Workers' Compensation. In-house/Direct Employee Case Managers may handle the same types of cases but are not subject to Rule 200.2 requirements. Only CAT certified Rehabilitation Suppliers can handle catastrophic cases.

B. Best Practices for Contact/Meeting with Physicians During Face-to-Face Visits (200.2 Case Management)

Before the Meeting:

- **Planned private meeting**: Provide 10 days' advance notice to the injured worker and their attorney notifying them of their option to attend, your role and issues to be addressed at the planned conference.

As a best practice, a proposed agenda may be included (for example: Discuss current treatment regimen, future treatment recommendations, current functional abilities, recovery expectations). Schedule appointment with treating provider.

- **Injured Worker Preparation (if injured worker to be in attendance):**
  - **List Creation:** Collaborate with the injured worker to create a list of:
    - Outstanding issues (prescriptions, DME, home health, therapy)
    - Pain complaints (intensity, location, quality, aggravating/alleviating factors)
    - Medication issues (refills, changes, effectiveness)
    - Recovery and treatment expectations
  - **Review Medical Records:** Ensure the physician has access to relevant records (office notes, reports, etc.) from other providers involved in the claim.
  - **If you are planning to discuss return to work and provide job description(s), all parties must receive a copy ahead of the meeting.**
  - If the injured worker is represented by an attorney, it is recommended that the job description(s) be reviewed with the injured worker and their attorney (if applicable).
  - If the injured worker's attorney declines consent to allow contact with the injured worker, the private medical meeting may take place provided proper 10-day advance notice is provided. However, the injured worker maintains the right to be present at the meeting, subject to the physician's agreement. In the absence of consent allowing direct contact with the injured worker, all efforts should be made to refrain from discussions with or advice to the injured worker. In these instances, it is critical to maintain accountability for your interactions during these meetings and clearly document in your reports to the parties the nature of the interaction with the physician and patient, noting that the injured worker or physician specifically requested the injured worker's attendance.

During the Meeting:

- **Introduction & Identification:**
  - Introduce yourself as a Qualified Medical Case Manager and who you are retained by (employer/insurer, attorney, etc.).
  - Explain your role.
  - Verify the physician's identity and specialty.
- **Injured Worker Concerns (if injured worker in attendance):**
  - Facilitate communication by ensuring the injured worker feels comfortable raising all concerns on their list.
  - Ensure injured workers understand the treatment plan, work restrictions, and their role in the recovery process.
- **Physician Recommendations:**
  - Clearly understand the physician's:

        - Treatment plan and rationale (explain to a claim adjuster, employer, and attorneys)
        - Work status recommendations (restrictions, return-to-work)
    - Confirm recommendations only address approved body parts per the claim.
- **Communication & Documentation:**
    - Ensure clear communication between all parties (physician, injured worker, Qualified Medical Case Manager, claim adjuster, employer, attorney).
    - Take detailed notes of the discussion, including:
        - Physician's assessment and recommendations
        - Treatment plan details (medications, therapy, etc.)
        - Work status and restrictions
- **Obtaining Orders & Approvals:**
    - If possible, obtain written orders for:
        - Physical therapy/occupational therapy
        - Medications
        - Durable Medical Equipment (DME)
        - Home health care (if applicable)
- **Next Steps:**
    - Discuss any follow-up appointments or actions needed.

After the Meeting:

- **Information Sharing:**
    - Provide a copy of your meeting notes to the injured worker, claim adjuster, employer (if applicable), and attorney(s) (if involved).
    - Submit physician orders and all documents reviewed/received to appropriate parties for necessary approvals.
        - Ensure timely coordination of authorized services.

- **Communication & Follow-up:**
    - Maintain open and timely communication with the physician and injured worker (if applicable) regarding any questions or updates.
    - Monitor the claim progress and follow up with the injured worker as needed.

Additional Considerations:

- **Consent:** Documented consent from the injured worker and/or his/her attorney is required to attend a medical appointment with them. 10-day advance notice is necessary for private conferences with physicians.

- **Respectful Communication:** Maintain a professional and respectful demeanor throughout all interactions.
- **Confidentiality:** Always comply with HIPAA regulations regarding protected health information. Medical information obtained may only be shared with authorized parties directly involved in the claim.

By following this checklist, you can ensure effective communication and collaboration with physicians, ultimately facilitating a smoother claims process and a faster recovery for the injured worker.

C. Appointment Summary Best Practice Checklist for Qualified Medical Case Managers (200.2 Case Management)

Reporting appointment summaries to claim parties:

1. Claim adjuster
2. Claimant and defense attorney(s)
3. Employer
4. State Board of Worker's Compensation (if needed due to SBWC involvement such as a pending rehabilitation conference or hearing).

The goal of reporting to all parties is to provide a concise, well-thought-out summary of the injured worker's medical appointment. This appointment could be with a physician, physician assistant, or nurse practitioner. The Qualified Medical Case Manager shall simultaneously provide copies of all correspondence, written communication, and documentation of oral communications with the employee's treating physician to all parties and their attorneys. The correspondence and written communication referenced herein includes, but is not limited to, medical records, medical reports, office notes, test results, and all other written documents received from the employee's treating physician.

1. Current medical status such as description, location, and intensity of symptoms, per the injured worker.
2. Outstanding issues that have not been resolved and why.
3. Update regarding injured workers social/psychological/physical status.
4. Physicians' findings upon exam.
5. Current diagnoses.
6. Physicians' assessment of subjective vs. objective findings.
7. Physicians' treatment plan and rationale.
8. Medication list. Be sure to document any changes in medication or dosages.
9. Work status. Is this permanent or temporary? Give specifics as to how long work restrictions are expected, per the provider.
10. Expected dates of MMI.

Use this summary as an opportunity to bring issues and concerns to light. Remember that this will be part of the claim and is discoverable.

D. Privileged and Confidential Communication (O.C.G.A. §§ 24-5-501 and 34-9-207)

O.C.G.A. § 24-5-501:

There are certain admissions and communications excluded from evidence on grounds of public policy, including, but not limited to, the following:

a. Communications between husband and wife;
b. Communications between attorney and client;
c. Communications among grand jurors;
d. Secrets of state;
e. Communications between psychiatrist and patient;
f. Communications between licensed psychologist and patient as provided in Code Section 43-39-16;
g. Communications between a licensed clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist, or licensed professional counselor and patient;
h. Communications between or among any psychiatrist, psychologist, licensed clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist, and licensed professional counselor who are rendering psychotherapy or have rendered psychotherapy to a patient, regarding that patient's communications which are otherwise privileged by paragraph (5), (6), or (7) of this subsection; and
i. Communications between accountant and client as provided by Code Section 43-3-29.

As used in this Code section, the term:

j. "Psychotherapy" means the employment of psychotherapeutic techniques.
k. "Psychotherapeutic techniques" shall have the same meaning as provided in Code Section 43-10A-3.

O.C.G.A. § 34-9-207:

a. When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician,

including, but not limited to, communications with psychiatrists or psychologists. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to the examination, treatment, testing, or consultation concerning the employee.

b. When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

c. If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

E. Utilization Review and Dispute Resolution (WC/MCO, Board Rule 208)

Utilization Review Requirements for WC/MCOs:

- The WC/MCO must have a **written utilization review program** outlining its procedures.
- Reviewers must be **qualified healthcare professionals**.
- Reviews must be based on **evidence-based standards and guidelines**.
- The program must include a **peer review process** to ensure quality and consistency.
- The program must have an **internal dispute resolution process** for addressing concerns.

The Medical Case Manager monitors adherence to the treatment plan. If there are inexplicable deviations from the treatment plan, the Medical Case Manager may staff with the Medical Director for further appropriate action.

If an employer or insurer utilizes a Board-certified WC/MCO pursuant to O.C.G.A. § 34-9-201(b)(2), and a dispute regarding authorization of treatment/testing prescribed by an authorized treating physician is not resolved within 30 days, then the injured worker or the injured worker's attorney may initiate the WC-PMT proceedings in subsection (c) of this Rule. Where no WC-PMT is filed, and the dispute is not resolved within 30 days as outlined in Rule 208(f), then the employer or insurer has 15 days from notification by the WC/MCO

to authorize the treatment/test or controvert the treatment/test. In no event will the employer or insurer utilizing a WC/MCO have more than 45 days from the receipt of the notice of a dispute as set forth in Rule 208(f) 65 to comply with this provision.

F. WC/MCO Return to Work Program and Board Rule 208

The WC/MCO shall provide an "effective program for return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health, safety, and other services." Board Rule 208 (a)(1)(P). The identification and implementation of appropriate transitional job duty opportunities and other efforts which promote the ultimate return to work of injured workers is a cornerstone of the WC/MCO's solution to escalating costs in workers' compensation.

WC/MCO Case Manager's Role in Return-to-Work Coordination

The WC/MCO's Medical Case Manager's role as an advocate for the injured worker, together with the injured worker's supervisor, the injured worker's human resources department, and the injured worker's authorized treating physician, is the identification and design of an appropriate transitional or light duty position. Medical restrictions or limitations must be considered when monitoring the injured worker's progress from transitional or light duty to full duty or permanent alternate duty.

The Managed Care Organization proactively assists the employers in structuring formal internal return to work programs. The structuring of internal return to work programs may include:

1. Identification of transitional or light duty positions available.
2. Preparation of job descriptions.
3. Orientation and training for employer and staff in safety programs and return to work philosophy, etc.
4. Evaluation of the success of the program and revision, as necessary.

Return to work with same employer may be in the form of:

- Transitional or light duty.
- Regular duty in the job held prior to the injury.
- Permanent alternate duty in the job held prior to the injury (job restructuring).
- A new job.

Other Return to Work Job Duties for Medical Case Manager:

- Includes those job duties of general, telephonic, and on-site case management, as needed.
- Reviews with injured worker, work restrictions prescribed by providers during the course of treatment.
- Coordinates with the employer and injured worker regarding tentative return-to-work date.
- Follows up with employer to notify of the status of the case as indicated.

- Provides follow-up services as needed after injured workers return to work to ensure successful outcome.
- Coordinates services and education between employer and physician regarding proactive modified work programs.
- Maintains one of the certifications required per Board Rule 208(h)(2) and adheres to all codes of ethics required by these credentials.
- Accountable for adherence to all applicable laws and regulations governing the provision of workers' compensation case management services.

Medical case management activities and return to work case management activities within a certified MCO should not be confused with those activities provided by a registered Rehabilitation Supplier. A rehabilitation plan for extended evaluation, independent living, return to work (with other than present employer), training, or self-employment is not the duty of a Medical Case Manager in a certified Workers' Compensation Managed Care Organization. In mandatory catastrophic cases, or by written agreement of the parties, these rehabilitation functions are provided by board registered Rehabilitation Suppliers.

Definitions:

Transitional Duty: A modification of the original job with the employer of injury. The objective is to return the injured worker to work as quickly as medically possible. The goal is to help the injured worker remain productive and speed his/her recovery. Transitional duty ensures rapid return to work when such work is medically appropriate. The essential functions of the job are reviewed with input from the injured worker, Medical Case Manager, employer/supervisor, and catastrophic Rehabilitation Supplier when appropriate. The injured worker is 'transitioned' back to his full job description as his recovery progresses and permits.

Light or Modified Duty: A temporary job assignment that is based on injured workers' physical limitations. The essential job duties shall be designed by the employer/supervisor.

G. Voluntary Rehabilitation Consent Form

Voluntary Rehab Consent (Draft)

Injured Employee's Name: _____

Date of Injury: _____

Claim Number: _____

Employer's Name: _____

Insurer's Name: _____

Rehabilitation Supplier's Name: _____

I, the undersigned, hereby consent to participate in a voluntary rehabilitation program as provided under Georgia Board Rule 200.1.

Understanding of Voluntary Rehabilitation:

- I understand that this is a **voluntary** program and that I have the right to refuse or withdraw from participation at any time.
- I understand that my participation does not create any obligation on the part of my employer or insurer to provide additional benefits.
- I acknowledge that the Rehabilitation Supplier will work collaboratively with myself, my employer, insurer, and treatment providers to develop rehabilitation recommendations.
- I understand that I am entitled to a private exam with my treating physician(s).
- I understand that the Rehabilitation Supplier will communicate simultaneously with all parties involved in my case, including providing copies of medical records, rehabilitation reports, coordinated appointments, and written or verbal communications with my treating physician.
- I understand that the services provided are intended to facilitate my recovery and may include coordination of, but are not limited to, medical treatment, physical therapy, occupational therapy, vocational rehabilitation, and job placement assistance.

Authorization to Release Medical Information:

- I authorize my employer, insurer, and Rehabilitation Supplier to obtain and exchange any medical information necessary for the evaluation and treatment of my injury in compliance with provisions set forth in O.C.G.A. §34-9-207. I have read, signed, and executed form WC-207 acknowledging same.

Communication and Updates:

- I agree to communicate regularly with the Rehabilitation Supplier and to provide any necessary information or documentation requested.
- I understand that the Rehabilitation Supplier will keep me informed of my progress and any changes to the rehabilitation plan.

Consent to Coordination of Services:

- I consent to the Rehabilitation Supplier coordinating appointments and services with my treating physician and other healthcare providers as needed.

By signing below, I acknowledge that I have read and understand the terms of this voluntary rehabilitation participation consent form.

Injured Worker's Signature: _____

Date: _____

Witness Signature: _____

Date: _____

H. Catastrophic Rehabilitation Registration Criteria and Requirements

Any Rehabilitation Supplier who has been registered at the State Board of Workers' Compensation for two years as a Georgia Rehabilitation Supplier is eligible to apply. Any registered Rehabilitation Supplier with any of the following credentials is eligible to apply after one year as a registered Georgia Rehabilitation Supplier:

- Prior employment as a Case Manager at a CARF Accredited Center of Excellence
- Current Life Care Planner Certification (CLCP or NCLCP)
- CRRN Certified Registered Rehabilitation Nurse

Any registered Rehabilitation Supplier with two years of workers compensation experience in other states is eligible to apply. Two years registration as a Georgia Rehabilitation Supplier is not required. A CV will be required.

Any supplier previously registered as a Catastrophic Rehabilitation Supplier in Georgia returning from hiatus will be eligible as soon as they have renewed their registration as a Rehabilitation Supplier.

Applicants will submit the Notification of Intent to Apply for Catastrophic Registration. If applying based upon the above credentials, the applicant must include the documentation with the Notification of Intent form. This form may be obtained from the State Board of Workers' Compensation at https://sbwc.georgia.gov/divisions-offices/managed-care-rehabilitation/rehab-suppliers. Upon Board receipt of this form, a Catastrophic Registration packet will be provided to the applicant along with an assigned application number for use in document submission.

To qualify, the applicant will submit: the required CEU certificates from AAACEU's (applicant name should appear); three WC-R2a's; and three corresponding initial reports. The applicant must select three of the four scenarios (spinal cord injury, amputation, brain injury, burns) provided as the basis for the initial report and WC-R2a in a problem-based case method.

A sample initial report is included in the application packet. The applicant's initial reports must utilize the specified organization of the sample report for ease of review by the catastrophic review committee. The initial reports must remain vendor, provider, and carrier neutral, with use of fictitious names for the vendors, physicians, etc. A WC-R2a Guide and sample WC-R2a are also included in the application packet for the applicant's reference. **Note: the applicant's name should not be included on the submitted WC-R2as and Initial Reports; the applicant's assigned number should be utilized.**

The applicant is expected to review the Managed Care and Rehabilitation's Housing and Transportation Guides and use these two documents in developing the plans. These documents are located on the Managed Care & Rehabilitation section on the Board's website: www.sbwc.georgia.gov.

Finally, a rubric is included in the packet as well, which provides an explanation of the review process. A grade of 3 or 4 is required to pass each submission. A grade of 1 or 2 is returned to the applicant for revision. As this is a scholarly exercise, professional medical and rehabilitation terminology is expected. The purpose of these submissions is to ascertain whether the applicant has the basic critical skills necessary to safely and effectively assess, plan, implement, coordinate catastrophic cases; including the ability to ask the pertinent questions when needed.

THE COMMITTEE WILL ONLY REVIEW COMPLETE APPLICATIONS: all the required documentation specified above must be sent as a packet for review to the same address specified on the Notice of Intent to Apply. The applicant will be advised of a decision within 60 days of submission of the application. If the applicant is not accepted as a catastrophic supplier, the reasons will be provided with useful information to help the applicant. The revised documentation may be submitted within 60 days; otherwise, an applicant will be required to begin the application process anew.

I. ICMS II Access/Registration for Form Submission

To obtain information on ICMS II access and registration, send an email to **ICMSTraining@sbwc.ga.gov** or contact Claims Assistance at (404) 656-3818 or (800) 533-0682

J. Assigning a Catastrophic Case to an Out of State Supplier

When a case is designated as catastrophic, and the injured worker moves/lives out of state it may be necessary to secure the services of a Rehabilitation Supplier that is local to the injured worker. When this occurs, the assigned Georgia Catastrophic Rehabilitation Supplier shall provide the most recent Rehabilitation and Case Management Procedure Manual to the local supplier. Furthermore, it is the responsibility of the Georgia Catastrophic Rehabilitation Supplier to initiate contact and set forth professional guidelines and expectations. The question of whether the Georgia Rehabilitation Supplier should conduct an onsite visit should be determined on a case-by-case basis according to medical/vocational necessity and the suppliers' ethical responsibilities as defined by their certifying body.

The Georgia Catastrophic Rehabilitation Supplier is responsible for assuring that all vocational and rehabilitation efforts, whether performed by the Georgia Rehabilitation Supplier or the local Case Manager or Rehabilitation Supplier, comply with the Georgia Worker's Compensation Act. The Georgia Catastrophic Rehabilitation Supplier will remain responsible to complete the requisite Board Forms, including WC-R2 and WC-R2A, as required. The local supplier will assist and provide services in conjunction with the Georgia

catastrophic supplier. The suppliers will work together professionally to fulfill the approved rehabilitation plan. If there is a conflict of Georgia law and the jurisdictional rules/laws of the other state, the Georgia Rehabilitation Supplier should address this with the Georgia State Board of Workers' Compensation.

K. Information Required to Process Requests for Catastrophic Designation

Note: This appendix is for employees and attorneys who are seeking catastrophic designation of the employees' injuries and is not a part of any duties of a catastrophic rehabilitation supplier or medical case manager.

- Completed Form WC-R1CATEE. When requesting a specific rehabilitation supplier, the supplier must be registered with the Board as a catastrophic rehabilitation supplier.
- Clear statement of which provision of O.C.G.A. § 34-9-200.1(g) (whether (1), (2), (3), (4), (5), or (6)) is the basis of the request.
- Summary of compensable injury-related diagnoses (may be in medical records).
- Recent (within the past year) medical records from the employee's authorized treating physician sufficient to demonstrate that the compensable conditions satisfy the definitional requirements of O.C.G.A. § 34-9-200.1(g).
- **Additionally, if request is based on a condition identified in O.C.G.A. § 34-9-200.1(g)(6):**
  - Work history for at least the past 15 years, including the physical requirements of each job;
  - Summary of educational attainment;
  - Medical documentation of the employee's *current* physical and/or mental restrictions. *Note: Statements of restrictions is strongly preferable to a simple "no work" statement; and consider whether a physician is vocationally qualified to make general statements regarding whether jobs available in substantial numbers in the national economy can be performed by someone with given physical limitations.*

A narrative summary (*e.g.*, brief or memorandum) of relevant facts (*e.g.*, description of accident, injuries, diagnoses, medical and other expert opinions) is *strongly encouraged*. Assertions as to physical abilities and medical conditions must be supported by documentation.

The above information is not exhaustive and may not be sufficient to establish that an injury is catastrophic in a given case. The employee or counsel should provide all relevant information that he or she believes supports the case for catastrophic designation.

HOUSING GUIDELINES AND CONSIDERATIONS

This housing information was prepared by a subcommittee appointed by the SBWC. It is provided as general information and to assist with appropriate considerations for housing issues that may arise while working with an injured worker during the rehabilitation process. It is not all-inclusive or specific to an individual injured worker's needs. It is to be used as a guide to explore the housing issues with all parties. The HOUSING GUIDELINES AND CONSIDERATIONS are not to be construed as having statutory authority but are instead intended as guidelines for the parties in considering housing issues. (The HOUSING GUIDELINES AND CONSIDERATIONS were, however, reviewed and approved by the State Board of Worker's Compensation before publication.)

Purpose Of Guideline

This section aims to help clarify the various housing issues which exist in some catastrophic workers' compensation situations. The primary guideline for determining housing needs is based on Georgia State Board of Workers Compensation Rule 200.1, which states the understanding that part of the mandatory Rehabilitation Services is to "coordinate reasonable and necessary items and services to return the injured worker to the least restrictive lifestyle possible." When necessary, this specifically includes suitable housing. While the Catastrophic Rehabilitation Supplier is required to be the point person to coordinate these services, all parties are charged with the fulfillment of this goal.

A. Overview

There has only been one case-law decision rendered on housing in the catastrophic claim setting, Pringle v. Mayor & Alderman of the City of Savannah, 223 Ga.App.751; 478 S.E.2d 139 (1996). The essence of this Court of Appeals decision addressed whether the Board had the right to mandate the provision of payments towards housing costs by the employer/insurer. In the Court's analysis, housing accommodation needs could be addressed as a medical need if the authorized treating physician(s) prescribes them. (Id. @ 752). It is also found that, pursuant to Rule 200.1 of the Workers' Compensation Act, which clearly requires the employer/insurer to provide necessary modifications to the injured worker's home, it is also a rehabilitation need. While the solution reached in Pringle is specific to the facts of that case, the case highlighted the issue that appropriate accessible housing may require alternative solutions if the injured worker's prior living arrangement is incapable of being modified. (Id. @ 754). In addition, the Court further held that the Board was within its discretion to mandate the employer/insurer fund additional payment towards housing costs if they result from needs necessitated by the compensable on-the- job injury. Finally, this decision also established the proposition that the injured worker is expected to contribute to his/her housing, as well.

There are many shades of grey in the interpretation of "least restrictive lifestyle." Each catastrophic claim, by its very nature, is different. Not every catastrophically injured worker is in need of housing assistance. Housing

provisions are guided by medical necessity based off functionality, accessibility, and safety needs under the guidance of the authorized treating physician. Any such recommendations should be discussed between the parties and documented in the rehabilitation plan (WCR2A).

It would be impossible to construct a law or rule on housing that would accommodate the varied needs of individual injuries. However, there is an evaluation process that should be implemented when addressing housing needs. Although ***payment*** for suitable housing is a claims issue in catastrophic injury cases, ***suitable housing*** itself is a rehabilitation issue. ***Every Catastrophic Rehabilitation Supplier ("Rehabilitation Supplier") is responsible for researching and coordinating appropriate housing for catastrophically injured workers whose injuries necessitate special housing accommodations.*** As such, it is imperative that the Board assigned Rehabilitation Supplier spearheads the implementation of this issue and is *always* kept in the loop. However, parties must recognize that the Catastrophic Rehabilitation Supplier is *not* the housing "expert." The Rehabilitation Supplier's role is the coordination of the consultation of experts and the gathering and dissemination of information of the various options to all parties upon which housing decisions may be made.

This paper is intended to serve as a guideline to suppliers involved in developing proposed housing plans. ***All phases of the housing process should be covered under specific rehabilitation Independent Living Plans***. All the plans should designate responsibilities with timeframes. The Rehabilitation Supplier should share information with all parties as soon as it is obtained.

B. Rehabilitation Supplier Responsibilities

The guiding principles that should remain in the forefront of the suitable housing evaluation are "functionality", "safety" and "accessibility." The Rehabilitation Supplier should immediately commence activity to obtain information regarding the injured worker's housing situation and preliminary functional and medical information from the authorized treating physician and/or appropriate healthcare provider.

The Rehabilitation Supplier should identify medical and/or functional factors related to the injury, including but not limited to the following, as determined by the authorized treating physician and/or appropriate healthcare provider: **[Note: A formal evaluation of the injured worker's functional abilities and deficits may be required to obtain all of the necessary information listed below.]**

- Working diagnosis(es)
- Level of independence or dependence with activities of daily living (ADLs) including basic self-care tasks such as bathing, dressing, toileting, eating, transferring in/out of bed, and continence with bowel and bladder.
- Level of independence or dependence with instrumental activities of daily living (IADLs) including managing finances, shopping, cooking, and transportation.
- Fine and gross motor dexterity

- Strength and endurance capacity
- Cognitive function and any cognitive related deficits
- Sensory deficits (auditory, tactile, visual)
- Trunk and lower extremity function.
- Gait and balance
- Prognosis and timeframe for improvement
- Co-morbid factors including any age-related factors
- Projected discharge date
- Projected home health care and/or nursing care upon discharge to home
- Projected surgeries and/or rehabilitation treatment

At the initial appointment, the Rehabilitation Supplier should obtain information from the injured worker and/or the injured worker's family/friends as to the injured worker's housing arrangement, including but not limited to the following:

- Address, including county and state
- Type of dwelling (home, trailer, apartment, condominium, etc.)
- Number of floors (ranch, 2 stories, split-level, etc.)
- Cost of rent or mortgage
- Identify the people who reside in the dwelling and pets
- Age of dwelling
- Number of bedrooms and number of bathrooms including half baths
- Flat lot or uneven, hilly terrain
- Location of exterior doors
- Presence of interior/exterior steps or stairs and handrails
- Type of vehicle injured worker drives and where it is parked at the dwelling

The next step for the Rehabilitation Supplier is to visit the residence to perform a preliminary assessment of needs. If adaptations are necessary, and it appears that the dwelling can be modified:

- The Rehabilitation Supplier will discuss with the authorized treating physician (ATP) to obtain a prescription for a home evaluation by a professional who is experienced in home accessibility issues (i.e., O.T., P.T. etc.).
- The Rehabilitation Supplier should then proceed to coordinate and attend the home evaluation to determine:
  - If modifications can be completed to the dwelling.
  - Specifications of what modifications should be made.

    - If modifications will be suitable for long-term housing needs.
- The Rehabilitation Supplier will then coordinate the acquisition of bids by licensed contractors and then present the bids to the parties. The parties will determine if the modifications are economically feasible. When a decision has been reached and if a contractor is selected modifications should be made.

If it appears that the dwelling cannot be modified for long-term accessibility, the Rehabilitation Supplier should then proceed with these additional steps:

- Discuss with parties their preferences for suitable long-term (permanent) accessible housing options, taking into account all of the variable considerations.
- If there is an agreement among the parties on a specific option, focus research and availability on that type of long-term (permanent) housing selected. Research should include costs for comparative purposes. Present research to all parties. If all parties agree on a selection, proceed to implementing the necessary steps to bring it to fruition.
- If there is not an agreement among the parties as to which long-term (permanent) accessible housing option is appropriate, then the Rehabilitation Supplier must research all of the appropriate options, given the specific needs of the injured worker. Research should include costs.
- If the parties do not agree on any aspect of long-term (permanent) housing, the Rehabilitation Supplier should immediately request a rehabilitation conference (WC-R5) to have the issues addressed by the Rehabilitation Coordinator overseeing the claim.
- Prior to the rehabilitation conference, the documentation, reflecting the results of the research, should be distributed to all parties so informed discussions may be held and decisions made at the conference.

The Rehabilitation Supplier will develop an Independent Living Rehabilitation Plan (WC- R2a) which outlines the rehabilitation services, specifically focusing on the housing needs. This should include performing all the research necessary to address the housing issue. This may require an addendum to an existing plan. If the parties do not agree on any aspect of long-term (permanent) housing, the Rehabilitation Supplier should immediately request a rehabilitation conference (WC-R5) to have the issues addressed by the Rehabilitation Coordinator overseeing the claim.

Regardless of the permanent housing decision, if the injured worker is ready to be discharged from in-patient care, if he/she cannot return to his/her prior living arrangements, and the permanent housing is not yet identified or ready, then temporary housing must be considered and addressed. Likewise, if an injured worker has already returned to his/her home and it is subsequently being modified, the injured worker may need to leave the premises during the construction. Temporary housing must be addressed. It is imperative for the Rehabilitation Supplier to identify this issue as early as possible to avoid decisions having to be made on an emergency basis.

The Rehabilitation Supplier will discuss with all parties the possible Temporary Housing options.
The Rehabilitation Supplier will discuss with the ATP to obtain recommendations for temporary housing while permanent housing is being established.

C. Temporary Housing

It is considered a "stop-gap" while long-term (permanent) solutions are contemplated and implemented. Extended housing in TEMPORARY HOUSING facilities should be addressed in a revised Rehabilitation Plan.

GENERAL CONSIDERATIONS

It is the Rehabilitation Division's expectation that a family unit, whenever possible, will stay together to include both family and pets. A motel room and/or rooms are not acceptable long-term housing except while necessary home modifications are being completed or pending closing on permanent accessible housing.

Prior to exploring options for Temporary/Interim Housing, at *least* the following should be considered:

Disability Type
- What modifications are necessary?
- Will there be attendant care needs?

Family Composition
- Is there a spouse/significant other?
- Are there children living at home? If so, who provides childcare or is there a need for children to be kept in a specific geographical area to attend school?
- Who will care for the pets, i.e., will family/friends or is boarding the pets required?

Pre-Injury Housing
- Are temporary modifications possible?
- Should other accessible properties be considered?
- Is the property owned or rented?

Geographical Convenience
- Medical appointments Community Services

OPTIONS TO CONSIDER

Assisted Living

Assisted Living may be a consideration for individuals if minimum assistance with transfers and ADLs is required. Advantages are socialization and ongoing planned activities, as well as transportation for both medical and non-medical outings. Some also have onsite therapies, pools, hair salons, and physical therapy or gyms. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

Corporate Rental Properties

Furnished apartments that are accessible are available with short-term lease options. These may be appropriate to consider while one's permanent housing needs are being addressed via home modifications or purchase of accessible housing.

Group Home

Group Home may be appropriate for temporary housing for individuals who need accessible housing as well as continuing Medical Services provided by a Specialty Facility outside of the geographical area of permanent housing needs: i.e., for individuals w/dual diagnoses: spinal and traumatic brain injuries. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

Independent Living

Another option for individuals, with or without a spouse and without dependent, is independent living. This option allows the injured worker to reside in a private apartment and utilize the amenities that are available onsite: i.e., planned onsite and offsite daily activities, available scheduled transportation for outings for medical appointments, as well as leisure activities.

Long-Term Stay Motels

Extended stay motels are available that usually include bedroom(s), living area with sleep sofa, small kitchenette, and laundry facilities onsite. Accessible rooms are available with roll-in showers in many of these. Rentals can be weekly versus monthly or long-term contracts. The needs of not only the injured worker to include attendant care requirements but also the family unit and /or pets as well as equipment/supplies must be considered. This option may require the need for multiple rental units.

Skilled Nursing Facility

If the injured worker requires ongoing licensed nursing care, this type of restrictive facility may prove beneficial during the research for permanent placement. However, this option should truly be limited to individuals that are medically impaired and require that level of nursing care on a continuous basis. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

D. Long-Term Housing

Long-Term housing options must be thoroughly explored and considered with the goal of providing reasonable and necessary accommodations to return the injured worker to the least restrictive lifestyle possible. Such Long-Term Housing shall be considered a permanent housing solution if it is the subject of a Partial Stipulated Settlement signed by the parties and approved by the State Board of Worker's Compensation.

GENERAL CONSIDERATIONS

There are numerous options to explore and evaluate as it relates to long-term housing. A rehabilitation Independent Living Plan needs to be drawn up and submitted to the State Board and parties to the case. The attending physician and various experts should be consulted for support and ideas on the choices for housing. These guidelines should enable the Rehabilitation Supplier to begin working with the client and family appropriately as soon as possible on permanent housing needs. The Independent Living Plan should include all steps to accomplish the chosen long-term housing solution and should be amended, as needed.

Present housing needs are not defined by an injured worker's prior living arrangements (e.g., value of home, size of home, number of rooms, etc.). Likewise, design and/or material upgrades, unrelated to safety, function, and/or accessibility that are outside usual and customary, are not the responsibility of the employer/insurer. The Rehabilitation Supplier may facilitate discussion amongst the parties on the most suitable and acceptable solution if there are conflicting requests. Parties are cautioned to anticipate potential changes in functional levels (See Section IX below), especially if resolving by partial settlement. Due consideration in light of these factors should be given as to who holds title to the home.

OPTIONS TO CONSIDER

It is the responsibility of the Rehabilitation Supplier to investigate multiple options simultaneously to enable the parties to determine which is most appropriate.

Apartment Accommodations

Sometimes an apartment is the best long-term option for housing. The Fair Housing Amendments Act of 1998 prohibits discrimination in housing because of disability. It also states that certain multi-family dwellings designed and constructed for first occupancy after March 13, 1991, must be built in a manner that makes them

accessible to persons with disabilities. The Act established design and construction requirements to make these dwellings readily accessible and usable by persons with disabilities. On March 6, 1991, the department published final Fair Housing Accessibility Guidelines to provide builders and developers with technical guidance on how to comply with the Fair Housing Act. Rental offices and sales offices for residential housing are open to the public by their nature and are places of public accommodation. Individuals with disabilities may ask the housing provider to make a reasonable accommodation to a "no pets" policy. Tenants may be required to provide proof of disability and substantiate the need for the service animal. A tenant and the Rehabilitation Supplier should keep in mind the following when looking at an apartment:

Distance from parking.
Age of apartment (newer apartments may require less modification). Accessibility features of the apartment amenities.
Design features. Flooring.
Size of and maneuverability between rooms.
Two accessible exits/entrances that may be utilized for emergency or evacuation needs.
Lighting.
Storage.
Accessible bathroom location.
Washer/Dryer locations.
Access to public transportation.

Condominium

The apartment accommodation section gives valid information which is applicable to choosing a condominium. The Rehabilitation Supplier would obtain written verification; the modification can be made.

A condominium is a form of home ownership in which individual units of a larger complex are sold, not rented. These units may be renovated apartments, townhouses, or even commercial warehouses. Contrary to popular belief, the word "condominium" does not apply to the type of unit itself, but the legal ownership arrangement.

Those who purchase units in a condominium technically own everything from their walls inward. All of the individual homeowners have share rights to most common areas, such as the elevators, hallways, pools, and clubhouses. Maintenance of these areas becomes the responsibility of a condominium association. Every owner owns a share of interest in the condominium association, plus an obligation to pay monthly dues or special assessment fees for larger maintenance problems.

Others may not be capable of external maintenance or the responsibility of lawn care. The overall price of a condominium townhouse may be much lower than an equivalent single-unit home. Buying a condominium

does allow equity to build, unlike paying monthly rent in an apartment complex.

Consideration for potential increase in assessments and fees needs to be considered and agreed upon by the paying party.

Modification of an Existing Home

The following is applicable to either the injured worker's current home or an existing home that will be purchased. Prior to determining if an existing home is a viable option, there are many variables that need to be considered:

Injured worker's desire to be in the home.
Condition of the home.
Size of the home (room sizes that will be utilized by the client).
Size of lot.
Slope of lot.
Levels of the home.
Need for public transportation.
Need for school district for children or jobs.
The building of an addition versus elaborate reconstruction.

The cost effectiveness of the modifications and/or additions. Proper analysis by the necessary experts is required for this determination. Remember, these steps need to be included in an Independent Living Plan.

New Home Construction

For the purpose of this housing paper, three building systems will be considered. These include Site-built, Modular, and Manufactured Homes. Selection of new home construction should be guided by medical necessity and at the direction of the authorized treating physician. (See ADDENDUM: Comparative Chart).

Site-built (traditional stick-frame) Home

Homes are built to specifications on site by construction workers, carpenters, electricians, plumbers, etc., who are supervised by the building sub-contractor or general contractor. Homes are built to meet or exceed local/regional code regulations.

Modular Home (prefabricated)

Homes are built to the same building codes as Site-built homes but are constructed off-site usually in a factory

setting. Sections of the home are constructed in separate components or modules, which are later assembled on- site, on a foundation which would be similar to a site-built home. Because of the controlled environment during the construction of individual modules, there is a reduction in overall pricing for modular homes, as well as a reduction in the time required to complete the overall construction project.

Manufactured Home (aka mobile home)

The Federal Construction Safety Standards Act (HUD/CODE) requires manufactured homes to be constructed on a non-removable steel chassis. Manufactured homes are built in an assembly line or factory environment. The building codes are not the same as the building codes for modular or site-built homes. The manufactured home would be transported on wheels, in a single or double-wide configuration, to the land on which it would be placed. Based on the HUD definition, a "mobile home" is a manufactured home which was built prior to the effective date that the Housing and Urban Development (HUD) code went into effect on June 15, 1976.

Facilities

The Rehabilitation Supplier should visit the facilities that are being considered for long-term living options, determine that the needs of the injured worker will be met, and coordinate with the family and the doctor. The following options for long-term housing may be appropriate or not appropriate based on individual needs. Another issue concerns family circumstances and pets. As indicated above, the Rehabilitation Supplier must obtain a referral from the ATP for these options to be considered.

Assisted Living/Nursing Homes

Assisted Living facilities have services available to the residents, and a monthly fee is paid often with additional fees for services, such as cooking, laundry, reminder to take medications, etc. For individuals aged 50 and above, Assisted Living may be a consideration if the injured worker needs minimum assistance. A clear definition of any and all assistance needed will dictate whether the assisted living facility is appropriate or not. Advantages are socialization and ongoing planned activities, as well as transportation for both medical and non- medical outings. Some also have onsite activities, pools, hair salons, and physical therapy or gyms.

There are several resources available to assess the quality of skilled nursing facilities. The Georgia Department of Communication Health Healthcare Facility Regulation Division offers GaMap2Care®-Find Facility that includes facility listings, inspection reports, and license verification (https://forms.dch.georgia.gov/HFRD/) The Georgia Health Care Association (www.ghca.info) offers a comprehensive checklist of what to observe (during a visit), questions to ask yourself and facility staff, and nursing home statistics. Finally, www.Medicare.gov/NHCompare has five-star rating system detailing information about the past performance of every Medicare and Medicaid certified nursing home in the country which can be researched at www.Medicare.gov by geography, proximity, and name. Medicare and Medicaid certified nursing homes are

rated as to their last inspection in the Nursing Home Compare Section. The Rehabilitation Supplier should not rely on this report alone because minimum standards are reflected in the report and conditions change frequently. The Ombudsman in the area of the home may be contacted for the most current information. The Rehabilitation Supplier should perform a site visit prior to the recommendation of a specific facility. The Rehabilitation Supplier should consider that not all nursing homes are appropriate for patients, with tracheotomies, for example. Individualized assistance will need to be addressed and provided separately per physician and physical or occupational therapist recommendations. For example, specific assistance with ADLs or transfers may be indicated. In addition, alternatives to nursing homes may be located at Elder Care Locator at 1-800-677-1166.

CCRCS (Continuing Care Retirement Community Services)

The Rehabilitation Supplier would need to use these facilities carefully and determine whether the geographic requirements are met. CCRCS housing communities provide different levels of care based on the individual needs from an independent apartment to skilled nursing. CCRCS are usually appropriate for ages 50 – 55 and over. The Rehabilitation Supplier would have to check the quality of the facility and nursing home. Most of these facilities require a large payment prior to admission and then no fees are charged. This would be a long-term arrangement and would need to be agreed upon by all parties and care would need to be taken in ensuring that the injured worker's best interest is served.

Specialized Facilities

Long-term specialized facilities would include those meeting the needs of injuries including brain injury, burns, spinal cord, etc. These exist locally and nationwide.

E. Choosing The Contractor

The best way to ensure a good outcome is to choose the correct contractor. The parties are responsible for conducting a due diligence investigation of any contractors considered to participate in the housing project. The Employer/Insurer, as the party responsible for payment, shall have the right to choose the contractor from the bids submitted by qualified vendors/contractors. Disputes regarding selection and qualification of the Contractor may be submitted to the MCR Division of SBWC.

As a reminder, it is the Rehabilitation Supplier's responsibility to gather all information and documentation regarding the housing project, to include the parties, The State Board of Workers' Compensation, third party vendors, general contractors and all subcontractors. This includes, but is not limited to, licensure, insurance, reports, bids, and designs.

CHECK LIST

All contractors must be licensed through the State of Georgia. It is suggested that the parties require the contractors to produce his/her verifiable license with the submission of any bid. The contractor **should have experience building handicapped accessible homes**. The parties should ensure that the contractor states in his/her contract that all the subcontractors utilized will be licensed and insured. For more information, you may contact the licensing board for residential and general contractors at their website, https://sos.ga.gov/state-licensing-board-residential-and-commercial-general-contractors.

Selection of the vendor is the responsibility of the parties. The Rehabilitation Supplier may be called upon to offer recommendations as to selection of contractors, vendors, etc.

Secure two to three bids that specify the scope of their work so they may be comparable. The bids should specify the duration of their validity.

Make sure that the contract is specific and clear. Some particulars to look for are draw schedules, permits, inspections, and dates to start and complete the project. A "spec sheet" should be attached to the contract, which spells out the specifics of the building project in detail, including, but not limited to, materials to be used, type of faucets, door sizes, water heater, appliances, flooring, paint grade, etc.

ARCHITECTURAL BARRIER REMOVAL AND OTHER PHYSICAL MODIFICATIONS

Modifications may be necessary to the physical environment for injured workers with mobility, cognitive, visual limitations, and/or other functional limitations. The goal of these modifications is to allow the injured worker to return to the home environment and function independently, as close to the pre-injury level as possible.

Modifications in this area include external ramps, lowered and/or raised countertops, widened doorways, modifications to the bath area to facilitate maximum access and use, in-home ramps and/or lifts, elevators, landscape design and grade, flooring material, etc.

Consideration should also be made for covered access and egress for injured workers who are mobility impaired. Additional consideration should be made regarding modifications to home workshops and other avocational areas that will maximize the injured worker's return to a level of activity enjoyed prior to the injury.

HOUSING CONSIDERATIONS IN ATTAINING AN ACCESSIBLE AND/OR LEAST RESTRICTIVE ENVIRONMENT

Not all injured workers will require these items. Any home modifications should be individualized to that injured worker and the type and level of his/her residual functional limitations. Likewise, design and/or material upgrades, unrelated to safety, function, or accessibility, are not the responsibility of the employer/insurer.

F. Things to Consider

Ramps – Recommended run and rise should be no greater than 1:12 (one inch of rise for every one foot of run). If runs exceed 30 feet, a resting platform will be required with a 5' square platform. Ramps with a grade of 1:12 should have one handrail. Ramps with a grade of 1:10 should have two handrails. These handrails should be placed at 2'8" and a lower guardrail should be centered 7" to the inside of the ramp.

Doorways – Recommended 36" minimum clearance, especially for new construction, for injured workers requiring wheelchairs for mobility. (Width may vary with the type of wheelchair and size of the individual). Maximum 1/2" beveled threshold with 5' x 5' level platform in front of doors and at top of ramp are recommended. Lever type handles are recommended 36" to 38" from the floor.

Hallways – It is recommended that hallways be at least 36", and preferably 42" wide, allowing a mobility-impaired injured worker and a non-mobility impaired individual to be able to pass safely.

Countertops – Desirable height for countertops for mobility-impaired individuals is 34". Cabinets – Recommended height for mobility-impaired individuals is 44".

Sinks – Top of sink is recommended to be at a height of 33". Faucet sets should be single lever, or, if separate hot/cold, use 2 ½" blade handle.

Flooring–Mobility-impaired injured workers utilizing wheelchairs are best accommodated by hardwood or similar type floors. Linoleum tends to wear excessively.

Lighting – Additional lighting will assist injured workers with low vision limitations in regard to their mobility. Mobility-impaired injured workers would best function with light switches mounted between 36" and 40" from the floor. Outlets should be no less than 18" to 20" from the floor.

Heating and Air Conditioning – For mobility-impaired injured workers, controls should be 36" to 44" from the floor, preferably with lever or push-button controls.

Appliances – For mobility-impaired workers, appliances should have front mounted controls. Consider a countertop range and separate oven with side hinge door and a side-by-side refrigerator and freezer.

Bathrooms – Considerations include: Tub vs. shower, handheld shower, single-lever mixing, roll in shower, and additional hose length for the handheld showerhead (must be tailored to the individual and the extent of injury and functional limitations). Step-in baths or lifts for entering the bathtub may need to be considered.

Toilets – Recommended toilet height for mobility-impaired individuals is 20" – 22". Toilet centered 18" from sidewall.

Fixtures – Recommendations include: 30" x 48" approach in front of all fixtures. Grab bars should be considered for the tub and shower. There should be knee space under the lavatory with lever type faucets.

Bedrooms – Attempt to insure a 5' turning radius in the bedroom, with furniture in place for mobility-impaired injured workers. Closet bar heights are recommended to be no higher than 54" from the floor, 52" preferred. Beds must be tailored to the individual and the type of injury. Chairs should be sturdy and stable.

HOUSING CONSIDERATIONS RELATED TO SENSORY DEFICITS:

Visual cues for those individuals experiencing industrial deafness:

- Blinking lights for the telephone, doorbell, etc.
- Accommodations to appliances and other home devices that will allow the injured worker to "see" rather than hear alarms, etc.
- Modifications to communication devices. This would include telephones, televisions, computers, etc.

Auditory Cues for those individuals experiencing industrial deafness:

- Auditory cues for the injured worker experiencing industrial blindness, cognitive disorders, or other disorder affecting sight and/or attention and concentration.
- Consider home devices and assistive technology that allow the injured work to hear rather than see actions taking place with microwaves, and other kitchen appliances.
- Creating a "lack of clutter" home space that will allow the injured worker the maximum freedom to fully utilize their home.

Tactile Cues for those individuals experiencing industrial deafness:

- Tactile cues for injured workers who are visually and/or cognitively impaired.
- Cueing for appliances and/or electronic devices via raised numerals, Braille patterning or similar configurations.
- Ridges and/or other texture changes approaching doorways, halls, or other various areas.

HOUSING CONSIDERATIONS SPECIFIC TO BURN INJURIES

While considering many of the accommodations noted above, workers who have experienced severe burns will also often require:

Environmental control systems that maintain a constant temperature and humidity range.

The burn patient may also require a separate room if he/she has open wounds that are infected. The room must be large enough to accommodate specialty equipment.

Consideration given to building a small, enclosed porch (based upon the need and severity of the burn) with windows so that the person could "be outside" but still not exposed to the sun or in a non-environmentally controlled area.

ASSISTIVE TECHNOLOGY

These are supplemental devices and/or equipment, not necessarily modifications, which allow maximum independent functioning to be reached by mobility, cognitively, visually and/or hearing-impaired injured workers. Consider currently available assistive technologies that promote independent functioning.

G. Moving & Storage

These issues should be reviewed with parties as part of the planning for accessible housing and included as part of the proposed independent living rehabilitation plan (WC-R2a), when appropriate:

STORAGE

The renovation of an existing living space or building of a new accessible living space may require that the injured worker's (and his/her family's) household goods be temporarily stored in a public facility. Consideration should be given as to the items being stored and whether a climate-controlled facility is required. The Rehabilitation Supplier will need to discuss the contract and arrangements for funding with the injured worker and insurance

carrier prior to the signing of a contractual agreement.

MOVING

Local professional household moving contractors may be needed to move the injured worker's/family's household contents to a storage facility during renovation of living space, temporary housing arrangements, or during construction of a new accessible living space. The Rehabilitation Supplier will need to discuss specifics of the moving contract (i.e., spacing arrangements, moving boxes purchase, storage, dates/times, and arrangements for payment of contract) with the parties and include the information in the plan.

H. Long-Term Factors to Consider for Aging Injured Workers

As time passes, everyone is affected by the aging process. However, it has been shown that individuals experiencing various types of disabilities may, and often do, encounter these problems much earlier in life and with more dramatic impact upon their ability to function independently than would occur in the general population.

GENERAL CONSIDERATIONS

In general, it is expected that the aging population will include the presence, development and/or increase of the following:

- Need for help with Activities of Daily Living (ADLs) including basic self-care tasks such as bathing, dressing, toileting, eating, transferring in/out of bed and continence with bowel and bladder.
- Need for help with Instrumental Activities of Daily Living (IADLs) including managing finances, shopping, cooking, and transportation.
- Fatigue.
- Weakness.
- Arthritis.
- Decreased stamina.
- Decreased brain function.
- Psychological issues.
- Change in nutritional needs.
- Development of Diabetes.
- Increased orthopedic disorders.
- Decreased mobility.

- Hypertension.
- Cardiovascular disease.
- Urinary and/or bowel problems.
- Skin changes.
- Changes in need for and sensitivity to medications.
- Increased reliance on assistive devices and personal care services.
- Social isolation.
- Increased potential for further injuries.

I. Additional Things to Consider and Discuss

LOCATION OF ACCESSIBLE LIVING SPACE

Consideration should be given to the proximity of the living arrangements of the injured worker to medical care, community services, school districts (if there are children in the family), and access to public transportation. The safety of the proposed neighborhood should also be considered, especially when the injured worker's mobility has been compromised.

POWER GRID/GENERATOR

Consideration should be given to the injured worker's specific need for life sustaining electrical medical equipment, power wheelchair, and/or heating/cooling of the living space. When such conditions exist, serious consideration should be given to living in a location which has access to multiple sources of power or circuits (power grid). In addition, a backup generator for crisis situations should be considered. Special consideration should be given to alternative power sources when the condition of the injured worker requires the use of life-sustaining equipment.

GARAGE VS. CARPORT

A carport gives protection from the weather but presents exposure to the elements when going into the home. A large enough garage with a direct entry into the home eliminates this exposure. However, this issue may be creatively addressed in other ways (i.e., awning extended from garage). Such Garage/Carport should contemplate accessibility to the home for the injured worker and accommodation for any specialized vehicles.

NEED FOR FENCING/BARRIERS

Safety considerations for the injured worker should be considered in determination of whether fencing/barriers should be included in the housing plan. The injured worker may have pets that will require fencing. Negotiation regarding funding of fencing needs to be undertaken during the planning phase of the accessible housing

project.

J. Financial Considerations

There is no singular solution as to how to address the funding dilemma surrounding the costs for accessible housing. There are as many potential solutions as there are ideas. The solutions are only limited by the creativity of, and negotiation by, the parties to the case. When addressing this aspect of housing, there should be careful attention regarding the injured worker's present housing status as it is impacted by his/her functional needs and available resources. After the assessment of these needs and availabilities are completed, a course can then be charted to fully address funding for the eventual specific housing needs. Everyone is encouraged to brainstorm the issue and be prepared to compromise.

The employer/insurer must provide accessible, safe housing suitable for the injured worker's post-injury condition. However, there is no requirement anywhere that the employer/insurer must build or buy a house for an injured worker. The injured worker and the employer/insurer both have a responsibility to contribute to the injured worker's suitable housing (Pringle case; see General Considerations, pg. 1, for essence of that decision).

The best practice is to restore the injured worker as close as possible to their pre-injury state of function.

Consideration should be given to additional housing costs beyond the basic rent or mortgage (e.g., taxes, insurance, homeowner association fees, upkeep of yard, maintenance of home, etc.).

Payment for specialists' evaluations required prior to permanent housing decision must be paid by the employer/insurer as part of the housing process.

If an injured worker has equity in a home which is no longer suitable, and the employer/insurer buys or builds a suitable home, the injured worker generally contributes the value of the equity in the pre-injury home toward the new home.

Employer/insurer is responsible for costs of title search, moving expenses, inspections, and closing costs.

Responsibility for payment of fees for any required funding for storage of the injured worker's possessions/equipment is determined on a case-by-case basis.

Each case involving housing is different, and there is no "one size fits all" resolution. The Rehabilitation Division is available to hold rehabilitation conferences to help parties reach agreements and decisions regarding housing and the financial aspects of suitable housing for injured workers.

K. Ethical Considerations

Certain principles of ethics apply in all healthcare settings. Familiarity with professional responsibilities of a Rehabilitation Supplier, and the Code of Ethics mandated by the varying underlying certifications required to be registered with the Board, can provide useful guidance in confronting the diverse ethical issues arising in accessible housing. During the process to obtain accessible housing, the Rehabilitation Supplier should be guided by principles of autonomy, beneficence, non-malfeasance, fairness, and veracity.

The Rehabilitation Suppliers have an ethical obligation in working with the catastrophically injured worker to ensure that accessible housing, when needed, is available. In fact, if it is an issue, the Board requires that Rehabilitation Suppliers develop an Independent Living Rehabilitation Plan that addresses the housing process. The injured worker's need for reasonable, appropriate accessible housing must be kept as the primary focus. The Rehabilitation Supplier's actions should reflect the role as advocate for the injured worker's safety, function, and accessibility.

Remember, the Rehabilitation Supplier is not the housing "expert." The Rehabilitation Supplier's role is the coordination of the consultation of experts and the gathering and dissemination of information of the various options to all parties upon which housing decisions may be made. All parties and the Rehabilitation Supplier have the responsibility to approach and implement the accessible housing process in an ethical manner.

Housing Guidelines
Addendum

Stick-Built (Traditional Home)		**Modular Home**	**Manufactured (Mobile) Home**
Foundation, Floors, Walls and Roofing	Concrete block, or poured concrete walls with floors, walls & roofing constructed to meet or exceed local and state building code requirements. Construction occurs on-site.	Same as stick-built with exception that construction includes modules delivered to site and construction is completed on-site, which may include use of crane for placement of modules.	Steel I-beam framing system with wood walls and sub-flooring, all of which is constructed in assembly line in manufacturing plant. Completed products are transported on wheel system to building sites. A foundation system may be added but is not necessary.
Accessibility	Accessibility is available through customized construction of doorways, halls, bathrooms, kitchens, floor, etc., including special lighting, sound, and ramping systems.	Accessibility is reported to be available. Customized construction would alter assembly-line production of modules, which will increase costs. Customized construction may not be practical due to additional costs.	Accessibility may be available, but manufacturers will need to be contacted for specific customization needs. Typical manufactured housing is not accessible. Flooring may need to be upgraded.
Codes	Construction will meet local and state building code requirements.	Construction of modules and completion of construction on-site will Meet local and state building code requirements.	Construction satisfies H.U.D. building code specifications, which are not equivalent to local or state building codes.
Maintenance	All homes require maintenance. The frequency and expense of maintenance will be dependent upon the original quality of the product and workmanship.		
Garage/Carport	Built on-site as part of house, or as a separate Garage/carport.	Built on-site, either attached to the house, or as a separate garage/carport	Built on-site as a separate garage/carport. The manufactured home is not built to withstand the load of an attached garage.

Safety	Built on fixed foundation with quality product.	Built on fixed foundation with quality product.	Homes may be "tied" to ground through tie-down system.
Cost	Accessibility accommodations will increase the cost of any building system. Research of cost for each specific accessibility modification situation will be necessary.		

TRANSPORTATION GUIDELINES AND CONSIDERATIONS

Purpose of Guideline

This section aims to address the transportation challenges faced by injured workers recovering from both catastrophic and non-catastrophic work-related injuries. Our focus is on facilitating a return to maximum independence, recognizing that transportation is an essential element of daily life. Georgia State Board of Compensation Rule 200.1 serves as the primary guideline for determining transportation needs. This rule emphasizes the goal of rehabilitation services: to provide "reasonable and necessary" items and services that empower injured workers to return to the least restrictive lifestyle possible. All parties involved share the responsibility to fulfill this objective.

A. General Considerations

The Rehabilitation Supplier, in collaboration with the injured worker and healthcare providers, should conduct a comprehensive assessment to identify the most suitable transportation solution.

An injured worker who experiences cognitive and/or physical limitations potentially impacting ability to drive safely will need to undergo appropriate evaluations to determine current cognitive and physical capabilities. This will determine suitability for resuming driving or the need for alternative transportation options.

Regaining driving independence is a key objective whenever possible. This allows injured workers to return to work, maintain social connections, and manage daily tasks, fostering a sense of normalcy and control over their lives. However, their previous driving record/history may impact decisions regarding transportation and driving potential may not be immediately clear after the initial injury.

To determine the most suitable transportation solution, a balanced evaluation should take place considering several factors. These include whether the option meets the injured worker's medical needs, prioritizes safety, and factors in accessibility and cost. Availability of public transportation, ride-sharing, and potential vehicle modifications should be weighed against the injured worker's location as well as both the short-term and long-term costs associated with each option.

B. Rehabilitation Supplier Responsibilities

1. Identify transportation needs of the injured worker which may include:
    a. Medical and rehabilitation appointments
    b. Personal business
    c. Social/ recreational/health maintenance activities

d. Pre-vocational and vocational activities
e. Avocational activities
f. Discretionary travel as agreed upon by the parties

In addition to identifying the types of activities requiring transportation, the Rehabilitation Supplier should also consider the frequency and distance of these trips. This will help determine the most suitable and cost-effective solution. For example, public transportation might be appropriate for frequent, short-distance errands, while a modified vehicle might be better suited for longer commutes to work.

2. Assess the need for an evaluation of the injured worker's physical and/or cognitive abilities as related to driving.
   a. Physical functions that impact driving ability may include, but are not limited to: range of motion, muscle strength, reaction time, mobility status, transferability, sensation and visual acuity. These assessments are particularly important for individuals with conditions like: Amputations, Neuropathy, Spinal Cord Injuries, Complex Regional Pain Syndrome, Visual Impairments, Seizures or Extremity Impairments. Beyond visual acuity, further testing may be necessary to identify any visual deficits that may hinder safe driving.
   b. Cognitive functions affecting driving ability may include, but are not limited to, processing speed and reaction time, concentration, attention span, special awareness and problem-solving. These may be associated with conditions such as, but not limited to: Brain Injury, Stroke, mental health conditions and medication-related impairment as determined by the treating physician. In brain injury/stroke cases, a neuropsychological evaluation will address deficits accurately and give data to help determine ability to drive, make judgments, learn new skills, etc.

The Rehabilitation Supplier must be aware that cognitive functioning is dynamic and can be affected by aging, functional changes, medications, and technological advances. It may be appropriate from time to time for the Rehabilitation Supplier to consider whether cognitive functional testing should be repeated or provided and should be addressed by the authorized treating physician. Further, it may be appropriate for Neuropsychological testing to be included.

3. Coordinate a driving evaluation with a Certified Driver Rehabilitation Specialist (CDRS). Any testing needs to be approved by the authorized treating physician.
4. Assess and recommend transportation options - A comprehensive assessment should consider both short-term and long-term transportation needs. This includes evaluating the worker's physical capabilities (age, conditioning, strength, weight, disease progression, and overall medical status) alongside their cognitive abilities, mental health, pain management needs, and social support network. The Rehabilitation Supplier should also consider vendor qualifications like knowledge, experience, reliability, service availability, and geographic proximity to the client. While public transportation and ride-sharing services can be options, their suitability depends on the worker's specific transportation needs. The Rehabilitation Supplier should

further assess if these services can safely meet the worker's limitations.

Using adaptive equipment modifiers registered with the National Highway Traffic Safety Administration (NHTSA) is recommended to ensure that Federal Motor Vehicle Safety Standards are met. (https://www.nhtsa.gov/vehicle-safety/adapted-vehicles)

a. Contract Taxi, Ride Sharing, or Medical Transport

1. Types of transportation (ambulance, medical transport, auto) should be based on the injured worker's mobility needs; i.e. ambulatory, cognitive or dependence on mobility devices. Additionally, some consideration may need to be given as to whether the injured worker requires supervision or accompaniment by a caregiver or family member.
2. Dependability of service, cost, availability in area needed, etc. should be considered on an individual basis.
3. Injured worker's level of confidence, competence and safety issues need to be relayed to the transportation company. Consider integration of employer provided transportation services or other services available through mobile apps and injured worker's mobile access, ability to effectively leverage and comfort level with the use of technology.
4. When arranging for non-emergency transportation by a third party, the Rehabilitation Supplier should be aware that reimbursement for services is regulated by the medical fee schedule.
5. Should issues arise in the coordination and provision of transportation services, the Rehabilitation Supplier may request a rehabilitation conference (WCR-5) to resolve deficiencies.

b. Public transit

1. May offer an alternative source for specific appointments and personal activities.
2. Consider access and availability of paratransit services specifically designed for individuals with disabilities.
3. Must consider convenience (travel time, route changes, stops in relation to destination), availability (route schedule), accessibility features, injured worker's physical and cognitive abilities, and safety issues.

c. Rental

1. Rental of handicapped, accessible vans for short-term transportation may be financially appropriate.
2. Some minimal adaptive equipment, such as hand controls, may be available through car rental agencies. Use of this type of equipment is not recommended prior to the injured worker receiving a driver's evaluation.
3. Must consider who is to hold the vehicle insurance on the rented unit. Clarify vehicle insurance details with the rental agency and insurance carrier. Determine who will hold the policy and confirm it provides adequate coverage.

d. Vehicle Modifications

1. Determining vehicle modifications should prioritize a comprehensive driving evaluation to assess the worker's functional abilities and recommend the safest and most appropriate adaptations for independent use. The evaluation goes beyond classifying the injured worker as a dependent passenger or driver.
2. Assess and determine cost effectiveness to modify employee's existing vehicle, considering the age of the vehicle, mileage and operating condition. A mechanical diagnostic evaluation may be necessary to determine if the injured worker's vehicle is suitable for modification. It is recommended to use an ASE Certified mechanic. In addition, it must be determined that any existing vehicle can be modified safely and within the context of Federal Motor Vehicle Safety Standards.
3. Average replacement schedule depends on mileage and condition of vehicle. In any assessment for replacement of a vehicle, incidence, frequency of repairs and expense of repairs should be considered.
4. Adaptive Equipment encompasses a wide range of options, including traditional hand controls and spinner knobs, but also extends to more advanced features like voice-activated controls, electronic stability, and advanced driver-assistance systems. Standard training programs exist for many types of adaptive equipment based on the recommendations outlined in the driving evaluation. The Rehabilitation Supplier should provide warranty information, including a schedule of equipment inspection to all parties and assist with scheduling as needed.
5. In rare cases, structural modifications like raised roofs or lowered floors on older vans may be necessary. However, these can impact vehicle safety and durability. Explore options like newer lightweight structural modifications when necessary to maintain vehicle stability. Some equipment such as hand controls and foot pedals may be moved to another vehicle. Consider cost to move equipment from one vehicle to another.
6. Financial considerations (See section 8).

e. Auto vs. van vs. truck (See section 4)

5. Develop and submit proposed Independent Living Rehabilitation Plan (per Rule 200.1 (II)(C)(2)) incorporating proposed transportation needs. The plan should prioritize developing a comprehensive transportation plan that maximizes the injured worker's mobility and independence, not just driving capabilities. This must be substantiated by documentation, including, but not limited to, driving evaluation, functional evaluations, seating/mobility evaluations, cost projections and physician orders. A plan should always be in place that allows the injured worker to be transported safely as a passenger, even if the injured worker is the primary driver.

   a. Maintain the requirement for a secure wheelchair lockdown system, even when the injured worker is not driving. An able-bodied driver should be able to operate the vehicle, if necessary

b. Development of a contingency plan outlining alternative transportation options or temporary solutions in the event the worker's primary vehicle (modified or unmodified) becomes unavailable. Consideration may be given to available roadside assistance programs to assist a non-ambulatory injured worker in the event of operational issues with the vehicle.

C. Driving Evaluation

1. General Considerations

A driving evaluation will assess the injured worker's functional capacity, including physical abilities, cognitive skills, reaction time, and visual processing. It will also help identify adaptive equipment needs. Referral for a driving evaluation with a Certified Driver Rehabilitation Specialist (CDRS) is strongly recommended and should be performed by a provider that has both clinical and on-the-road evaluation capabilities available. Specific adaptive equipment should be listed as a result of the evaluation, in order to obtain physician orders and clear and cost-effective bids as needed.

a. According to Georgia Law (Code Section 40-5-35) a driver must be seizure free for 6 months.
b. A driver's license or learner's permit is required to be scheduled for a driving evaluation.
c. Both a car and a van may need to be available for assessment. The injured worker should test all equipment being recommended during the "on the road" evaluation.
d. The optimal time for referral varies based on physical recovery, ability to learn new tasks/techniques, and the effect of medications on the central nervous system and cognitive function.
e. Information needed includes physician prescription and a brief medical summary (current report addressing functional abilities impacted by disability and medications).
f. If the injured worker does not pass the evaluation, re-evaluation should be discussed with the authorized treating physician for guidance on appropriate timeframe. A driver's training/rehabilitation program may assist the injured worker in passing the evaluation.

2. Specific Considerations
   a. Physical - If the injured worker uses a mobility device (power or manual wheelchair, scooter) or functional/adaptive aids, this equipment needs to be available for the driving evaluation.
   b. Cognitive/Psychological – The injured worker's psychological condition may be considered in whether a driving evaluation is appropriate. Consult the authorized treating physician regarding the timing of this evaluation. Referral to a mental health professional may be appropriate to determine if a driving evaluation is appropriate based on the worker's specific condition.

D. Vehicle Types/Equipment Needs

The injured worker's capability to transfer himself/herself, with or without assistance, and ability to load/unload his/her mobility device, must be considered in all aspects of vehicle purchase and modifications. The most suitable vehicle and any necessary modifications will be dependent on the injured worker's functional capacity and a comprehensive driving evaluation is an important aspect in determining the most appropriate options. (See Decision Tree).

1. Automobile

   Automotive design recommendations will depend upon the physical size and limitations of the injured worker, type and size of mobility device to be utilized and the need for accommodation in driving controls to safely drive vehicle. Many of these questions will likely be addressed as part of the driving evaluation.

   The injured worker should test his/her ability to load and unload the mobility device into the automobile being considered for purchase.

   a. Accommodations may include accelerator and/or brake modifications, hand controls and a power driver's seat. Consideration should be given to automatic windows, door locks and side mirrors and other adaptive features that maximize safe vehicle operation
   b. Assess need for two-door or four-door design to facilitate loading/unloading of mobility device.
   c. Seat height should accommodate both transfers and visibility.
   d. Distance between the steering wheel and injured worker must allow for transfer of mobility device into vehicle. This may require a powered driver's seat.
   e. A bench seat may be more practical than bucket seat for making transfers. Selection of interior upholstery should be considered based on the injured worker's bowel and bladder continence.
   f. Assess the vehicle's capability to bear the weight of adding a loader type lift. (see section 6) Outside Carriers, Lifts and Ramps below for additional information.
   g. If transfers, loading/unloading and vehicle operation requires significant expenditure of energy from the injured worker, the appropriateness of an automobile versus a van should be reassessed. Future and premature damage to the injured worker's upper extremities should be considered.

2. Truck

   If a truck is utilized, the structure, height of truck, need for extended cab (particularly for a lift) and a canopy to the truck bed need to be addressed. Lifts are available for putting a wheelchair/scooter into the bed of a truck and for positioning the injured worker into the driver's seat.

3. Mini-Van, SUV or Full-Size Van
   Structure, weight, tonnage, lift platform options, size of engine, wheelbase, lowered floor and/or raised roof, terrain, individual level of function and technology requirements are all factors that determine appropriate vehicle purchase.
   a. The vehicle should be large enough to provide safe ingress and egress, as well as maneuverability of interior space.
   b. Family size, cargo capacity, vehicle handling, visibility, fuel economy, maintenance costs, tire replacement, ground clearance and garage access are considerations for any vehicle.
   c. Vehicle selection factors include size, ease of entry/exit, interior maneuverability, and potential for modifications like lower floors or raised roofs (ensuring weight capacity and stability). However, recommendations for lowered floors and raised roofs should be obtained through the completed driver's evaluation.

E. Handicapped Permit and License Plate

The authorized treating physician will determine whether the injured worker will qualify for a handicapped permit/plate. In the case of a long-term disability, an injured worker may be issued a portable handicapped permit and/or a handicapped license plate. Portable permits offer flexibility for use in any vehicle, while license plates are linked to a specific vehicle. Temporary permits are available for short-term needs.

1. Handicapped Permit form is obtained from the local State Driver's License Office and must be completed by the authorized treating physician. Some physicians have this form in their offices and online resources are available for obtaining handicapped permit applications through the Georgia Department of Revenue-Motor Vehicle Division. The completed form requires a physician's certification and notarization. The permit is portable and can be used in any vehicle in which the injured worker travels.

2. Handicapped license plates are obtained from the local county tag office. A medical provider must complete the handicapped permit form, and it must be notarized. Fees are comparable to standard license plates. To obtain a handicapped license plate, the disabled person must have the vehicle title in his/her name. This license plate is not portable or transferable.

F. Outside Carriers, Lifts and Ramps

Safety, security, exposure to weather, handling and maneuverability of the vehicle, possible damage to mobility equipment, cargo space, injured worker's functioning level, vehicle modifications, medical necessity and cost are all factors to consider in determining the appropriate system. Long-term durability and maintenance requirements of different systems should also be considered.

1. External lifts/trailers
   The vehicle must be retrofitted with an approved hitch and platform. The size of engine and type of vehicle determines if the vehicle can accommodate the weight and installation. The wheelchair/scooter is transported outside of the vehicle. This system allows for easy access to equipment and no cargo space is required. Consideration should be given for an external cover for the lift including the injured worker's ability to apply and remove covering. The Rehabilitation Supplier should further identify the manufacturer's recommendation for weight limits for the lift and ensure compliance for same.

   The injured worker must be able to position and lock down the scooter/wheelchair and be able to ambulate from the back of the vehicle, if no one is available to assist.

2. Inside lift
   An inside system allows the injured worker to transport mobility equipment inside the vehicle and independent operation where feasible should guide selection. The Rehabilitation Supplier should identify the manufacturer's recommendation for weight limits for the lift and ensure compliance for same.

   a. An unoccupied hoist lift positions the wheelchair/scooter into the bed of a truck or through the rear door of the vehicle. The injured worker must be able to attach the wheelchair/scooter to the lift and be able to ambulate to get into the vehicle, if no one is available to assist.
   b. Fully automated lifts allow the injured worker to be lifted inside the vehicle while occupying his/her mobility device and can be operated independently or with assistance. The type of lift is determined by the total combined weight of the injured worker and the mobility device. This information should be provided through the driving or dependent passenger evaluation.

3. Ramps

   a. Automated Ramp
      Allows injured worker to ingress/egress (enter/exit) while occupying a mobility device and can be operated independently or with assistance.
   b. Manual Ramp
      Manual ramps are available for occupied mobility devices if attached to a vehicle, assuming the ramp angle is safe, and the mobility device has adequate traction and power. Manual ramps require assistance.

G. Accessible Covered Areas

Mobility problems may restrict the speed at which an injured worker may *enter* (ingress) and *exit* (egress) from a vehicle. Exposure to the elements may be particularly hazardous to an injured worker's health and the

preservation of the mobility device. Consideration should be given on a case-by-case basis as to whether covered parking is needed and as consistent with the housing guidelines.

H. Financial Considerations

1. Consider purchase versus rental, pre and post injury insurance rates based on covered driver, policy limitations and maintenance costs for vehicle. Case parties need to determine, prior to the actual purchase and modifications, their financial responsibility in the transportation process and payor responsibilities. This must be documented in an Independent Living Rehabilitation Plan.
2. Traditionally, vehicles are considered an ongoing rehabilitation expense due to scheduled replacement of vehicle and ongoing maintenance and repairs related to prescribed adaptive equipment.
3. If a vehicle is purchased or modified and that vehicle is utilized in rehabilitation services (such as medical appointments, pharmacy, rehabilitation/vocational services, etc.), the injured worker is reimbursed for mileage per the Georgia Workers' Compensation Fee Schedule unless negotiated otherwise. The reimbursement compensates for gasoline and wear and tear on the vehicle.
4. Maintenance costs to the prescribed adaptive equipment are the responsibility of the employer/insurer unless negotiated otherwise.
5. Extended Warranties on the entire vehicle are strongly recommended to protect all parties, increasing the life of the vehicle and adaptive equipment and reducing replacement time.
6. General maintenance, including replacement of consumable items, for the vehicle remains the responsibility of the injured worker, unless negotiated otherwise.
7. Insurance: generally, the injured worker is responsible for continuing payments of the vehicle insurance premiums, based on pre-injury vehicle insurance costs. The employer/insurer is responsible for additional insurance premium costs due to the increased value of the vehicle and modifications required, unless negotiated otherwise.
8. Cell phone service, as medically prescribed, is essential for persons with the potential to develop a medical or vehicle emergency while driving independently or being transported.
9. The injured worker is responsible for maintaining current tags/ad valorem tax, based on pre-injury vehicle costs, with the employer/insurer being responsible for additional costs due to increased value of the vehicle and modifications, unless negotiated otherwise.
10. Title determination must be addressed by case parties on an individual case basis. To obtain a handicapped license plate, the disabled person must have the vehicle title in his/her name.
11. If the vehicle is to be purchased by the carrier, it is expected to be used as a trade-in for subsequent vehicle purchase.

I. Ethical Considerations

The concept of rehabilitation is especially vital to individuals who require restoration to independence. Rehabilitation Suppliers have an ethical obligation in working with the catastrophically injured worker to

ensure that transportation is available, not only for medical appointments and independent living activities, i.e.: shopping, but also for recreational and social activities. The Rehabilitation Supplier has a vital role in the process of obtaining appropriate transportation, taking into consideration the injured worker's preferences and the cost effectiveness for the employer/insurer.

J. Disclaimer

This transportation guideline is being provided as general information and to assist with offering appropriate solutions for various transportation issues that may arise while working with a catastrophically injured worker during the rehabilitation process. It is not all-inclusive or specific to an individual injured worker's needs. It is to be used as a guide to explore transportation issues with all parties.

DECISION TREE
Car versus Van

Does the worker's functional capacity allow for safe and independent transfers (considering strength, endurance, and potential for injury)?

No Consider a van with accessible driver controls or wheelchair-accessible vehicle depending on worker's needs.

Yes Car is a possibility. (If the person owns a vehicle that is not a car, such as a pickup truck, SUV or van, make sure they can transfer into their personal vehicle, not just vehicle) Proceed to next question.

Does the person have a mobility device? (walker, crutches, canes, wheelchair, scooter)

No Car is a possibility (evaluate transferability into personal vehicle if applicable)

Yes Proceed to next question

Can the person load and unload their mobility device independently?

No Proceed to next question.

Yes Car should be possible (If the person owns a vehicle that is not a car, such as a pick up, SUV or van, ensure that they can load this device into their personal vehicle, not just any vehicle)

Can the person load and unload their mobility device using adaptive equipment such as a lift or topper? (Note: Not all are compatible with certain wheelchairs and scooters or with all vehicles)

No Van should be considered

Yes Car can be considered.

Can the person transfer efficiently to a level or downhill surface?

No Consider a van for a wheelchair driver with a lowered floor in cargo and driver areas and an automatic lockdown.

Yes Consider a van with a transfer seat. This may allow the person to avoid some structural modifications. (Keep in mind they may have to reposition their legs several times while moving into position under the wheel. Tall people or people with bad extensor spasms can have problems with the narrow space between seats)

Is their seated height more than 5’3’? (applies to dependent passengers also)

No Consider flat top or lowered floor minivan.

Yes Consider raised roof and doors.

Is their seated height more than 5’5”? (applies to dependent passengers also)

No Can consider either lowered floor minivan or full-size van. See next question.

Yes Should only consider full size van.

Can the person push or drive up a minivan ramp?

No Should only consider full size van

Yes Can consider either lowered floor minivan or full size van

MOBILITY AND ASSISTIVE DEVICE GUIDELINE

Purpose Of Guideline

This section aims to help clarify the various mobility and assistive device issues, which exist in catastrophic and non-catastrophic workers' compensation claims. The primary guideline for determining mobility needs is based on Georgia State Board of Workers' Compensation Rule 200.1, which emphasizes the goal of Rehabilitation Services: to "provide items and services that are reasonable and necessary for the injured worker to return to the least restrictive lifestyle possible". All parties are charged with the fulfillment of this goal.

A. General Considerations

The Rehabilitation Supplier needs to identify the mobility, and assistive device needs of the injured worker, taking into consideration appropriate options as discussed in this guideline. In the assessment and recommendation of mobility options, short-term and long-term needs must be considered. Injured worker considerations include age, conditioning, strength, weight, height, disease progression, overall medical status, home and work environments, and transferability of device. Vendor considerations should include knowledge, experience, reliability, availability for service and geographic location in relation to the injured worker. However, selection of vendor is at the discretion of the employer/insurer.

B. Rehabilitation Supplier Responsibility

Pursuant to State Board Rules, the Rehabilitation Supplier is responsible for visiting and assessing the injured worker's home at the onset of their involvement and when significant changes have been noted in level of function. The home assessment should address the injured worker's ability to complete ADLs, IADLs and the possible need for equipment/assistive devices that will limit the barriers to independence. Aging combines with disability to create greater needs and impact to function. These visits are to assess possible needs regarding DME, assistive devices, accessibility and to determine if there are barriers to independence.

- Needs should be discussed with the authorized treating physician, obtaining prescriptions, as necessary.
- Research all positive/negative factors for recommending what is medically necessary, as well as appropriate, for the injured worker's specific needs.
- Consider safety, reliability, extent of mobility needs, terrain, individual usage, resources in the area and costs of each choice (short term and long term), with input from professional evaluations.
- Consider all aspects of the injured worker's life, including medical and rehabilitation appointments, personal business, social, recreational and health maintenance, pre-vocational and vocational activities, and maximum functioning in the home environment.
- Caregivers and the injured worker should be provided with clear instructions as to the use, care, and storage of equipment.

- The injured worker and caregivers should demonstrate the ability to properly utilize any equipment provided.
- An independent rehabilitation plan should be completed listing all mobility equipment including a maintenance and repair schedule.

C. Wheelchairs And Accessories

1. General Considerations

Advancements in wheelchair designs have led to improved performance and functionality including weight reduction, smaller turning radius, enhanced comfort, greater durability, and the ability to participate more fully in daily activities. The two distinct categories of wheelchairs, power or manual, break down into subcategories which specify weight, frame type, and drive-wheel position. Options and accessories such as lateral supports, customized seating, and specialty controls can be customized to suit the injured worker's specific needs.

Wheelchairs and scooters both provide motorized transportation; however, wheelchairs offer advantages of greater customization and better maneuverability in small areas. A formal seating evaluation with a Licensed Physical Therapist is recommended prior to recommending appropriate motorized transportation for an injured worker.

Selection of wheelchair is dependent on the medical needs of the injured worker including height, weight, level of independence and whether caregiver assistance is required to operate the chair.

2. Wheelchair Considerations

- Physical characteristics and cognitive abilities
- Environments in which the chair will be used (Indoors, Outside Terrain, Work Environment)
- Home environment (refer to home modification section)
- Power vs. Manual
- Length of need
- Purchase vs. Rental
- Transportability (refer to lift section and transportation paper)
- Vocational/Avocational activities of the injured worker
- Backup wheelchair

3. Power vs. Manual Wheelchair: Questions to Consider

Injury level: C1 – C5	Yes___No____
Injury level: C6 – S1	Yes___No____
Does injured worker have good upper body strength and balance?	Yes___No____
Does injured worker have good control of their hands, arms, and shoulders?	Yes___No____
Are there co-morbid or pre-existing conditions that affect function?	Yes___No____
Has there been a change in functional mobility?	Yes___No____
Are there special considerations for vocational and avocational use?	Yes___No____
Will the injured worker be using mobility devices to cover long distances?	Yes___No____
Will the injured worker have to navigate steep or rough terrain?	Yes___No____
Is the injured worker an amputee?	Yes___No____

4. Power Wheelchair vs. Scooter: Questions to Consider

Can injured worker operate/steer scooter?	Yes___No____
Will the injured worker have a caregiver assisting with use of equipment?	Yes__No____ _____
Can the injured worker operate a joystick?	Yes___No____
Will the injured worker drive while sitting in the equipment, now or in the near future?	Yes___No____
Does injured worker require specialty controls (i.e., sip & puff, head controls, chin control, etc.)?	Yes___No____
Does the injured worker require specialty seating (i.e., tilt, recline, solid seat pan, etc.)?	Yes___No____
Where will the equipment be used?	Inside___ Outside __
If outside, what type of terrain will the equipment have to transverse?	Rough____ Even _____
Does injured worker need mobility assistance inside the home?	Yes___No____

5. Types of Wheelchairs

	Manual	**Power**
Description	***Wheelchair propelled by the user or someone else. Non-powered***	***Wheelchair that uses a motor for propulsion***
Pros	• *Lightweight* • *Range of chair only limited by physical stamina of the person propelling it* • *Easier to transport than power wheelchairs* • *Minimal maintenance* • *More options for recreational activities and community activities*	• *Preserves and conserves user's energy* • *Handles slopes better than a manual chair* • *Frees one hand* • *Allows mobility options for individuals who cannot use manual chairs* • *Less demand on upper extremities* • *Makes power tilt and recline an option*
Cons	• *Dependent upon user's stamina* • *Long-term use will cause wear on shoulder joints, wrists, and elbows* • *May require assistance overcoming steep angles or long inclines*	• *Difficult to transport* • *Range is dependent upon battery life* • *More responsibility for maintenance, upkeep, and use*

6. Types of Manual Wheelchairs

There are two main categories for manual wheelchairs: Folding and Rigid. Beyond this distinction, manual wheelchairs are classified by weight. The following is a brief description and comparison of the frame type.

	Folding	**Rigid**
Description	***Standard wheelchair - Seat and back are made to fold "sling style." Folds in half by pulling straight up on the middle of the seat***	***Back typically folds down onto seat and wheels may have a quick release axle to remove the wheels and make the frame as small as possible***
Pros	• *The chair becomes very narrow when folded and this makes it easy to transport. Choices available, including types of wheels, tires, casters, arm rests, wheel locks.*	• *Lightweight – eliminating the crossbars necessary in a folding chair helps reduce the weight* • *Allows more options for specialized backs. Easier to propel.*
Cons	• *Heavier* • *Fewer customization options*	• *It can be difficult to transport*

7. Power Wheelchair Wheel Placement

Power wheelchairs fall into three main categories: Rear-Wheel Drive, Mid-Wheel Drive, and Front-Wheel Drive. Each main category can be subdivided into groups specifying weight capacity and ability to modify the seating system. The following is a brief description and comparison of the main categories for power wheelchairs:

	Rear-Wheel Drive	**Mid-Wheel Drive**	**Front-Wheel Drive**
Description	***Drive wheels are located at the rear of chair and push the***	***Wheels are in center of chair. Chairs usually have front and rear casters.***	***Wheels are located at front of chair. Motors pull the occupant. Chair has***

	occupant. Front casters swivel.	***Front casters may or may not touch ground.***	***rear casters that act as anti-tippers.***
Pros	• *Steering and handling performs similar to a car. Better suited for outdoor settings. Chair demonstrates ability to clear obstacles* • *Tends to be more stable at high speeds (offers the highest speeds available)* • *Best front stability though some chairs have a tendency to wheelie*	• *The best turning radius available* • *Easy to maneuver in confined area* • *Does not tend to wheelie and has good rear stability* • *Models with front and rear casters on ground offer the best front and rear stability available* • *Performs better than rear-wheel drive chair when climbing obstacles*	• *Because the drive wheels are closest to occupant's feet, feels more natural and for many is easier to maneuver around corners or tables* • *Handles well on soft ground* • *Best rear stability (will not wheelie)* • *Design allows for good leg positioning* • *Excellent climbing capability*
Cons	• *Driving stability makes this the best choice for people with reduced coordination or specialty controls (i.e., sip-n- puff, etc.)* • *Poor turning radius*	• *Easy to learn and control chair making it a good option for new users* • *Design allows for good leg positioning* • *Slower speeds than rear-wheel drive chair*	• *Slowest maximum speed* • *Tends to fishtail, especially at higher speeds* • *Controls may have to be modified if steering presents a*

	• *Front casters can sink in soft ground or become entrapped on obstacles while trying to climb over them* • *Weight distribution can make the chair feel less stable* • *Leg positioning can be difficult due to the large casters*	• *Tends to fishtail at high speeds and starting off* • *Depending on how front anti-tippers are arranged, may tilt forward while descending a hill or stopping suddenly* • *Front and rear casters may have tendency to hang-up if driving off of a paved surface* • *Less adaptable for outdoor use* • *Propensity for more servicing and/or repairs due to the number of wheels*	*problem due to fishtailing* • *If front anti-tippers are present, may tend to tilt forward while descending a hill* • *May be difficult for user to operate due to larger turning radius and feeling of instability* • *Not ideal for outside terrain*

8. Tires

Tire choice is important because it can determine the type of ride and handling the user will experience and the amount of maintenance necessary for proper upkeep of the chair.

	Pneumatic	**Solid or Flat-Free**
Description	***Air filled***	***Tire with solid insert, foam filling, or one complete solid unit***
Pros	• *Softer ride*	• *No flats*

	• *More appropriate for varied terrains*	• *Lasts longer* • *Less maintenance*
Cons	• *Flats* • *Does not last as long* • *Pressure must be monitored*	• *Heavier* • *Depending on tread, less traction* • *Rougher ride*

9. Seating Evaluation

Seating and positioning can be very complicated and involved. Only a Licensed Therapist specialized in seating evaluations should evaluate an injured worker for his/her mobility needs. Wheelchairs, scooters, cushions, backs, supports, shower chairs, and specialty options will be based on an injured worker's physical condition and injury level.

Seating may have to be readdressed periodically due to pressure areas and changes in function or physical condition (i.e., amputation, weight, age, strength, activity level, etc.).

An order from an authorized treating physician is needed for the seating evaluation and for any equipment that is recommended as a result of the seating evaluation. The equipment, including maintenance and repair schedule, should be included in the individualized rehabilitation plan (WC-R2A).

10. Seat Cushions

Cushions can be very complicated and involved. For this reason, only a Licensed Therapist should prescribe a cushion for an injured worker. Cushions are typically prescribed at the initial seating evaluation. Often a second cover and/or cushion, for back up, are requested as a precautionary measure.

On a basic level, cushions serve two purposes: pressure relief and postural support. **A Licensed Therapist should evaluate the injured worker and prescribe a cushion that meets the physical needs of the injured worker, while providing the necessary comfort. Secondary covers and/or cushions are usually prescribed as a precautionary back up measure.**

When choosing a cushion, it is important that the physical needs of the injured worker are met, but comfort has to be considered as well. Despite the fact that a cushion meets the physical requirements of relieving pressure and providing support, the injured worker may not feel comfortable sitting on it. Because there are so many options available today, there is usually more than one type of cushion that will meet the necessary physical and comfort requirements of the injured worker.

A. a. Types of Cushions

	Foam	**Gel/Solution**	**Air**
Description	***Foam cushions can be made of a single density or layers of different densities.***	***Can be made as a bladder of gel or solution, or typically it is used in combination with a forming material such as foam.***	***Often uses balloon-like cells or air-foam flotation to provide additional support.***
Pros	• *Lightweight* • *Easy to modify in the field to the injured worker's needs* • *No risk of leakage* • *Selection of densities makes it easy to customize*	• *Weight is distributed evenly over gel due to its ability to conform to the shape of the body – better pressure relieving properties* • *Helps maintain a comfortable temperature*	• *Lightweight* • *Depending on design, air offers better weight distribution by contouring to the body and dispersing weight*
Cons	• *Not as durable; may need changing once a year or less* • *If it becomes compressed, it can impair skin integrity* • *Can insulate skin, increase temperature, adding moisture and*	• *Will leak when punctured* • *Heavier* • *Does not offer maximum stability for users without good postural control* • *Chance of bottoming-out as gel is dispersed*	• *May leak* • *High maintenance. Must frequently check air pressure to ensure proper inflation* • *Depending on design, offers less postural support than*

	increasing the chance of skin breakdown		*other types of cushions (Although, the introduction of chambers and new designs offer better support)*

b. Combinations

Over time, several companies have combined different materials to enhance their effectiveness. Examples include cushions that utilize air with gel or foam. This combination provides a cushion with more stability that retains the pressure relieving benefits of gel and air. Some cushions utilize the combination of air and foam in a way that allows the user to mold the cushion to their body through the use of a valve.

c. Custom Cushions

On site cushion customization is available and may be best to meet the specialized need of the injured worker. A well-trained seating technician can create a customized mold utilizing a combination of materials and adhesive. Custom cushions can improve comfort and stability and reduce pressure points. The cushions tend to be expensive and may require adjustments.

11. Tilt & Recline

Tilt, recline, and tilt & recline, are options available for some power and manual chairs. These features are used by themselves, or in combination, to provide help with weight shifts, comfort, and transfers.

a. Tilt

Typically used for weight shifting, this feature helps reduce the risk of pressure sores by allowing the user to adjust his/her center of gravity and therefore the point at which most pressure is exerted. It can also be used to help control spasms and provide better seating by creating a proper fit and stability in the chair that might be useful on steep ramps.

b. Recline

The recline feature is commonly offered, in a limited form, on most chairs as an added comfort feature. This feature can also provide better support and when full recline is available, help with weight dispersion and transfers.

12. Wheelchair Backs

The back of a wheelchair is an important component because it provides comfort, support, and helps maintain correct posture. The following is a brief description and summary of use:

Types of Backs	***Description***	***General Use***
Sling	*Standard back on a folding wheelchair. Typically made of vinyl or nylon.*	*Manual wheelchairs and power wheelchairs. Mostly for people with posture control.*
Tension Adjustable Sling	*Similar to standard sling back, but has straps that allow the user to adjust the tension for better support.*	*Manual wheelchairs and power wheelchairs. User needs to have good posture. Adjustability adds comfort and allows user to remain in chair for longer periods of time* .
Rigid	*Made of non-flexible material, such as plastic or metal, with some type of cushion for comfort. Many are slightly concave to "cradle" user and provide some lateral support. Depending on style, may allow for attachments such as lateral supports or headrests, to be mounted to them.*	*Manual and power wheelchairs. Provides a high level of support. Typically prescribed for users who need additional support to someone who needs a high level of postural support.*
Deep Contour Rigid	*Made of non-flexible material, such as plastic or metal, with some type of cushion for comfort. Back has a very aggressive concave shape that "hugs" the user and offers greater lateral support. Depending on style, may allow for attachments such as a headrest to be mounted to it.*	*Manual and power wheelchairs. Provides a high level of support. Typically prescribed for users who need a high level of postural support, especially lateral support.*
Custom Specialized	*Custom backs are made specifically for the user. Many use a solution with an activator to mold the cushion in the exact shape of*	*This type of back offers the highest level of support and is typically prescribed for users*

the user's back.	*with special needs.*

13. Specialty Options

The vast selection of accessories and options available today allow for various combinations to meet the needs of the injured worker. Through standard options and accessories, it has become easier to customize chairs. The following is a brief listing of some options available today:

- Lateral Supports – Using a combination of such supports reduces the risk of scoliosis. Additionally, improper seating positioning can be avoided. This helps reduce the risk of further injury, including skin breakdown.
- Headrest – Headrests are needed for proper posture, comfort, and can assist the injured worker with breathing and swallowing. There are a wide variety of designs available, and it should be easy to find one that best meets the injured worker's needs.

Drive controls provide alternative means of controlling different mechanisms of a power wheelchair and often allows the injured worker more independence.

- Joysticks, usually mounted on an armrest, allow for fine speed control and movement in any direction.
- Chin controls allow the injured worker to operate the wheelchair with their chin rather than a joystick.
- Switches act more like a switch, with specific directions (forward, reverse, left, and right) that are either on or off.
- Sip and puff utilizes the injured worker's breath to control the wheelchair.
- Eye gaze allows the injured worker to control the chair utilizing eye movements,
- Head array controls the wheelchair using head movements.
- Proximity switches are Bluetooth-paired switches that can be used as a drive control.
- Attendant controls allow the caregiver to maneuver the wheelchair.

Environmental controls allow the injured worker to operate devices in their home from their wheelchair. This can include controlling lights, thermostats, remote-controlled doors, phones, televisions, etc.

14. Backup Wheelchair

A backup wheelchair is necessary to provide the injured worker with a means of mobility if a primary wheelchair requires repairs and/or maintenance. The backup chair must meet the basic functions of the primary chair but does not have to be an exact replica as it is intended for short-term use only. Consideration

should be given for a backup chair that can be operated with the assistance of a caregiver for an injured worker in a power wheelchair. The equipment should be documented in an individualized rehabilitation plan.

15. Wheelchair Repair & Maintenance

Repair and maintenance of a wheelchair may vary based on the type of equipment and the user. It is recommended that the manufacturer's warranty and schedule of maintenance be provided to the injured worker and parties.

The most commonly replaced items on a wheelchair are:

- Tires and tubes
- Arms and arm pads
- Batteries
- Footrest
- Casters
- Brakes
- Battery chargers
- Joysticks/Motors/Gears

D. Scooters

1. General Considerations

Scooters are either three or four wheeled electric mobility devices that provide standard seating and have handles on a tiller for ease of steering. Transporting scooter into the community should be considered at the time of evaluating viability and selection of scooter as well as ability of the injured worker to load and unload the scooter. Protective covering should also be considered to protect the scooter from inclement weather.

2. Types of Scooters

	Three-Wheel Scooter	**Four-Wheel Scooter**
Description	***Scooter with two wheels in the back and a single wheel in the front, controlled by a tiller.***	***Scooter with two wheels in the back and two in the front, controlled by a tiller.***
Pros	• *Better turning radius* • *Weighs less than four-wheel model*	• *Better performance outside the home and on uneven terrain*

	• *Easier to transport than a four- wheel model*	• *More stable* • *Maximum possible weight capacity is usually higher*
Cons	• *Tips easier than four-wheel mode.* • *On the higher end of the spectrum, the maximum weight capacity is usually less*	• *Poor turning radius. Does not perform well indoors* • *Heavier*

3. Scooter Repair & Maintenance

Repair and maintenance of a scooter may vary based on the type of equipment and the user. It is recommended that the manufacturer's warranty and schedule of maintenance be provided to the injured worker and parties.

The most commonly replaced items on a scooter are:

- Tires and tubes
- Arms and arm pads
- Batteries
- Battery chargers
- Throttle and speed potentiometer

E. Prostheses – Upper and Lower Extremity

1. General Considerations

The purpose of prosthetics is to maximize function, independence, and appearance while improving an injured worker's quality of life and physiological health.

2. Referral Process

The Rehabilitation Supplier should:

- Secure referral for prosthetic evaluation from the authorized treating physician
- Coordinate assessment by a Certified Licensed Prosthetist or Certified Licensed Prosthetist/Orthotist
- Work with Certified Licensed Prosthetist/Orthotist to identify option(s) dependent upon the injured worker's level of amputation, joint function, weight bearing mechanics, medical status, level of activity

and physiological integrity of residual limb.

- Counsel injured worker in selection of prosthesis throughout the decision-making process.
- Obtain written order(s) from Certified Licensed Prosthetist/Orthotist and coordinate signature(s) from authorized treating physician(s).
- Provide orders and service estimate(s) to parties for authorization.
- Possess a general understanding of catastrophic versus non catastrophic designation, reference https://law.justia.com/codes/georgia/title-34/chapter-9/article-6/part-1/section-34-9-200-1/

B.

3. Interdisciplinary Team (may include)

- Injured worker, family and/or caregiver
- Physicians (Orthopedic Surgeon, Vascular Surgeon, Plastic Surgeon, Physical Medicine and Rehabilitation, Dermatologist, Pain Specialist)
- Rehabilitation Supplier
- Certified Licensed Prosthetist/Orthotist (CPO)
- Physical/Occupational Therapist

4. Prosthetic Issues/Concerns

The Rehabilitation Supplier should consider the following issues:

a. Function versus Cosmetic/Aesthetic

- The balance between function and cosmetic/aesthetic considerations in prosthesis design is largely dependent upon the primary functional objective for prosthetic use. For example, a prosthesis for a wheelchair user would be both cosmetic and functional, decreasing medical complications, increasing balance in wheelchair and supporting the amputated limb, while improving overall appearance.
- The Certified Licensed Prosthetist/Orthotist should educate the injured worker on possible trade-offs between a functional and cosmetic prosthesis, as applicable.
- Both functional and cosmetic prosthesis may be appropriate and should be determined by the Certified Licensed Prosthetist/Orthotist and endorsed by the authorized treating physician.

b. Basic versus High Tech

The Certified Licensed Prosthetist/Orthotist will recommend a prosthesis that will meet the injured worker's specific needs including employment demands, and home and recreational environments. Current and future prosthetic technology should always be considered.

c. Weight of Prosthesis

The weight of the prosthesis should be part of the Certified Licensed Prosthetist /Orthotist's assessment and recommendations.

5. Psychosocial Factors

The Rehabilitation Supplier should be aware of possible interplay of psychosocial factors such as body image, depression, anxiety, coping mechanisms, social support, gender issues, and cultural factors that may impact the injured worker's desire and success in utilizing the prosthesis. The injured worker's treatment team, including Certified Licensed Prosthetist/Orthotist, authorized treating physician, and parties should be apprised of psychosocial issues.

6. Back-up Prosthesis

A back-up prosthesis may be required if daily prosthesis is in need of repair and/or maintenance, so as not to impede work and lifestyle. Additional equipment may be recommended by the Certified Licensed Prosthetist/Orthotist and treatment providers taking into consideration additional functional needs, safety and injury worker's pre-injury status. These may include:

- Back-up Prosthesis
- Consideration of water/shower leg
- Consideration of activity specific prosthesis

7. Replacement and Repair Schedule

Warranty information for each component of the device should be secured from Certified Licensed Prosthetist/Orthotist and provided to the injured worker and parties. The Rehabilitation Supplier should schedule routine maintenance appointments. Physiological changes that affect prosthetic fit and/or function should be submitted to the authorized treating physician to opine on. Items should be included in the individualized rehabilitation plan (WC-R2A).

8. Driving Equipment Needs (refer to Transportation Guideline for additional details)

The Rehabilitation Supplier should assess the injured worker's need for an adaptive driving evaluation and/or instructional training to safely operate a motor vehicle. Concerns should be discussed with Certified Licensed Prosthetist/Orthotist and authorized treating physician.

9. Need for Assistive Aids with Prosthesis (refer to canes/walker section)

Address the need for possible assistive aids that, when utilized in conjunction with prosthesis, can promote the injured worker's ADLs, quality of life, and work potential with Certified Licensed Prosthetist/Orthotist and authorized treating physician. If ordered, coordinate a formal occupational therapy evaluation to identify specific aids to assist injured worker.

10. Return-to-Work Considerations

When deemed appropriate, the Rehabilitation Supplier, in conjunction with the parties and the authorized treatment provider(s), should complete a comprehensive job analysis to properly assess the return-to-work process. Referral to appropriately qualified vocational specialist may be utilized to complete job analysis.

11. Housing/Home Modification Needs

Pursuant to State Board Rules, the Rehabilitation Supplier should conduct a visit and assess the injured worker's home (Refer to Home Evaluation Section) and consult with authorized treatment providers and accessible housing experts to identify home modification needs.

12. Supply Needs as Related to Prosthesis

Orders for supplies necessary to maintain the prosthesis, including socks, shrinkers for reduced limbs, body powder/ointments, small tool kit, skin dressing, medications for skin breakdown, etc. should be obtained from the Certified Licensed Prosthetist/Orthotist and/or authorized treatment provider. The Rehabilitation Supplier should coordinate the provision of supplies as needed. Items should be included in the individualized rehabilitation plan (WC-R2A).

13. Physical Rehabilitation/Training for Amputee

The Rehabilitation Supplier is responsible for coordination of occupational and/or physical therapy upon referral from the Certified Licensed Prosthetist/Orthotist and the authorized treating physician.

- Identify Certified OT and/or PT with experience in working with amputees. Training may include use/care of prosthesis.
- Cardiovascular training and strength/endurance training.
- Development of home exercise programs for long-term health maintenance.
- Maintain communication with therapist(s), Certified Licensed Prosthetist/Orthotist, treatment providers and injured worker to ensure participation in therapy and goals are being met. Address any issues or

concerns.

14. Potential Complications/Challenges

The Rehabilitation Supplier should be aware of and/or identify potential complications related to the amputation injury and address same with the authorized treatment providers, Certified Licensed Prosthetist/Orthotist, and injured worker. Complications /challenges may include, but are not limited to:

- Weight changes
- Pregnancy
- Co-morbid medical diseases/factors (i.e., Diabetes, Peripheral Vascular Disease)
- Limb volume changes (weight, atrophy, edema)
- Skin ulcerations/break down
- Phantom limb pain/sensation
- Contractures
- Scoliosis
- Compromised integrity of sound limb
- Bony overgrowth/spurs
- Neuromas
- Matching skin tones, when applicable

F. Vision Impairment

1. General Considerations

Vision impairment equipment is multifaceted, but is typically utilized to improve sight, increase mobility, and/or enhanced communication. Work related vision injuries are most commonly seen in physical trauma to the eye(s), optical nerve damage, and/or traumatic brain injury.

2. Vision Products for Visually Impaired

There are many products for the visually impaired, which can be classified as Computer Software/Accessories, Personal Mobility, Wayfinding, or Recreational. Examples of each would include, but are not limited to:

- Computer Software/Accessories – including voice activation/recognition, screen magnifiers, talking computer screens, Braille displays/printers, speech technology for Windows and Internet accessibility, etc., (refer to the appendix for specific examples of available equipment).
- Personal Mobility - aids which include guide dogs, (Refer to Service Animals Section) a variety of canes, flashlights, reflective tape, wheelchair/scooter accessories, raised strip patterns, directional bar mats, etc.

- Recreational – Tandem tricycle, swimming goggles with panoramic vision, etc.
- Wayfinding – talking map and global positioning system (GPS), Braille/tactile directional signage, MotionPAD messages, STEP-SAFE(R) warning system, rubber tactile warning strip, etc.

G. Home Modifications to Accommodate Mobility Needs (Refer to Housing Guideline for more details)

General Considerations

The planning of appropriate housing and/or home modifications to match the specific accessibility needs of the Injured Worker is one of the most important parts of the mobility process. Refer to Housing Guideline for additional information.

H. Worksite Considerations for Mobility

1. General Considerations

When considering worksite accommodation for injured workers with mobility limitations, the process must be conducted on a case-by-case basis, with input from the injured worker. When necessary, a detailed job analysis should be provided by qualified professionals (i.e., OT's, PT's, Ergonomic Specialist, etc.) and a referral to appropriately qualified vocational specialists may be utilized to complete job analysis.

2. Worksite Evaluation

Before conducting a worksite assessment, it is important for the rehabilitation professional to become familiar with the industry, e.g., its terminology, processes, work methods, materials, products, machines, equipment, and key occupations. This provides the basis for conducting a worksite assessment and makes it possible to communicate effectively with workers and supervisors. Such information is most easily obtained by touring the plant or office.

When performing a work site evaluation, observe the entire work cycle. Ensure that all required tasks are understood and described, even those tasks performed infrequently. Interviewing incumbent employees is probably one of the best ways to obtain reliable information about a job. Front-line supervisors are also important sources of information about job expectations. Taking photographs and/or videotapes to record the job being performed can aid understanding and provide documentation of the job's requirements.

The injured worker with mobility limitations is most likely to require accommodations in the form of modifying the physical environment of the workplace to ensure that he/she can access the work area. Keep in mind that this area includes not only the individual's workstation, but also the washroom facility, cafeteria,

conference rooms, and the areas where he/she is expected to go in order to do the assigned work tasks effectively.

If the injured worker has performed the job being evaluated, he/she should review the work site evaluation report and any other documentation for accuracy. If there are any issues, they need to be addressed with all parties.

Accessibility at the job site should be outlined by the qualified professionals (i.e., OT's, PT's, Ergonomic Specialist, etc.) to ensure safety and accessibility needs are appropriately addressed when making worksite accommodations.

I. Transfer Devices

1. General Considerations

There are many types of transfer devices both portable and permanently installed. Prior to selecting a transfer device, one should consider the following: immediate needs versus the long-term needs of the injured worker based upon diagnosis, prognosis, age, and housing (permanent vs. transitional) to allow the injured worker maximum independence in safe transfers. Furthermore, training should be provided for caregivers and family members who will assist the injured worker with lift transfers. The weight of the individual should also be considered, especially if one is totally dependent on care.

The Rehabilitation Supplier should provide warranty information, including a schedule of equipment inspection to all parties and the injured worker. Equipment and maintenance schedule should also be included in the individualized rehabilitation plan (WC-R2A).

2. Overhead Lifts

- Ceiling track lifts can be used to transfer an individual from bed to wheelchair or into the bathroom from bedroom.
- Wall to Wall Lift Systems can be used in areas with small space: (i.e., toilet to bathtub, or bed to wheelchair), if the ceiling will not accommodate a ceiling lift. This type of lift can also be used as a portable lift system, thereby allowing it to have multiple functions.
- Consideration of overhead lift selection may include a Sure Hand lift which allows for the ability of the injured worker to operate the device independently.

3. Hoyer Lifts

- Mobile and Stand-Up Lifts are available and are operated as hydraulic, battery or electric powered
- Types of seating available for Hoyer lifts vary to include slings designed to meet the individual needs of the injured worker: (i.e., slings w/headrests, openings for toileting, full body, as well as size)-(Bariatric)
- Sling free sit/stand lifters
- Trapeze Bar with or without bases
- Stand Assist Lifts to enhance circulation, for supported walking and weight bearing exercise

4. Personal lifts

- These lifts are similar to Hoyer seats or can be a swiveling car seat which swings out of the vehicle and then back in again, after the injured worker is seated in it.
- Allows an injured worker to be lifted from a chair or to transfer into a vehicle (when not able to transfer) and does not require other stabilizing devices to sit in a standard car seat.

5. Pool Lifts

- Automatic and/or water-powered lifts are available and can be used in pools or in-ground spas with built in benches
- Water hose powered lifts with built in seats
- Portable aquatic lifts that are battery charged
- Pool lifts can be used to lower individuals into a pool or whirlpool

6. Miscellaneous Transfer Aids

- Lift vests to assist an individual with transfers from wheelchair or to assist with ambulating using a mobility device

J. Mobility Aides

1. General Considerations

The Rehabilitation Supplier should consult with and obtain orders from the authorized treatment providers, Certified Licensed Prosthetist/Orthotist, and/or Licensed Physical/Occupational Therapist as to whether or not the injured worker requires mobility devices such as a cane, walker, and/or crutches.

2. Canes, Walkers, and Crutches

Canes

- Straight canes
- Adjustable height straight canes

- Adjustable height quad base canes
- Ortho-grip adjustable height quad canes
- Wood versus metal versus Lucite

Walkers

- Standard walker
- Standard walker with wheels
- Rollite walker with wheels, seat, & brakes
- 4-wheel Rollator walker
- 3-wheel Rollator walker (no seat)

Crutches

- Fixed, standard crutches.
- Wooden or aluminum adjustable height walkers
- Forearm crutches with adjustable height

3. Power Lift Chairs/Recliners

- Designed for individuals who have difficulty rising from a seated position
- Available in various fabric and styles and may be considered based on bowel/bladder continence.
- Raise up and tilt forward to assist an individual in getting out of chair
- Can recline into a nap position, allowing for weight shifts when they are used for long periods of time
- The weight, height, and grip/grasp of the individual need to be taken into consideration
- Arm rests, varying chair back heights and seat heights are available.
- Eating trays can be attached and stored in enclosed compartments when not in use.

4. Shower Chairs and Benches

- Available for users who can either transfer onto a shower seat or who need to shower in a chair rather than being able to sit or stand to shower
- Consideration should be given as to whether the injured worker is able to operate the shower chair independently. Shower chairs and benches are assessed according to the size and weight of the individual user
- Turning radius of the shower chair in a bathroom should be considered
- Shower benches should be stable enough to support the user as he/she moves to bathe.
- Benches can be built into shower surrounds, be freestanding or attached to a bathtub.

5. Porch/Vertical Lifts and Chair Lifts

- Porch/Vertical lifts may be used when a ramp is not feasible due to space or as a personal preference. Porch/vertical lifts are used to move individuals and their mobility devices from one

level to another. When feasible and in an outdoor environment they should be covered.

- Stair chair lifts require a stairway wide enough for the lift and should have additional clearance for other individuals in the residence to use the stairway. These lifts generally require space at the bottom and/or the top of the staircase to swivel to get onto or off the lift.
- Consideration should be given as to whether the injured worker is able to operate the lift independently.

K. Service Animals

1. General Considerations

Service animals are available to perform tasks for the injured worker. Service Animals are legally defined within the ADA. Federal laws protect the rights of people with disabilities to be accompanied by their service animals in public places. See ADA Requirements: Service Animals.

The Rehabilitation Supplier should consult with and obtain orders from the authorized treatment providers, Certified Licensed Prosthetist/Orthotist, and/or Licensed Physical/Occupational Therapist as to whether or not the injured worker would benefit from the assistance of a service animal.

An extensive training period is required to train the service animals. Reputable agencies should be researched to ensure appropriate training and the assessment of an injured worker's candidacy for a service animal.

A person's stamina, safety, social interaction, level of functioning with activities of daily living (ADLs), and other general benefits may be evaluated when determining the appropriateness of using a service dog.

L. Exercise Equipment

1. General Considerations

Rehabilitation Suppliers should coordinate with an Authorized Treating Physician and Licensed Therapist regarding the needs for the exercise equipment needed for the Injured Worker.

The injured worker may benefit from strength, cardiovascular, balance, flexibility, and proprioceptive training. Additional benefits may include range of motion, physical and cardiovascular endurance, improving and maintaining physical functions, avoiding complications of immobility (i.e., obesity, diabetes, hypertension, skin problems, contractures, muscle weakness, decreased function, etc.).

A prescription should be obtained from the authorized treatment provider, and the equipment should be included in the individualized rehabilitation plan (WC-R2A). The Rehabilitation Supplier should seek the guidance of a Licensed Therapist for the development of a home exercise program that utilizes the equipment.

The Rehabilitation Supplier needs to ensure that the injured worker and the caregivers understand and can demonstrate the use of the equipment. The Rehabilitation Supplier should address the repair and maintenance of all equipment purchased. Ample storage for exercise equipment in a home setting is often problematic, and the storage requirements need to be considered in equipment and housing decisions.

M. Recreational Mobility Issues

1. General Considerations

Therapeutic recreation focuses on improving self-confidence, as well as physical, cognitive, emotional, and/or social functioning and returning the injured worker to as independent, active, and healthy of a lifestyle as possible. The goal is to help overcome barriers that prevent or limit an injured worker from enjoying recreational activities.

2. Assessment

An assessment of an injured worker's current mobility status and his/her ability to re-enter the community at the current functional level can be done through a Recreational Therapist. The Recreational Therapist can make recommendations based on the injured worker's recreational interests and/or need for adaptive aids.

N. Ethical Considerations

Rehabilitation Suppliers have an ethical obligation in working with the injured worker to ensure that adaptive mobility equipment is available for independent living and avocational activities. The Rehabilitation Supplier has a vital role in the process of obtaining orders for appropriate mobility equipment. The Rehabilitation Supplier shall document all adaptive mobility equipment, usage, warranty and service requirements in the individualized rehabilitation plan (WC-R2A).

O. Consideration Checklist for On Site Accommodations

1. Physical Environment

A. Entering/exiting facility - Mobility from parking lot through exterior entrance

___ Is there adequate "handicapped" parking available?
___ Is there an accessible route to the facility?
___ Will ramp construction / vertical lift system be required?
___ Are handrails needed on exterior steps?
___ Is a door threshold modification needed?
___ Is a door width modification needed?
___ Are door handles/hardware modification needed?
___ Is an automatic door installation required?

B. Traversing through Work Environment - Mobility in the destination areas, *e.g.*, office space, bathroom, community space, path to gain access to specified destinations

___ Will obstacles need to be relocated?
___ Will structural change be required to improve maneuvering space?
___ Are emergency egresses available and well-marked?
___ Are hallway and/or door width modifications needed?
___ Is proper lighting available?
___ Is there adequate temperature control?

C. Accessing Bathroom Features - Components used within the public bathroom space including sink, stall, commode

___ Are proper door width modifications needed?
___ Are door handles/hardware modifications needed?
___ Are door swing side changes needed?
___ Is the door closer timing adequate to allow time for exiting?
___ Are structural changes needed for improved maneuvering / turning radius requirements?
___ Are the sink height / depth / clear space / controls adequate?
___ Is the sink hot water pipe insulation adequate?
___ Is the mirror height adequate?
___ Is the stall width / clear space / hardware adequate?
___ Is the toilet seat height adequate?
___ Are grab bars available and do they conform to ADAAG guidelines?

D. Accessing Workstation Features - Creating a functionally appropriate space where the individual resides to complete primary job duties

___ Are door threshold and width modifications required?
___ Are structural changes needed to improve maneuverability?
___ Will obstacles need to be relocated: furniture, shelving, equipment?
___ Will proper seating need to be provided?
___ Will workstation modifications be required to improve proper postural positioning, (i.e., raising the surface for wheelchair access?

2. Assistive Technology and Equipment

A. Using work tools and furnishings - Devices/equipment necessary to complete job tasks to include communication and computer equipment modifications

___ Will tool and equipment placement and/or modifications be required?
___ Will writing aids be necessary to improve upper extremity mobility?
___ Is telephone headset needed?
___ Is telephone placement and/or mounting needed?

___ Are telephone alternatives required?
- ___ Speaker phone
- ___ Voice activated phones
- ___ Computer software/onscreen dialing
- ___ Telephone amplifiers

___ Is alternate computer placement needed?
___ Is replacement or upgrading of computer equipment needed?
___ Are adapted controls and switches needed?
___ Is improved interface capacity required?
- ___Accessibility feature within word processor
- ___Trackball
- ___Head mouse
- ___Joystick mouse
- ___Touch screen
- ___Keyboard alternative

___ Are software alternatives required?
- ___ Speech recognition
- ___ Speech synthesizer
- ___ Word prediction
- ___ Screen reader
- ___ Optical character recognition (OCR)
- ___ Screen magnification
- ___ Memory and attention aids
- ___ On screen keyboards

3. Adaptive Strategies

A. Environmental Access - Access to facilities without structural modifications
___ Can alternative routes be used?
___ Is Telework/Telecommuting an alternative?
___ Can the work schedule be adjusted?
___ Can the job tasks be restructured?
___ Can non-essential duties be eliminated or re-assigned?
___ Can work materials be arranged more consistently?