

Georgia State Board of Workers' Compensation



Procedure Manual Rehabilitation & Managed Care

The Procedure Manuals are to be used as reference tools 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. The Procedure Manuals are updated annually to reflect any changes in the workers' compensation law or rules. Copies of the Procedure Manuals may be obtained online at the Board's web site at www.sbwc.georgia.gov.

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**REHABILITATION & MANAGED CARE
PROCEDURE MANUAL**

Table of Contents

	Page
Introduction	3
Rehabilitation and Case Management	3
Appointment of a Board Registered Catastrophic Rehabilitation Supplier	5
Rehabilitation Supplier Duties in Catastrophic Cases	7
Communications in All Rehabilitation Cases	11
Rehabilitation Case Closure	12
Change of Registered Rehabilitation Supplier.....	12
Approval and Objections	13
Employee Failure to Cooperate.....	13
Failure of a Party or Counsel to Cooperate.....	14
Board Conferences/ Supplier Role in Settlement Mediations	14
Code of Ethics	15
Appropriate Services/Disputed Charges/Rehabilitation Peer Review	16
Rehabilitation Supplier Qualifications and Registration	16
Catastrophic Rehabilitation Supplier Procedures for Application and Certification.....	17
Appendices to Procedure Manual	19
INFORMATION REQUIRED TO PROCESS REQUESTS FOR CATASTROPHIC DESIGNATION	20
HOUSING GUIDELINES AND CONSIDERATIONS	22
TRANSPORTATION GUIDELINES	48

REHABILITATION & MANAGED CARE

Introduction

This Chapter 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 every rehabilitation supplier's, case manager's, and certified Managed Care Organization's responsibility to maintain knowledge of changing laws and rules regarding rehabilitation and certified MCOs. To order copies of the *Georgia Workers' Compensation Laws, Rules, and Regulations Annotated*, call Lexis Law Publishing at 1-800-542-0957 or contact them on the web at www.lexis.com. This Procedure Manual is also revised yearly. The most recent version is available at the Board's web site, www.sbcw.georgia.gov.

A. Rehabilitation and Case Management

Rehabilitation suppliers assess, plan, implement, coordinate, monitor and evaluate options and services to meet an injured employee's health care needs. They deliver and coordinate services under an individualized plan; provide counseling; vocational exploration; psychological and vocational assessment; evaluation of social, medical, vocational and psychiatric information; job analysis, modification, development and placement; in addition to other services through communication with the injured employee and others and available resources to promote quality cost-effective outcomes that lead to return to work. Rehabilitation suppliers shall provide these services independently in a manner consistent with their education and experience and refer to other professionals as appropriate. Rehabilitation suppliers shall serve as an advocate for the injured employee within the confines of the Workers' Compensation Act. Individuals performing any of these functions must be registered with the Managed Care and Rehabilitation Division of the State Board of Workers' Compensation as a rehabilitation supplier.

Case Management services may be utilized by the Parties to assist with medical care coordination and communication consistent with Board Rule 200.2 and within the ethical bounds of Rule 200.1 (IV).

The goal of these services is to restore the injured employee to suitable employment. If this is not possible, then the injured employee should be restored to the highest possible level of physical functioning and to a level of independence similar to that possessed by the employee prior to his or her injury.

Only Board registered rehabilitation suppliers shall perform the activities outlined in O.C.G.A. §34-9-200.1 and Board Rule 200.1. The activities defined by Board Rule 200.2 may be provided by a qualified Case Manager and is subject to the Rules of Ethics of that Case Manager's Certifying Organization. Violations of Board Rule 200.2 may be subject to disciplinary complaints filed in accordance with Board Rule 200.1 (IV).. Complaints must be received in writing to the Division Director of Managed Care and Rehabilitation at the Board. An investigation of the complaint will be conducted to determine if a hearing should be scheduled. However, direct employees of insurers, third party administrators and employers

may perform a portion of these activities in the administration of their workers' compensation claims.

O.C.G.A. §34-9-200.1 requires the employer/insurer to provide rehabilitation services that are reasonable and necessary to catastrophically injured employees. For cases with dates of injury on or after July 1, 1992, catastrophic injury is defined in O.C.G.A. §34-9-200.1(g) as follows:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the 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 subparagraphs (a) through (e) preceding this paragraph.
4. Second- or third-degree burns over 25 percent of the body as a whole, or third-degree burns to 5 percent or more of the face or hands.
5. Total or industrial blindness.
6. (A) Any other injury of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy for which such employee is otherwise qualified; provided, however, if the injury has not already been accepted as a catastrophic injury by the employer and the authorized treating physician has released the employee to return to work with restrictions, there shall be a rebuttable presumption, during a period not to exceed 130 weeks from the date of injury, that the injury is not a catastrophic injury. During such period, in determining whether an injury is catastrophic, the board shall give consideration to all relevant factors including, but not limited to, the number of hours for which an employee has been released. A decision granting or denying disability income benefits under Title II or supplemental security income benefits under Title XVI of the Social Security Act shall be admissible in evidence and the board shall give the evidence the consideration and deference due under the circumstances regarding the issue of whether the injury is a catastrophic injury; provided, however, that no presumption shall be created by any decision granting or denying disability income benefits under Title II or supplemental security income benefits under Title XVI of the Social Security Act.

(B) Once an employee who is designated as having a catastrophic injury, under this subsection, has reached the age of eligibility for retirement benefits as defined in 42 U.S.C. Section 416(l), as amended March 2, 2004, there shall arise a rebuttable

presumption that the injury is no longer a catastrophic injury; provided, however, that this presumption shall not arise upon reaching early retirement age as defined in 42 U.S.C. Section 416(1), as amended March 2, 2004. When using this presumption, a determination that the injury is no longer catastrophic can only be made by the board after it has conducted an evidentiary hearing.

Please see the Appendix, ***Information Required to Process Requests for Catastrophic Designation***, at the end of this Chapter for the procedure to follow when filing a request for catastrophic determination of a claim. All requests for catastrophic determination shall be submitted to the Division of Managed Care and Rehabilitation.

B. Catastrophic Designation and Appointment of a Board Registered Catastrophic Rehabilitation Supplier

1. In any catastrophic injury case, the employer/insurer shall designate a Board registered catastrophic rehabilitation supplier within 48 hours of accepting the injury as compensable, or notification of a final determination of compensability, by filing a Form WC-R1 (Request for Rehabilitation) with the Board. This may occur simultaneously with the filing of the Employer's First Report of Injury (Form WC-1) or within 20 days of notification that rehabilitation is required. (Form WC-1 must be filed first to create a Board file.)
2. If the employer/insurer does not file the Form WC-R1, or catastrophic designation is being requested by the employee or the employee's attorney, the employee shall file a Form WC-R1CATEE to request catastrophic designation and the appointment of a catastrophic supplier. The requesting party shall send copies of the Form WC-R1CATEE to all parties and the supplier and complete the certificate of service on the Form WC-R1CATEE. The requesting party shall also attach all documentation required for the review process to determine catastrophic designation. Please see the Appendix at the end of this Chapter, ***Information Needed to Process Requests for Catastrophic Designation***, for a list of information needed by the Board to process requests for catastrophic designation.
3. The employer/insurer are given 20 days to file an objection by filing Form WC-Rehab Objection [online Form MC-NFN-12 Rehab Objection], or any party may file a WC-14 Hearing Request within 20 days. [Note: if an employee is filing a WC-R1CATEE and a WC-14, not attachments to the request are required]
4. When a Board determination is made, either by MC&R or an administrative law judge (ALJ), that a case is catastrophic, the employer/insurer are given 20 days to request the assignment of a catastrophic rehabilitation supplier by filing a WC-R1. If the employer/insurer does fails to select a supplier, or files an appeal to the Appellate Division and the catastrophic designation is upheld on appeal, the Board will select the catastrophic designation, and may, in its discretion, appoint a supplier requested by the employee.

5. Subsequent to either an employer's designating an employee's injury as catastrophic or a board determination as to the catastrophic or non-catastrophic nature of an employee's injury, either party may request a new determination, based on reasonable grounds, as to the catastrophic or non-catastrophic nature of the employee's injury.
6. For cases with dates of injury prior to July 1, 1992, unless excused by the Board, any case party shall file a Form WC-R1 with the Board at any time for the designation of a rehabilitation supplier. For all dates of injury, the Board recognizes the following as case parties: employee, employer, insurer, servicing agent or third party administrator if there is one on the case, counsel for employee, counsel for employer/insurer, Subsequent Injury Trust Fund if there is a reimbursement agreement or order, and counsel for the Subsequent Injury Trust Fund if counsel has been assigned.
7. ***Rehabilitation suppliers and case managers are not considered to be case parties.*** The Forms WC-R1 and WC-R1CATEE are used to request initial appointment. The Form WC-R1 is also used to reopen rehabilitation. The request shall include pertinent medical information available concerning the injured employee, as well as a statement supporting the need for rehabilitation services. The requesting party shall complete and send copies of the Form WC-R1 or WC-R1CATEE to all parties and the supplier and complete the certificate of service on the Form WC-R1 or WC-R1CATEE. If the Board deems a rehabilitation supplier is needed and no party has requested appointment, the Board may appoint a supplier and will notify all parties and the involved supplier.
8. Reporting to the Board on rehabilitation cases is required only if the injury or case is designated as catastrophic or if the injury occurred prior to July 1, 1992. Reporting to the Board on voluntary rehabilitation/case management cases is allowed, but not required. Reporting on activities pursuant to Board Rule 200.2 shall be shared with all parties and/or their counsel.
9. For suppliers who meet additional education and experience criteria, the Board may assign a catastrophic designation. Please see the section regarding the process for qualifying as a catastrophic rehabilitation supplier at Section N of this manual. Only rehabilitation suppliers who are registered with the Board as catastrophic rehabilitation suppliers shall be assigned as rehabilitation suppliers to the cases of injured employees whose injuries have been designated as catastrophic. If a supplier who does not hold the catastrophic designation is assigned to work with an injured employee, and then discovers that the employee's injuries are catastrophic in nature, it is the supplier's responsibility to notify the Board and all case parties of the situation and to close their file.
10. In the event rehabilitation services are being voluntarily provided by agreement of the parties, and the case is subsequently determined to be catastrophic secondary to the provisions of O.C.G.A §34-9-200.1(g) (6), the employer/insurer shall file a Form WC-R1 to designate a catastrophic supplier.

C. Rehabilitation Supplier Duties in Catastrophic Cases

1. Rehabilitation Supplier Duties

Catastrophic Rehabilitation Supplier Duties are found in Rule 200.1 (II)(B)(1-12). The Board registered rehabilitation supplier shall have sole responsibility for each individual case. The rehabilitation supplier shall complete, with the injured employee, the initial rehabilitation evaluation within 30 days of appointment to the case. The catastrophic rehabilitation supplier shall also complete, in person with the employee, an appropriate plan of services on Form WC-R2A within 90 days of appointment to the case. The case may be closed after the initial rehabilitation assessment, when appropriate.

Initial evaluation means a personal interview between the employee and approved catastrophic rehabilitation supplier. The rehabilitation supplier reviews the medical and other records to determine if the employee is in need of rehabilitation services and the feasibility of providing rehabilitation services. The written evaluation report shall provide the supplier's conclusion as to why the employee would or would not benefit from rehabilitation services, and provide an indication of what further services are needed.

A Board-registered rehabilitation supplier may obtain specific services from another qualified individual, facility, or agency for direct services outside the scope of expertise of the supplier upon Board approval of a plan that specifies such services.

The registered rehabilitation supplier shall complete, sign and file all rehabilitation reports with the Board as required by the rules, and send copies of those reports, as well as any available medical reports, simultaneously to all case parties, as soon as the supplier creates or receives such reports. All correspondence and reports should include the supplier's registration number and Board claim number. The employee's attorney may accept service of the employee's copy.

The written initial rehabilitation report shall include at least the following information, whether the report is written by a counselor or a nurse, and shall always be submitted along with the first Form WC-R2 (transmittal report) or Form WC-R2A (proposed rehabilitation plan) submitted to the Board, within 90 days of the supplier's appointment to the case:

- a. Summary of current medical status, secondary conditions affecting recovery, treatment, prognosis and estimate of time frames, if possible;
- b. Employer contact (specify name and title) regarding return to work possibilities, including same job, modified job, different job, graduated return to work, or termination;
- c. Social history;
- d. Educational background;
- e. Employment history;
- f. Average weekly wage at the time of injury;
- g. Transportation availability;
- h. Summary of positive and negative indicators for return to work; and

- i. Statement of supplier's conclusion regarding the employee's need for rehabilitation services and the likelihood of whether the employee will benefit from further rehabilitation services.

2. Plan Submission; Objections; Approval

In all catastrophic injury cases, for as long as rehabilitation services are necessary, the registered rehabilitation supplier shall submit a proposed Individualized Rehabilitation Plan (Form WC-R2A) to the Board, copied to all parties. The initial proposed plan is due within 90-calendar days of the supplier's appointment. 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's services to complete the plan. The objectives shall be stated in measurable terms and shall be related to the established goal. The proposed plan will include documentation of the participation of the employee in person in the development of the rehabilitation plan including comments, if any, regarding opposition to the plan, and will be signed by the employee or his/her attorney. If the employee or his/her attorney fails to, or refuses to, sign the plan within 20 days of submission, despite the rehabilitation supplier's attempts to obtain same, the rehabilitation supplier shall file the plan with the Board with it marked "unsigned" across the top of the form. In addition, the rehabilitation supplier shall write the date the plan was submitted to the employee and his/her attorney on the employee's signature line.

See Board Rule 200.1 (II)(C)(4) for procedures regarding approvals and objections.

Unless excused by the Board, for catastrophic injury cases, after the initial plan is approved, the supplier shall submit progress reports, with updated medical reports and supporting documentation, every 90 days under cover of a Form WC-R2. ***Catastrophic-injury cases are to be covered by a current plan at all times; a new proposed plan is due to the Board 30 days prior to the expiration of the preceding plan.*** Medical care coordination and independent living plans, (which are not allowed in non-catastrophic injury cases with dates of injury prior to July 1, 1992) as well as extended evaluation, return to work, training, and/or self-employment plans may be written for catastrophically-injured employees. The first proposed rehabilitation plan is due to the Board within 90 days of the rehabilitation supplier's appointment.

See Board Rule 200.1(II)(C) for types and descriptions of plans.

Extended evaluation plans (written for no more than one year) are 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.

All return-to-work situations, whether to the employer of injury or to a new employer, are to be covered by a return-to-work plan submitted by the assigned rehabilitation supplier. Such

plans should clearly document the expectations and requirements of both the employee and the employer. The 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 employee is returning. Return-to-work plans are written in the following order (the “return-to-work hierarchy”):

- a. return to work with the same employer;
- b. return to different job with same employer;
- c. return to work with new employer;
- d. short-term training;
- e. long-term training;
- f. self-employment.

In some catastrophic injury cases, parties may agree that training is the most efficient way to return an employee to work, and the employee may be able to begin training while recovering from his or her injury. In most cases, however, the feasibility of direct placement must be considered first, and then ruled out, before a training plan can be written. Likewise, short-term training must be considered before a plan for long-term training. The rehabilitation supplier shall document the reason a specific type of plan is proposed, and why another type of plan, earlier in the hierarchy, is not feasible. The return-to-work plan shall be in place for no longer than a one-year period.

All job search plans (written for no more than one year) 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 on the plan. The plan must be submitted along with a current release to return to work from the authorized treating physician(s). Employment goals should be reasonably consistent with the employee's prior vocational status, including average weekly wage, as well as within the employee's current physical abilities. All treating physicians must concur that the employee is released to return to work.

Training plans (written for no more than one year) should be submitted only when direct placement (placement with the employer of injury or with another employer) is not possible or feasible, unless all parties agree to training. If this is the case, it should be clearly documented on the proposed training plan. All training plans shall be submitted with complete documentation of the proposed training program, including its length and total cost, and should include a provision that the employee must maintain at least passing grades for the plan to continue. Training plans are in place for no more than one year.

Self-employment plans (written for no more than one year) are submitted only when direct placement and training plans are documented as not possible or feasible. The self-employment plan must further document that the proposed type of self-employment is likely to be successful. An extended evaluation may assist in determining success in self-employment.

Medical Care Coordination plans (written for no more than one year) are to be submitted only in cases of catastrophic injury. These plans must address the employee's comprehensive medical needs.

Independent Living plans (written for no more than one year) are to be submitted only in cases of catastrophic injury. These plans must address the employee's comprehensive rehabilitation needs, including suitable housing and transportation. If a plan incorporates any of these issues, it should be designated Independent Living, even if other aspects of services are incorporated as well.

The rehabilitation supplier shall always submit whatever type of rehabilitation plan the supplier believes, in his or her independent professional judgment, is most appropriate at the time, irrespective of any case party's opinion on the matter. Any party may object by filing Form WC-Rehab Objection [online Form MC-NFN-12 Rehab Objection] once the plan is submitted to the Board, and the Board will issue a decision on the matter and/or hold a conference to discuss it.

3. Non-catastrophic Medical Care Coordination

Rule 200.2, effective January 1, 2016, provides for Medical Case Management Services. The medical case manager may obtain medical records, communicate with the examining physicians and communicate with the employer and insurance adjuster. Consent of the injured worker is not required for Case Management. Consent is required if the Case manager communicates directly with the injured worker. The Case Manager may meet with examining providers if 10 days advance notice is given in writing to the injured worker or that injured worker's attorney. Case Management services are subject to the Administrative Enforcement – Professional Conduct provisions of Rule 200.1 (IV)(A-M).

4. Non-Catastrophic Medical Care Coordination – Voluntary Rehabilitation

The parties may agree to voluntary rehabilitation services in non-catastrophic cases pursuant to Rule 200.1 (III). Rehabilitation Suppliers in voluntary non-catastrophic cases must simultaneously communicate with all parties and shall adhere to the ethical standards of their certifying body.

5. Consultant

A rehabilitation supplier may contract with an employer/insurer or attorney to review files, give recommendations regarding case management, safety and rehabilitation issues, and perform job analyses of employment positions. All recommendations and reviews must be submitted directly to the employer/insurer or its agent requesting the rehabilitation services. Rehabilitation suppliers retained for these purposes are considered to be consultants and ***shall not communicate, in person or in writing, with the injured employee, the employee's attorney, or the employee's authorized treating physician(s).*** The supplier shall provide unbiased, objective opinions.

6. In-House Nurse/Case Manager

If a nurse or case manager is the “direct” employee of the employer, insurer, or third party administrator (“TPA”), O.C.G.A. § 34-9-200.1, Rule 200.1 and Rule 200.2 do not apply. That person has the same standing that an adjuster has (i.e., a party to the claim), and may have contact with the treating physicians. However, this person must **clearly identify themselves as the employee of the party** and ensure they are clear that they have no fiduciary duty to the employee. Furthermore, since that person is viewed as a representative of the party, if he or she makes any representation to an employee, employee’s attorney or treating physicians, it can be held to be binding on the party. Internal decisions must be made as to authority of this person to commit the party to a position and followed by the direct employee.

D. Communications in All Rehabilitation Cases

A rehabilitation supplier shall provide copies of all correspondences simultaneously to all parties and their attorneys. A rehabilitation supplier shall provide adequate information to all parties and providers regarding the medical treatment and condition of the injured employee. Rehabilitation suppliers recognize the employee’s attorney as the employee’s representative.

The rehabilitation supplier shall provide professional identification and shall explain his or her role to the physician at the initial contact with the physician. In all cases, the rehabilitation supplier shall advise the injured employee that he or she has the right to a private examination by the medical provider outside the presence of the rehabilitation supplier. The supplier shall not attend an examination except by revocable written consent from the employee and/or his/her attorney.

The rehabilitation supplier shall not obtain medical information regarding an injured employee in a private conference with the physician. In catastrophic claims, the rehabilitation supplier may meet with the physician and the employer immediately following a private examination. If a private meeting is required, the rehabilitation supplier must reserve with the physician sufficient appointment time for the conference and give the injured employee and his or her attorney prior reasonable notice of their option to attend the conference. If the injured employee or the physician does not consent to a joint conference, or if in the physician’s opinion it is medically contraindicated for the injured employee to participate in the conference, the rehabilitation supplier shall note this in his or her report and may, in those specific instances, communicate directly with the physician. The rehabilitation supplier shall report to all parties and the employee’s attorney the substance of the communication between him or her and the physician. Exceptions to the notice requirement may be made in cases of medical necessity or with the consent of the injured employee or his or her attorney. The rehabilitation supplier shall simultaneously send copies to all parties of all written communications to medical care providers.

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

E. Rehabilitation Case Closure

The registered rehabilitation supplier shall submit Form WC-R3, Request for Rehabilitation Closure, with certificate of service completed as indicated on the form, when:

1. The supplier believes that rehabilitation is no longer needed or feasible;
2. The employee has successfully returned to full-time work for at least 60 days and is no longer in need of the supplier's services;
3. A stipulated settlement which does not include further rehabilitation services has been approved; or
4. The Board has issued a decision closing rehabilitation.

In catastrophic-injury cases, rehabilitation may remain open after the employee has returned to work for 60 days, if the employee would benefit from further medical care coordination by the supplier. On all Form WC-R3s submitted for closure, the supplier is required to complete Section V and attach a closure report.

Regardless of any case party's opinion, the rehabilitation supplier is responsible for requesting closure of rehabilitation whenever his or her professional opinion is that rehabilitation is no longer needed or feasible. If the supplier is unsure if a case should be closed, he or she may write to the Board's Rehabilitation Coordinator and request an opinion on the issue. An objection to closure may be filed within 20 days of the certificate of service on the WC-R3 by filing Form WC-Rehab Objection [online Form MC-NFN-12 Rehab Objection]. The Board's Rehabilitation Coordinator will issue an administrative decision on all requests.

Upon review of the file at any time, the Board may determine that closure is appropriate and may issue an administrative decision to close rehabilitation.

A case party may also file WC-R3 requesting the Board close rehabilitation with the certificate of service completed as indicated on the form. The closure request must include an attached statement with specific reasons for closure. Any case party may file a written objection to closure. As above, whether or not an objection is filed, the Board's Rehabilitation Coordinator will make a determination and issue an administrative decision.

F. Change of Registered Rehabilitation Supplier

On any mandatory rehabilitation case, changes in rehabilitation suppliers may be requested only by parties to the case and shall only be made by approval of the Board. The party shall file Form WC-R1 requesting a change in supplier to include the name and address of both suppliers and the specific reasons the change is requested. The requesting party shall send copies of the Form

WC-R1 to all parties and both suppliers and complete the certificate of service on the Form WC-R1. WC-R1 forms which do not comply will be returned to the party making the request. 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 statute, objections to change requests must be filed within 15 days of the certificate of service on the WC-R1 request (not 20). See Rule 200.1 (II)(H)(3)].** If the Board determines that a rehabilitation supplier should be removed from a case and the Board determines that rehabilitation is still needed, the Board may direct a change of supplier and will notify all parties and involved rehabilitation suppliers of this decision. The replaced supplier shall file a completed Form WC-R3.

In the event of a request for a change of registered rehabilitation supplier, the Board designated rehabilitation supplier shall maintain responsibility for providing necessary rehabilitation services, unless excused by the Board, until all appeals have been exhausted.

G. Approval and Objections

For all properly filed Form WC-R1 initial requests for rehabilitation in post 7/1/1992 claims, absent objections filed with the Board on Form WC-Rehab Objection [online Form MC-NFN-12 Rehab Objection], and copied to all parties and involved rehabilitation suppliers, within 20 days of the date of the certificate of service on the Form WC-R1, the request for rehabilitation assessment or services will automatically be approved, and the Board's Rehabilitation Coordinator will issue an administrative decision.

Whether or not objections are received, the Board will evaluate and issue decisions on all Requests for Catastrophic Designation on a Form WC-R1CATEE.

A rehabilitation supplier is *not* officially designated as the catastrophic rehabilitation supplier on a claim until the Board's Rehabilitation Coordinator issues an Administrative Decision assigning the supplier to the claim.

The parties may bypass the Managed Care & Rehabilitation Division and take the issue of catastrophic designation directly to a hearing: [Rule 200.1(II)(A)(3)} In the alternative to filing an objection, **after a WC-R1CATEE is filed**, within 20 days, either party may file a WC-14 request for hearing to have an Administrative Law Judge determine the catastrophic designation issue.

Refer to Board Rule 200.1 (II)(A)(3-4) for specific information regarding objections and the appeals process.

H. Employee Failure to Cooperate

An employer/insurer's application to suspend or reduce an employee's income benefits for failure to cooperate with mandatory rehabilitation shall be filed with the Board on Form WC-

102D, outlining its contentions and requesting an order on that issue. The employer/insurer may suspend or reduce weekly benefits for refusal of the employee to accept rehabilitation (as awarded by the Board) only by order of the Board.

A case party may wish to request a rehabilitation conference prior to filing a motion to request suspension of income benefits.

I. Failure of a Party or Counsel to Cooperate

A party or attorney may be subject to civil penalty or to fee suspension or reduction for failure to cooperate with rehabilitation services. Failure to cooperate may include, but is not limited to, the following:

1. Interference with the services outlined in a Board-approved rehabilitation plan;
2. Failure to permit an interview between the employee and supplier within 10 days of a request by the supplier or other obstruction of the interview process without reasonable grounds;
3. Interference with any party's attempts to obtain updated medical information for purposes of rehabilitation planning;
4. Failure to return the proposed rehabilitation plan signed or file written objections to the plan within 20 days of receipt; or
5. Failure to attend a rehabilitation conference without good cause.

J. Board Conferences/ Supplier Role in Settlement Mediations

1. Board Conferences

An Administrative Law Judge or Rehabilitation Coordinator may schedule mediation or administrative rehabilitation conference to resolve problems interfering with the rehabilitation process as needed. In addition, a case party, or rehabilitation supplier, may file a completed Form WC-R5 Request for Rehabilitation Conference with certificate of service as indicated on the form, if it is felt that there is a need for a conference. The Board's Rehabilitation Coordinator, in his/her discretion, may schedule the administrative rehabilitation conference. The parties should make all efforts to resolve the problem before requesting a conference. The Rehabilitation Coordinator may try to resolve the problem in other ways before scheduling a conference. All parties and the supplier are required to attend, or be represented by someone with full authority, at Board conferences. Express permission may be sought *in advance* of the conference to be present by phone or absent from the conference. If required and a party fails to attend or to send a representative, then the conference may be held or canceled at the discretion of the Rehabilitation Coordinator. Rehabilitation conferences differ from mediation in that the Rehabilitation Coordinator will issue an administrative decision after a conference, even if no agreement is reached. These

documents are sent to all case parties and involved rehabilitation suppliers and become part of the Board file.

See Board Rule 200.1 (II)(E)(2-3) for responsibilities of rehabilitation suppliers and case parties to attend rehabilitation conferences, and possible penalties for failing to do so. Rehabilitation conferences can succeed only if all parties are either present or represented by individuals who have full authority to decide all disputed rehabilitation issues.

2. Rehabilitation Suppliers' Role in Settlement Mediations

When the Board approves a settlement agreement in a catastrophic injury claim, the rehabilitation needs of the injured worker must be considered. When the ADR Unit of the Board schedules a settlement mediation conference, all aspects of an injured worker's claim will be addressed. As the future rehabilitation needs of the injured worker are one of the issues that must be addressed, input from the rehabilitation supplier is often valuable. As such, the Board's preference is for the supplier to attend the settlement mediation if possible.

Usually, the mediator will excuse the supplier after the supplier gives his/her input. The supplier may give a number where the supplier can be reached if questions arise after the supplier's departure. The employer/insurer or self-insurer shall be responsible for paying reasonable costs for the supplier to attend settlement mediations on catastrophic injury cases.

However, the role of a rehabilitation supplier should be limited solely to the rehabilitation aspects of the case. When asked by the mediator, the rehabilitation supplier should give input on the employee's future medical and rehabilitation needs, including costs of future medications, projected surgeries, orthotics, prosthetics, training programs, attendant care, and other rehabilitation and medical expenses. A rehabilitation supplier should never become involved in negotiations regarding how much an injured worker's case should settle for, or whether or not the injured worker should settle. If the injured worker queries the supplier, the supplier should refer the worker to his or her attorney or to the Board if the worker is not represented.

K. Code of Ethics

Each rehabilitation supplier and case manager shall comply with the professional standards and code of ethics as set forth by his or her certification or licensure board. Rehabilitation suppliers shall not provide rehabilitation services until registered with the Board. 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 case manager is providing services for an employer with a posted WC-P3 W/C MCO panel (§34-9-201(b)(3)) unless the claim is designated catastrophic. Catastrophic Rehabilitation Suppliers, operating under Rule 200.1 and Case Managers operating under Rule 200.2 are subject to the Administrative Enforcement and Professional Compliance provisions of Rule 200.1 (IV)(A-M). Problems or questions concerning ethics should be addressed to the rehabilitation supplier's licensure board.

Violations of Board Rule 200.1 or 208 shall be addressed to the Division Director of the Managed Care and Rehabilitation Division of the State Board of Workers' Compensation, unless the information is protected by law, through the complaint process.

L. Appropriate Services/Disputed Charges/Rehabilitation Peer Review

Rehabilitation suppliers shall provide appropriate services as needed to return the injured worker to suitable employment consistent with prior occupational levels or to restore the injured worker to optimal physical functioning. Rehabilitation expenses shall be limited to the usual, customary and reasonable charges prevailing in the State of Georgia. In non-catastrophic cases, the Georgia Rehabilitation Fee Schedule guide applies. In catastrophic cases, other than the hourly rate, the supplier's billing for services is *not* limited to this fee schedule. The charges shall be paid within 30 days from the date of receipt of the charges. When the payor disputes the charges, the payor shall file a request for peer review, within 30 days of receipt of the charges, with the rehabilitation peer review organization. Thereafter, the payor may request a mediation conference by filing a Form WC-14 with the Board. Peer review is outlined in the Rehabilitation Fee Schedule Foreword.

M. Rehabilitation Supplier Qualifications and Registration

Rehabilitation suppliers must be certified or licensed as one of the following: Certified Rehabilitation Counselor (CRC), Certified Disability Management Specialist (CDMS), Certified Rehabilitation Registered Nurse (CRRN), Work Adjustment and Vocational Evaluation Specialist (WAVES), 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) (3), and Board Rule 208 are exempt from this registration requirement, as they are approved through the certification process of the managed care organization. Any individual, who holds one of the certifications or licenses listed above, regardless of residence, may become registered as a Georgia Workers' Compensation rehabilitation supplier.

Only Board registered suppliers shall be designated as catastrophic rehabilitation suppliers. Any rehabilitation counselor or nurse who is not registered with the Board as a rehabilitation supplier pursuant to Rule 200.1 will not be eligible to serve as the registered catastrophic rehabilitation supplier for any Georgia Workers' Compensation rehabilitation case.

If an injured employee does not live in Georgia or a state adjoining Georgia, the assigned rehabilitation supplier or case manager may associate a counselor or nurse who lives near the employee to assist with rehabilitation. However, the Board registered assigned supplier in mandatory cases maintains sole responsibility for the case, all rehabilitation services, reporting to the Board on the case, and must perform personally the initial interview and plan development interviews. The assigned supplier may submit the associated counselor or nurse's reports along with his or her own reports and required forms.

N. Catastrophic Rehabilitation Supplier Procedures for Application and Certification

Catastrophic Registration Process:

Georgia Rehabilitation Suppliers may apply to obtain their Catastrophic Registration in the following manner. Suppliers currently approved and registered as Catastrophic by the State Board of Workers' Compensation need not reapply. The registration process described herein applies only to suppliers not currently approved and registered to provide services to catastrophically injured patients.

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 at any time:

- Prior employment as a case manager at a "Certified Center of Excellence"
- Current Life Care Planner Certification (CLCP or NCLCP)
- CRRN Certified Registered Rehabilitation Nurse

If applying based on the above credentials, a CV and/or a copy of the certificate will be required.

The applicant 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/rehab-suppliers>. Upon Board receipt of this form, a Catastrophic Registration packet will be provided to the applicant.

To qualify, the applicant will submit: the required CEU certificates from AAACEU's; 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. Alternatively, a candidate can opt to spend 40 hours in observation at a specialty care facility, such as Shepherd Center for brain or spinal cord injury, and eliminate the course specific CEU's for that observation (brain or spinal cord). Documentation will be required instead of the CEU certificate for that particular observation. The pre-approved vendor for the requisite CEU training is AAACEU which may be accessed at <https://www.aaaceus.com/GA-SBWC.asp>. An applicant wishing to use a different CEU vendor must have the courses and hours approved in advance by the Catastrophic Committee.

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 is also included in the application packet for the applicant's reference.

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

Appendices to Procedure Manual

1. Information Required to Process Requests for Catastrophic Designation
2. Flow Chart for Applying to Become a Registered Catastrophic Rehabilitation Supplier (Under Review)
3. Notification of Intent to Apply to Become a Registered Catastrophic Rehabilitation Supplier (Under Review)
4. Catastrophic Supplier Applicant's Proposal Form for Observation/Experience Component (Under Review)
5. Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant (Under Review)
6. Catastrophic Supplier Applicant's Proposal Form for Training (Under Review)
7. Documentation of Training Attended by Catastrophic Supplier Applicant (Under Review)
8. Housing Guidelines and Considerations
9. Transportation Guidelines and Considerations
10. Mobility & Assistive Devices Guide - Considerations for Everyone Involved

INFORMATION REQUIRED TO PROCESS REQUESTS FOR CATASTROPHIC DESIGNATION

- Completed Form WC-R1CATEE (current version can be obtained by calling the Board's mailroom at 404-656-3870) with appropriate box checked at top (when requesting a specific rehabilitation supplier, the supplier must be registered with the Board as a catastrophic rehabilitation supplier)

AND

**IF FILING IS BASED ON O.C.G.A. §34-9-200.1(G) (1)-(5)
(SPECIFIC MEDICAL DIAGNOSES):**

- Current medical diagnoses
- Current (within the past year) medical records from the employee's authorized treating physician(s)
- Hospitalization admission and discharge summaries, if available
- For head injuries, a copy of neuropsychological evaluation, if one has been completed
- For multiple digit amputations, diagrams showing sites of amputations
- For burn injuries, percentage of body burned and what type of burns (first, second, third); whether or not five per cent or more of face or hands incurred third degree burns
- For industrial blindness, documentation of employee's current vision

**IF FILING IS BASED ON O.C.G.A. §34-9-200.1(G)(6) (EMPLOYEE IS RECEIVING SSDI
AND/OR IS UNABLE TO WORK DUE TO INJURY):**

If the employee IS receiving Social Security disability (SSDI) benefits or Supplemental Security Income (SSI) benefits. The information requested below should be included but is not considered dispositive or exhaustive of other information which might be relevant to the determination of whether the injury should be considered catastrophic:

- A copy of the Social Security Administration's findings and award of Social Security Disability (SSDI) or Supplemental Security Income (SSI) benefits

OR

- If a judicial decision or rationale was not issued, documentation from the Social Security Administration listing the diagnoses based on which the employee was found to be disabled, as well as notification that he was approved for SSDI or SSI

OR

- If such documentation is unavailable, an affidavit detailing the disability(ies) on which the Social Security award was based, and information about whether or not each of the disabling conditions was related to the employee's work injury

AND ALSO

- The employee's current medical diagnoses (may be included in SSA award)
- Work history for the past 15 years, including physical requirements of each job (may be included in SSA award)
- Education level (may be included in SSA award)

- Current (within the past year and preferably the last six months) opinion from the employee's authorized treating physician(s) regarding whether or not the employee is released to return to work and if so, with what restrictions (may be included in SSA award)
- Information regarding whether or not the Workers' Compensation injury and its residuals were the sole factor or a contributing factor to the disability used as the basis for the Social Security Administration's award of benefits

If the employee IS NOT receiving Social Security disability benefits:

- The employee's current medical diagnoses
- Work history for the past 15 years, including physical requirements of each job
- Education level
- Current (within the past year and preferably the last six months) opinion from the employee's authorized treating physician(s) regarding whether or not the employee is released to return to work and if so, with what restrictions
- Relevant medical records

HOUSING GUIDELINES AND CONSIDERATIONS

This housing information was prepared by a subcommittee appointed by the Board. It is being provided as general information and to assist with giving 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 to 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 PAPER

The purpose of this paper is 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 employee 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.

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 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 employee'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 employee'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 employee is expected to contribute towards 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. 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. To begin

with, 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 employees 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.

REHABILITATION SUPPLIER RESPONSIBILITIES

The two guiding principles that should remain in the forefront of the suitable housing evaluation are “safety” and “accessibility”. This necessarily contemplates the employee’s functional status. It may take several experts in varying fields to reach a reasonable conclusion.

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 employee’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)
- 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
- 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 done.

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 (See Section VI), the modifications should be implemented.

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 all parties' preferences for suitable long-term (permanent) accessible housing options, taking into account all of the variable considerations (See Section V below).

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 of the research necessary to address the housing issue. This may require an addendum to an existing plan.

Regardless of the permanent housing decision, if the employee 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 employee has already returned to his/her home and it is subsequently being modified, the employee 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 a prescription for temporary housing while permanent housing is being established.

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?

Geographical Convenience

Medical appointments

Community Services

OPTIONS TO CONSIDER

Assisted Living

Assisted Living may be a consideration for individuals aged 50 and above, 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 aged 50 and above, with or without a spouse and without dependent, is independent living. This option allows for 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 include usually one bedroom, 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 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.

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 to be 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 as set forth in Section XII.

GENERAL CONSIDERATIONS

Long-term housing is often the most difficult task the injured worker and the Rehabilitation Supplier will face as a team. There are numerous options to explore and evaluate. A rehabilitation Independent Living Plan needs to be drawn up and submitted to the State Board, even if all parties do not agree. The task of reaching a decision and finalizing the needs is often time consuming. 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. Of course, in all cases, the insurer and attorneys need to be involved. The Independent Living Plan should include all steps to accomplish the chosen long-term housing solution and should be amended, as needed.

Parties need to remember that housing needs are disability driven and based upon residual functional capacities. 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, or accessibility, are not the responsibility of the employer/insurer. Parties are cautioned to anticipate potential changes in functional levels (See Section IX below), especially if resolving by partial settlement (See Section XII below). 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 on the basis 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 by their nature open to the public 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 that 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.

A condominium arrangement is not the best option for every potential homeowner. There can be a noticeable lack of privacy in the common areas – the pool must be shared with every other condominium owner, for example. Those who would prefer to own all of their amenities and maintain their own lawn and garden may want to pursue single home ownership options instead of a condominium. It can also be more difficult to sell a condominium unit as opposed to a home with acreage. Condominium owners only own their units, not the ground beneath them.

Those who may benefit the most from condominium living are veteran apartment renters who don't mind having close neighbors. 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.

One thing to be aware of, when living in a condominium setting, is the political reality of an owner's association. Decisions may be made in monthly meetings which will cost individual owners more money, but not necessarily deliver equal benefits for all. The potential increase for assessment of fees needs to be considered and agreed upon by the paying party. It can be nearly impossible to avoid being affected by at least one condominium board decision, so active participation in meetings and discussions may be more compulsory than you might expect. Condominium living may be more advantageous financially than apartment rentals, but it does require more active participation in community events.

Modification of an Existing Home

The following is applicable to either the employee'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. (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 (pre-fabricated)

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 doublewide 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. MemberoftheFamily.net provides an annual survey rating system for actual potential for (resident) harm, violations, and repeat violations. The Georgia Nursing Home Association (www.gnha.org) 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.

Board and Care Homes

Board and Care homes are designed for people who do not meet the needs of independent living but do not require nursing home services. Most provide assistance with some ADLs, for example, eating, walking, bathing, and toileting. Many of these facilities do not take Medicare and Medicaid and are not strictly monitored. The Rehabilitation Supplier would have to carefully research and monitor these facilities.

CCRCS (Continuing Care Retirement Community Services)

The Rehabilitation Supplier would need to use these facilities carefully and determine that the geographic requirements are met. CCRCS housing communities provide different levels of care based on the individual needs from 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.

CHOOSING THE CONTRACTOR

The best way to ensure a good outcome is to choose the correct contractor. The parties are responsible to perform 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 Trial Division of the State Board of Worker's Compensation for resolution.

As a reminder, it is the Rehabilitation Supplier's responsibility to gather all information and documentation regarding the housing project, to include the parties, third party vendors, general contractors and all subcontractors. The Rehabilitation Supplier must distribute it all to the parties to the claim. 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 of 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, www.sos.state.ga.us/plb/contractors.

Check references; ask questions; try to see their work; get as much information as possible.

Did the contractor keep the schedule and contract terms?

Were they pleased with the work?

Did the contractor listen to requests and respect these?

Would they hire the contractor again?

Check the contractor out with the Better Business Bureau, Chamber of Commerce, the Consumer Fraud Unit and/or the District Attorney.

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.

Obtain a copy of the selected contractor's General Liability Insurance and Workers' Compensation coverage, if required. Parties are advised to verify their validity.

For large-scale housing modification or building projects, parties might want to consider including, as part of the contract, a “performance bond”. A “performance bond” is additional insurance the general contractor may purchase to cover the cost of the project in the event the general contractor is unable to complete the project (due to illness, death, or bankruptcy). The general contractor must pass both a criminal background and credit evaluation in order to obtain this insurance bond. There is a fee for purchase of the “performance bond”, based on value of the project, which may be shown as an option in itemized costs of proposed contract.

The contractor is responsible for knowledge and adherence to all pertinent City/County/State building and zoning codes. Likewise, he/she is also responsible for securing all required building permits and inspections. Parties should include this in the contract.

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.

The contract should specify requirements for a final payment, i.e., a lien clearance letter, certificate of occupancy, or other necessary documents.

RED FLAG CLUES CONCERNING CONTRACTOR

Cannot produce a valid address or phone number.

Uses undue pressure.

Does not give references.

Prices the project substantially lower compared to other bids.

Quotes a “special price” for anything.

References do not check out.

Unable to verify license and insurance coverage.

Asks for pay 100% up front or an unusual first advance.

Asks you to sign a completion certificate before the job is done.

GENERAL ACCESSIBILITY

In terms of housing for the catastrophically injured worker, “accessibility” can be generally described as: The provision of specific modifications to the present or future home that will allow the injured worker to function safely within that environment, where possible, as closely to that which was enjoyed prior to the injury. 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.). Accessibility needs are based upon the disability and function of the Injured Worker.

GENERAL CONSIDERATIONS

Board Rule 200.1 notes that housing is most appropriately addressed in an Independent Living Plan (WCR2-a). Board Rule 200.1 (5) (ii) states “An Independent Living Plan

encompasses those items and services, including housing and transportation, which are reasonable and necessary, for a catastrophically injured employee to return to the least restrictive lifestyle possible.”

Limitations associated with physical injuries are the most common, and usually the most obvious, issues to be addressed. Less obvious, however, are the limitations associated with cognitive or “unseen” injuries and their residual impact on the injured worker and their ability to deal with their environment.

The *Americans with Disabilities Act of 1990 (ADA)*, as amended, was drafted primarily to address commercial and public buildings, employment and related issues.

While not mandatory for private residences, this act does, however, provide important and basic guidelines for the design and construction of housing that is compatible with the needs of individuals experiencing physical and/or cognitive impairments. There are no ADA codes applicable to private residences.

Primary issues of concern in the development of accessible housing of any type should include, but not be limited to:

- General safety.

- Fire safety: The ability to enter and exit home in a safe and efficient manner, preferably, the ability to exit the home from two (2) distinctly different areas.

- The ability to access the various areas of the home to perform ADLs. These areas include, but are not limited to, the bathroom (including the commode, shower/bath and vanity), the kitchen (including cooking and storage areas), the bedroom (including dresser and closet areas), and the driveway (including a garage or carport).

- The ability to communicate with others outside of the home should a problem develop (police, fire, family).

- Consideration of the injured worker’s lifestyle, hobbies, interests, and other avocational activities that were performed prior to the injury.

- The need to relocate for easier access to support programs, medical treatment and/or suitable transportation.

- Family makeup.

- Financial responsibility.

The types and extent of any home modifications are dependent upon the type of injury, the functional limitations associated with the injury, aging factors, and the anticipated level of independent living which the injured worker will likely attain. As such, they are individualized to each case and require the input of multiple experts.

Modifications and issues common to all disability groups include:

- Safety – Preferably two (2) accessible exits from the residence that lead to separate outdoor areas.

- Structural and electrical wiring meeting acceptable building practices and state/local codes.

Maximized ability to access, use, and move about the residence freely without obstruction or hazard.

The need to develop creative approaches to individual problems uniquely associated with the injured worker and their functional limitations.

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.

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 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

In addition to many of the modifications noted above, particular attention should also be paid to:

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 the injured worker experiencing industrial blindness, cognitive disorders, or other disorder affecting sight and/or attention and concentration.

“Talking” watches, appliances and other devices 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 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.

Wheelchair access may need to be considered if the injured worker has mobility impairments. (See specifics above).

Inside laundry facilities are imperative to keep sheets and other materials clean. Infection can spread if laundry is taken outside the home.

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, such as suctioning devices, Pegasus type beds, wheelchairs, etc.

Specialized wiring if custom computer equipment is required to communicate with the hospital, physicians, etc.

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, that allow maximum independent functioning to be reached by mobility, cognitively, visually and/or hearing impaired injured workers.

Computers, computer software, environmental controls, automatic dialers and other similar equipment.

Emergency services contact equipment.

Cell phones, pagers, and other equipment that allow communication during emergencies or medical crisis.

Power doorways and other technological aides to assist in maximizing independence.

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. Resources include "you store it" facilities found in most communities. The moving company that is moving the contents of the household may offer storage as an added service. Storage costs are based upon size of the space needed. Consideration should be given as to the items being stored and whether a climate-controlled facility is required. Most spaces can be leased on a monthly basis. A contract with the storage facility is usually 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. When obtaining bids for moving the injured worker's household contents, the Rehabilitation Supplier needs to obtain proof of the moving company's vehicle and liability insurance. Parties should consider insuring the contents of the household against damage and loss. 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.

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 ADLs.
- 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.

DISABILITY AND AGING

As stated above, individuals with disabilities tend to age faster.¹ A general principal of this concept is the “40/20” rule. This means that functional issues begin to emerge when a person reaches 40 years of age or has been disabled 20 years, whichever comes first. Additionally, a combination of this rule 50/10, 55/5, etc. also seems to carry forth the validity of this phenomenon.

Experts in the field of rehabilitation medicine indicate that individuals with a severe disability age faster.² Over the years, the organ system capacity declines gradually, over

¹ Forman, Lawrence S., et al (2007) Aging and Life expectancy with a Disability.

² Kemp, B.J. (2005) What the rehabilitation professional and the Consumer need to know, *Physical Medicine*

a 50- to 60-year period, until it reaches 20% to 40% of peak, at about age 75. In people with disabilities, this decline is accelerated from an average of 1% per year in the non-disabled person to between 1.5% and 5% per year depending upon the organ system. Adults who have a disability after maturity seem to age at a rate faster than normal from that point forward. Those who sustain a disability prior to maturity may never reach that peak capacity.³

SPECIFIC DISABILITIES

Each disability has increased areas that appear to be affected more during the aging process.

- Spinal Cord Injuries
 - About 40% of persons with spinal cord injury under the age of 60 need some help with self-care, but as they age, this need for assistance increases to 70% at age 75.⁴
 - Loss of lean muscle mass (sarcopenia).
 - Shoulder impingement (shoulders “wear out” after pushing a manual wheelchair for years).
 - Osteoporosis secondary to the inability to bear weight and/or exercise properly.
 - Earlier onset of arthritis.
 - Decreased stamina with the need to utilize power devices such as power wheelchairs.
 - Long-term care relationships often become strained and there is a need to change providers.
 - Psychological changes such as depression, isolation and/or avoidance of the public.
 - Change in nutritional needs secondary to lowered metabolic rate, changes in hormones, and less muscle mass.
 - Increased spasticity. Overuse injuries such as carpal tunnel, shoulder and elbow bursitis, potential fractures, kyphosis and scoliosis.
 - Hypertension. Hypertension is nearly twice as common in individuals with paraplegia as in able-bodied verified by controlled studies.
 - Cardiovascular disease. As much as 200% higher incident in individuals with spinal cord injuries.
 - Skin fragility. Aging decreases skin tone and thickness thus leading to an increase in decubitus ulcers and difficulty in healing.
 - Urinary tract infections. There is a 400% higher rate of developing bladder cancer with a long-term indwelling catheter.

Rehabilitation Clinics of North America, 16:1

³ Kemp, B.J. (2005) *Living with a Disability: A different way of aging*. UCI Medical Center, Irvine, CA.

⁴ *Aging and SCI*, (February 1997). University of Washington, Rehabilitation Medicine, Northwest Regional Spinal Cord Injury System.

- Increased injury potential. Extremity fractures occur in approximately 40% of individuals with long-term spinal cord injury.
- Brain Injuries
 - Long-term relationships often become strained and there is a need to change providers.
 - Fatigue and loss of stamina due to deconditioning and restricted mobility.
 - Sleep disturbances add to fatigue.
 - Late onset psychosis and possible post-traumatic epilepsy.
 - Decreased sense of smell and tastes cause changes in diet and nutrition.
 - Decreased physical activity can lead to the development of adult onset diabetes.
 - Impaired gait secondary to brain injury lead to back and hip problems requiring surgical and/or equipment intervention.
 - If seizures present, neurotoxic effects of long-term anti-convulsants must be considered.
 - Psychological stress and/or depression develop from the increasing dependency needs, feelings of powerlessness and isolation.
 - Social isolation secondary to the inability to participate in physical and social activities.
 - Increased risk of repeat traumatic brain injury.
- Amputations
 - Fatigue occurs sooner with limb loss.
 - Weakness and loss of muscle mass due to improper fit of prosthesis.
 - High risk for increased arthritis.
 - May require equipment for mobility assistance.
 - Issues of overuse of unaffected limbs.
 - Personality and other psychological changes secondary to traumatic loss of limbs.
 - Nutritional changes.
 - Impaired gait stresses back and non-impaired leg.
 - Loss of muscle mass may necessitate frequent changes in the prosthesis itself.
 - Skin fragility in the amputation area leads to skin breakdown and decreased ability to heal.
 - Higher risks of frequent falls causing additional injuries.
- Burns
 - There is a high incidence of cancer in burn patients. The scars cause an inflammatory reaction that can lead to malignant lesions. The scar tissue then becomes malignant.
 - The grafted skin also thins out over time and peels off. Hands are especially susceptible to open areas, tenderness and loss of fine motor function.

- Facial and hand burns can be the most disabling over time. Burns of the feet also present long-term problems due to pressure from shoes and scar breakdown.
 - Facial scars can become very tender over time especially if the person does not wear sun protection every day. Hair may stop growing over scarred areas even though it comes back right after the burn.
 - Nerves are trapped in the scars, and many people have chronic pain in some areas of grafting which may increase over time.
 - Scar tissue may change, become infected and/or inflamed and close monitoring of the burn area is required especially as the individual ages.
- Vision
 - Traumatic vision loss increases in individual's potential to develop coronary artery disease by 2-3 times over non-traumatic vision loss subjects.⁵
 - Travel becomes more difficult secondary to cognitive changes associated with aging.
 - Co-morbid factors, osteoporosis, vascular disease, or other health problems may decrease the ability to perform ADLs previously performed with little or no difficulty.

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 employee requires the use of life sustaining equipment.

WATER VS. SEPTIC TANK

Many areas within the State of Georgia do not have access to city or county sewer systems. Sewer systems may provide advantage of less upkeep in future, and may be

⁵ *Archives of Physical Medicine and Rehabilitation*, Volume 86, Issue 5, May 2005.

consideration if choice is available. If septic tank is necessary, each county has specific requirements for “perk” tests for the land where building is proposed. Each county may require specific type of septic tank system to be used, how the “drain field lines” will be placed, etc. The Rehabilitation Supplier must be sure that housing contractor who will be completing housing project is considering these needs as part of the overall bid/projected costs. The maintenance/upkeep of the system should be specifically addressed.

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 on 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.

UNIVERSAL DESIGN

More of a conceptual approach to accessible housing rather than specific criteria found in the General Accessibility subsection, the theory of universal design is the design of products and environments to be usable by all people, to the greatest extent possible, without adaptation or specialized equipment. It was developed by a group of design advocates at the North Carolina State University, College of Design, *Center for Universal Design*, in Raleigh, North Carolina and incorporates a number of principles:

- Equitable Use – The design is useful and marketable to people with diverse abilities.
- Flexibility in Use – The design accommodates a wide range of individual preferences and abilities.
- Simple and Intuitive Use – Use of the design is easy to understand, regardless of the user’s experience, knowledge, language skills, or current concentration level.
- Perceptible Information – The design communicates necessary information effectively to the user, regardless of ambient conditions or the user’s sensory abilities.
- Tolerance for Error – The design minimizes hazards and the adverse consequences of accidental or unintended actions.
- Low Physical Effort – The design can be used efficiently and comfortably and with a minimum of fatigue.
- Size and Space for Approach and Use – Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user’s body size, posture, or mobility.

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 in regard to the injured employee'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). An injured worker should not be placed in the position of having to declare bankruptcy because of their need for post-injury accessible housing.

The best practice is to restore the injured worker as close as possible to their pre-injury state of function. Under the principle of normalization, an injured worker (and his family members who live with him) should not have to pay more than 25 percent of his/their income toward housing costs. Household income should include income of the injured worker and others who reside in the home.

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.

PARTIAL STIPULATED SETTLEMENTS FOR HOUSING

A housing stipulated settlement is considered a partial settlement and resolves only the housing portion of an injured worker's workers' compensation case. It does not affect other benefits or resolve an injured worker's claim in its entirety. Generally, insurers wish to end all responsibility for housing by agreeing to a stipulated settlement. The employee normally gets a home suitable to their restricted capacity, and the insurer relieves itself of any future responsibility for housing for the injured worker.

GENERAL CONSIDERATIONS

Because housing stipulated settlements usually, permanently resolve all issues relating to housing, the stipulation must spell out quite clearly, exactly what is and what is not covered by the stipulation, including, but not limited to, temporary housing, moving, storage, maintenance of the yard, maintenance of the house, and taxes/insurance.

The Board's Rehabilitation Coordinators are available to hold conferences to discuss possibilities/ramifications of housing stipulations which are being considered by the parties. All housing stipulations must consider end of life issues, as well as what happens if later in the claim the injured worker is medically required to live in a nursing home, rehabilitation facility, or assisted living home as a result of residuals from the injured worker's injury.

ISSUES TO CONSIDER

It is not true that anytime an injured worker settles the housing portion of his case, the employer/insurer pays in full for the building of a new home for the employee, although this may be the case if all parties agree, or an ALJ orders it.

If the injured worker has equity in a pre-injury home which is not suitable for his current medical condition, and parties agree that a new, suitable home will be bought or built, generally the injured worker is expected to contribute the value of the "old" home's equity toward the cost of the new home.

Who holds title to the house is a matter for parties to negotiate.

The possibility of a change in the life circumstances or marital status involving the injured worker, or other major family change, should be addressed in the stipulation. Normally the home is titled in the name of the injured worker, but if the employee and his/her spouse jointly owned a pre-injury home, that may not be the case.

What happens to the house when the injured worker dies is also a matter of negotiation.

All standard real estate closing procedures must be followed even in cases of stipulated housing settlements.

If there is a probable need for future attendant care, then sufficient space for an attendant should be included in any long-term housing arrangement.

If modifications or building is considered, it is always better to plan for reasonable foreseeable long-range needs so that a one-time renovation or build will be sufficient for the injured worker's lifetime.

Will temporary housing be needed pending the modifications or building? If so, the stipulation should address this issue.

Housing must take into account the family configuration, including pets, children.

Stipulated settlements for housing are not, as of this writing, subject to attorney fees.

ETHICAL CONSIDERATIONS

Certain principles of ethics apply in all healthcare settings. Familiarity 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-maleficence, 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 wall and sub-flooring, all of which is constructed in assembly line in manufacturing plant. Completed product is transported on wheel system to building site. 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 manufacturer 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.
Appreciation and Depreciation	Homes appreciate through approximately 80 years. Depreciation typically begins at 80 years, sometimes earlier, dependent upon quality of construction and materials, as well as frequency of adequate maintenance.		Depreciation occurs more quickly, depending on quality of product. If placed on a masonry foundation, appreciation is possible for many years.
Maintenance	All homes require maintenance. The frequency and expense of maintenance will be dependent upon the original quality of the product and workmanship.		
Garage	Built on-site as part of house, or as a separate garage	Built on-site, either attached to house, or as a separate garage	Built on-site as a separate garage. 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.
Longevity	Longevity has a direct relationship to the quality of the original product and associated maintenance over years.		
Cost	Accessibility accommodations will increase the cost of any building system. Researching costs for each specific accessibility modification situation will be necessary.		

TRANSPORTATION GUIDELINES

PURPOSE OF PAPER

The purpose of this paper is to help clarify the various transportation issues, which exist in catastrophic and non-catastrophic workers' compensation situations. The primary guideline for determining transportation is based on Georgia State Board of Compensation Rule 200.1, which states the understanding that the goal of Rehabilitation Services is to *“provide items and services that are reasonable and necessary for catastrophically injured employees to return to the least restrictive lifestyle possible.”* All parties are charged with the fulfillment of this goal.

II. TRANSPORTATION

A. General Considerations

The Rehabilitation Supplier needs to identify transportation needs of the injured worker, taking into consideration appropriate options as discussed in this paper.

An injured worker who experiences cognitive and/or physical injuries which impact his ability to drive, will need to be involved in appropriate evaluations to determine cognitive and physical abilities, before being cleared to resume driving and to determine transportation needs. It is preferable for the injured worker to maintain driving independence. However, their previous driving record/history may impact decisions regarding transportation. Driving potential often cannot be determined right after initial injury, due to other medical complications or factors.

Research all positive/negative factors for providing what is medically necessary, as well as appropriate, for the individual's specific needs. Consider safety, reliability, extent of transportation needs, location of individual geographically, resources in the area and costs of each choice, short term and long term.

B. Rehabilitation Supplier Responsibilities

1. Identify transportation needs of the injured worker for
 - a. Medical and rehabilitation appointments
 - b. Personal business
 - c. Social/ recreational/health maintenance
 - d. Pre-vocational and vocational activities
 - e. Avocational activities
2. Assess the need for an evaluation of the injured worker's physical and/or cognitive abilities as related to driving
 - a. Physical functions affecting driving ability may include, but are not limited to: range of motion, muscle strength, reaction time, mobility status, transfer ability, sensation and visual skills. These may be associated with conditions such as, but are not limited to: Amputation, Neuropathy, Spinal Cord Injury, Complex Regional Pain Syndrome, Visual Impairments and Extremity Impairments.

Additional visual testing may be necessary to identify visual deficits that may affect driving.

- b. Cognitive functions affecting driving ability may include, but are not limited to: processing speed, concentration, attention span, reaction time, visuospatial judgment and ability to generalize. These may be associated with conditions such as, but not limited to: Brain Injury, Stroke, psychological factors and medication issues 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 an ongoing, dynamic process, affected by aging, functional changes and technological advances. It may be appropriate from time to time for the Rehabilitation Supplier to consider whether cognitive function testing should be repeated or provided. Further, it may be appropriate for Neuropsychological testing to be included.

- 3. Coordinate a driving evaluation with Certified Driver Rehabilitation Specialist.
- 4. Assess and recommend transportation options - consider short-term vs. long-term intervention. Injured worker considerations include: age, conditioning, strength, weight, disease progression and overall medical status. Vendor considerations include knowledge, experience, reliability, availability for service and geographic location in relation to the client. Public Transportation and Ride Sharing services may be considered as part of this assessment. Before utilizing to Public Transportation or Ride Sharing Services, the Rehabilitation Supplier should address whether such services meet the injured worker's transportation needs.

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. (www.nhtsa.dot.gov/cars/rules/adaptive/Modifier/Index.csm)

- a. Contract taxi, Ride Sharing, or medical transport
 - 1) Type of transportation (ambulance, medical transport, auto) should be based on the injured worker's mobility needs; i.e. ambulatory or dependence on mobility devices.
 - 2) Dependability of service, cost, availability in area needed, etc. should be a consideration on an individual basis
 - 3) Injured worker's level of confidence, competence and safety issues need to be relayed to the transportation company
- b. Public transit

- 1) May offer an alternative source for specific appointments and personal activities
- 2) Must consider convenience (travel time, route changes, stops in relation to destination), availability (route schedule), accessibility (does the injured worker have mobility/cognitive skills to use system), 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

d. Modification of vehicle

- 1) Should be based on a dependent passenger or driving evaluation, type of mobility device and/or prescribed vehicle equipment needs
- 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 condition of vehicle and projected life expectancy of vehicle. 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 for a new vehicle is approximately 7 – 10 years, depending on mileage and condition of vehicle. Replacement of vehicle is not in all instances required at vehicle age of 7-10 years. In any assessment for replacement of a vehicle, incidence, frequency of repairs and expense of repairs should be considered.
- 4) Adaptive Equipment ranges from spinner knobs and left footed accelerators to high tech hand controls and computerized joystick systems. Adaptive equipment training may require 5 to 40 additional hours, for the injured employee as recommended by the driving evaluation. In special circumstances, this could be higher.
- 5) Rarely are structural modifications (raised roof, lowered floor) performed on older vans. Additional weight could cause accelerated wear and tear and may be dangerous. 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 J)

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

5. Develop and submit proposed Independent Living Rehabilitation Plan (per Rule 200.1 (II)(C)(2)) incorporating proposed transportation needs. This must be substantiated by

documentation, including, but not limited to: driving evaluation, functional evaluations, seating/mobility evaluations, cost projections and physician orders.

- a. A plan should always be in place that allows the injured worker to be transported safely as a passenger, even if he is the primary driver.
 - 1) A secure lock down should be in place for the wheelchair, even if unoccupied.
 - 2) An able-bodied driver should be able to operate the vehicle, if necessary
 - 3) If the injured worker's vehicle is not modified so that he/she can be transported as a passenger, an alternative transportation service needs to be provided.
 - 4) Likewise, if the modified vehicle is inoperable, alternative transportation needs to be provided.

C. Driving Evaluation

1. General Considerations

A driving evaluation will assess physical, visual, perceptual and cognitive skills, as well as identifying safe/unsafe-driving techniques. 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 unless otherwise specified by the Certified Driver Rehabilitation Specialist (CDRS)
- 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 in 6-12 months may be an option. 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 Employee’s psychological condition may be considered in whether a driving evaluation is appropriate. Consult the treating physician regarding the timing of this evaluation.

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 (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.
- 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
- f. Assess the vehicle’s capability to bear the weight of adding a loader type lift.
- 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 also for positioning the injured worker into the driver’s seat.

3. Mini-Van versus 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 van purchase.

- a. A van has to be large enough to provide easy 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 van.
- c. Full size vans, such as the Ford E-250 may be preferred due to the higher gross vehicle weight rating, heavy-duty systems, and overall durability. With modifications, this vehicle can accommodate clear unobstructed entry for individuals with a seated height of up to 60 inches or more. Recommendations for lowered floors and raised roofs should be obtained through a driver's evaluation.

E. Handicapped Permit and License Plate

The 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 has the choice of either a portable handicapped permit or a handicapped license plate. Temporary permits are available for short-term use.

1. Handicapped Permit form is obtained from the local State Driver's License Office and must be completed by the treating physician. Some physicians have this form in their offices. The permit form must be notarized. 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. The physician must complete the handicapped permit form and it must be notarized. Fees for this license plate are the same as a regular plate. 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 and cost are all factors to consider in determining the appropriate system.

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 this type carrier can be considered. The wheelchair/scooter is transported outside of the vehicle. This system allows for easy access to equipment and no cargo space is required.

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.

- 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 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

Generally, ramps are used on mini vans only, due to the safety concerns and degree of incline.

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 that the mobility device has adequate traction and power. Manual ramps require assistance.

G. Portable Ramps

Portable ramps are available for wheelchair /scooter users to carry in their vehicles to allow access to areas not handicapped accessible. These ramps are lightweight and available in varying lengths.

H. Home Ramp System

Refer to Housing Guidelines and Considerations Section regarding ramp specifications for covered areas.

I. 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. In such cases, the Board will require a covered parking area. For example, people with spinal cord injuries have a hard time regulating their body temperature, so exposure to rain/cold, etc., could have medical consequences.

Where feasible, it is preferred that the covered parking area be attached to the home. Parking requirements will vary on a case-by-case basis. The parties should take a common sense approach as to what each injured worker will need, based upon his/her individual factors.

J. Financial Considerations

1. Consider purchase versus rental, pre- and post-injury insurance rates, 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 who is paying for what. 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 Worker's Compensation Fee Schedule, unless negotiated otherwise. This 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.
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 cost 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.

K. Ethical Considerations

The concept of “normalization” is especially vital to individuals who require adaptive equipment for independent functions. Access to the community is an important aspect of normalization. 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 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 insurer. Each injured worker has individual physical needs and life-style requirements. The independence offered by the appropriate vehicle and mobility equipment can be life changing.

L. Disclaimer

This transportation information is being provided as general information and to assist with giving appropriate solutions for various transportation 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 transportation issues with all parties.

DECISION TREE: Car versus Van

Can the person transfer independently and efficiently to a car? (If it takes too long or takes too much energy, it might not be worth the effort.)

No Consider a van with a person driving from a wheelchair or transfer seat. Skip to #5

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 should be possible

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 pickup, SUV or van, make sure 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? (NOT compatible with all 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's 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 flattop 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.

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