

REHABILITATION REPORTING GUIDELINES

K-WC-R 93-6 (11-16)

R93-2 Vendor Referral Report

Required from vendors to report the following:

- a. Receipt of all referrals for medical management; and
- b. Receipt of all referrals for vocational assessment and/or rehabilitation plan.

Submission of report should occur at time of referral, not with a plan or closure report. Date of referral is required. A copy of this report must be sent to all parties, including any attorneys representing the parties.

R93-3A Vocational Assessment

Required from qualified rehabilitation counselors for all vocational assessment referrals to:

- a. Determine the need for and capability of benefiting from vocational rehabilitation services to restore the injured employee to work at a comparable wage; and/or
- b. Report the results of formal testing performed by a qualified vocational evaluator.

A copy of the assessment must be sent to all parties, including any attorneys representing the parties.

R93-3B Vocational Rehabilitation Plan

Required from qualified rehabilitation counselors to:

- a. Document the services needed to restore the injured employee to work at a comparable wage;
- b. Document the input of the claimant into development of the plan; and
- c. Clearly identify services and responsibilities.

Plan requirements:

- a. Unless an R93-2 and medical documentation have been previously filed with the Division, they must accompany the plan when submitted to the Division.
- b. Supporting documentation must be legible, and should be clear as to relevance (e.g., is job analysis that of job at time of injury or for placement).
- c. The plan will be implemented only if the claimant and insurance company/employer agree to its contents, per their signatures.
- d. Original signatures of parties are not required. A qualified rehabilitation professional (QRP) must sign, not type in name.
- e. Must be submitted in advance of plan start date, except in highly unusual circumstances.
- f. A copy of the plan must be sent to all parties, including any attorneys representing the parties.

The Rehabilitation section will attempt to mediate any disagreements if requested by any party.

R93-3C Plan Amendment

Required from qualified rehabilitation counselors to report changes to an agreed-upon rehabilitation plan.

Changes in the plan must be justified and agreement noted by signature of all parties. Original signatures of parties are not required. QRP must sign, not type in name.

A copy of the amendment must be sent to all parties, including any attorneys representing the parties.

The Rehabilitation section will attempt to mediate any disagreements if requested by any party.

R93-3 Rehabilitation Vendor Progress Report

Required from qualified rehabilitation counselors to report case progress and identification of issues that need to be resolved before the assessment or plan can be completed.

Rehabilitation Reporting Guidelines

K-WC-R 93-6 (11-16)

A progress report is to be submitted within 30 days after a referral for vocational assessment and at 30-day intervals thereafter until the assessment and/or plan is completed.

A vendor report to the insurance carrier may be submitted in place of the R93-3 if the report clearly addresses the issues that need to be resolved before the assessment or plan can be completed.

A copy of this report must be sent to all parties, including any attorneys representing the parties.

R93-5 Closure Report

Required from vendors to report closure status on vocational rehabilitation cases. This information will be used to report to the Legislature and others on the effectiveness of vocational rehabilitation on returning injured workers to competitive employment.

Closure report requirements:

- a. The cost billed to the insurance company by the reporting vendor.
- b. Any subcontracted costs must be reported separately from the reporting vendor's costs if the total cost is different from that billed by the reporting vendor.
- c. Average weekly wage (AWW) at the time of injury.
- d. If AWW at time of closure is unknown, state why.
- e. A copy of this report must be sent to all parties, including any attorneys representing the parties.

Closure report should be submitted within five days of closure.

R87-7 Medical Management Closure Report

Required from medical managers to report all medical management case closures.

Closure report requirements:

- a. Total cost of medical management services. If two or more medical case managers (MCMs) have been assigned to the case (sequentially or simultaneously), and the closure reports are to be submitted at the same time, each closure report should show the final outcome, and each R87-7 must show the same combined cost for all MCMs. If two or more medical case managers have been assigned to the case (sequentially or simultaneously), and the closure reports are submitted at different times, each closure report may show the associated outcome for the MCM reporting, and each R87-7 must clearly state that the cost reported is for the MCM only, and the cost for other MCMs assigned will need to be added to the present amount for a total cost.
- b. If claimant returned to work, the report must include the date of return to work, AWW on date of injury and AWW at return to work (RTW).
- c. If worker is never taken off work (if worker continues working after injury), treat that the same as RTW. In such cases, the date of RTW equals the date of injury.
- d. If claimant has returned to a modified or accommodated job, there must be documentation of specific modifications and/or accommodations, and an opinion on whether the position is within the claimant's permanent restrictions.
- e. If using "insurance company requested closure" as closure reason, explain the reason closure was requested. Stating that the insurance carrier is closing their file is not an explanation.
- f. A copy of this report must be sent to all parties, including any attorneys representing the parties.

R99-8 Vendor's Request for Additional Expenditures

Required from qualified rehabilitation counselors to request expenditures beyond that provided in the Kansas Workers Compensation Schedule of Medical Fees.

Justification for additional expenditures must be provided through a complete breakdown of anticipated costs. Copies should be submitted to all parties.

The Division of Workers Compensation will review the additional expenditure request and provide recommendations to all parties. Expenditures may not be exceeded without prior approval by the Division of Workers Compensation.