DEPARTMENT OF FAMILY AND MEDICAL LEAVE (DFML)

APPEALS HANDBOOK

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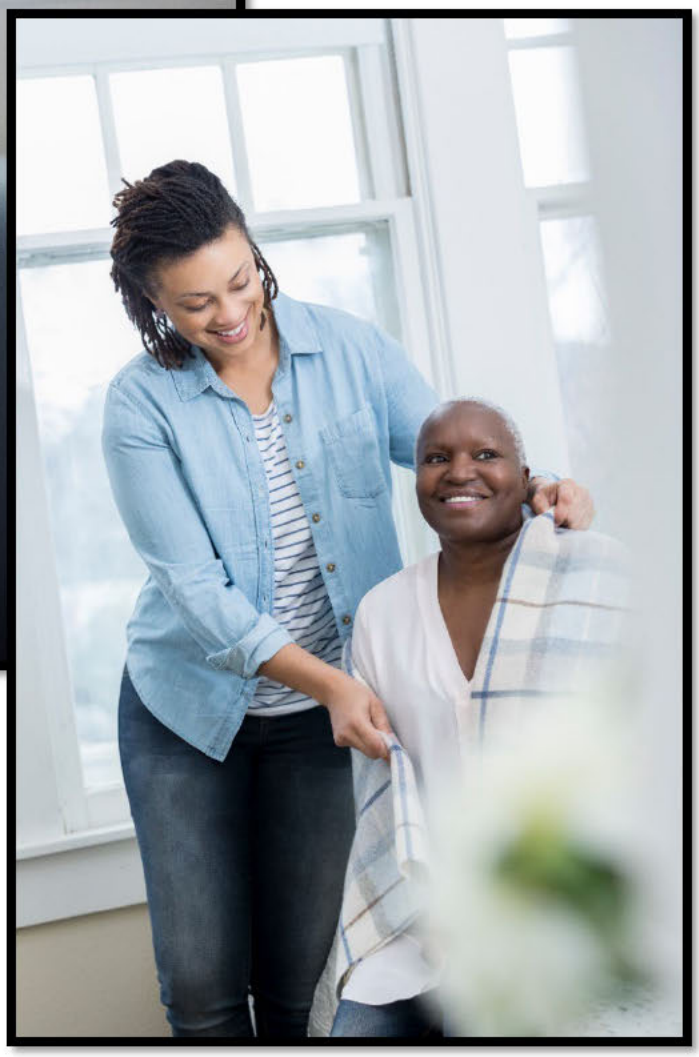

DFML
MA Department of Family and Medical Leave

Table of Contents

CHAPTER ONE: INTRODUCTION TO DFML APPEALS

I. Appeals Handbook Purpose

The DFML Appeals Handbook was created to serve as a quick reference resource for all DFML Appeals staff. The information included within is a training document as well as required knowledge for all Appeals staff. It is expected that all procedures and decisions made by the DFML Appeals team will be made consistently and in full accordance with the Handbook. This information contained within is subject to change and will be updated periodically to reflect changes to relevant statutes, regulations, and DFML sub-regulatory policy.

II. DFML Appeals Mission Statement

The Department of Family and Medical Leave (DFML) Appeals Department strives to resolve as many appeals of Paid Family/Medical Leave (PFML) initial determinations as efficiently as possible. Decisions are made in accordance with relevant laws and agency procedure, and in the claimant's favor whenever possible[2] while ensuring the integrity of the PFML Trust Fund.

III. Staffing Roles

The DFML Appeals Team is currently comprised of:

- **Appeals Manager**- responsible for ensuring appeals are disposed of timely and in accordance with applicable laws and procedures.

- **Office Support Specialists (OSS)-** assists the Appeals Manager with administrative duties, assigns appeals evenly to Review Examiners, schedules hearings and prepares relevant notices, fields and takes timely action on incoming phone calls and correspondence.

- **Review Examiner I (RE I)-** reviews all incoming appeals and takes appropriate action to resolve as many as possible without the need for an administrative hearing.

- **Review Examiner II (RE II)-** holds administrative hearings and issues written decisions on eligibility.

[2] When performing your duties, all DFML Appeals Staff are to keep in mind the legislative mandate of the PFML Program:

"This chapter shall be liberally construed as remedial law to further its purpose of providing job-protected family and medical leave and family and medical leave benefits. All presumptions shall be made in favor of the availability of leave and the payment of family and medical leave benefits under this chapter." G.L. c. 175M, § 8(h).

IV. The DFML Appeals Process

A. Submitting an Appeal

Claimants may appeal any aspect of a DFML determination. Most appeals arise from the denial of an application. However, claimants may also request an appeal to review an element of an approved claim, such as whether the benefit rate, or leave start and end dates are correct.

Claimants may submit appeals online, through mail, fax, or over the phone via a contact center agent. The ability to appeal online is specific to claims filed through the claimant portal (which comprises the majority of PFML claims). Appeals of a DFML determination must be filed within 10 calendar days of the receipt of notice. Appeals filed after this deadline may be approved upon showing of good cause (See Chapter: 9 Good Cause).

Once an appeal is entered into the PFML claims processing system, it is sent to an OSS to assign to a RE for review at the reconsideration level.

B. Reconsideration

DFML employs a two-stage review process to help resolve as many appeals as possible without the need for an administrative hearing. DFML refers to the initial attempt to resolve an appeal without a hearing as “reconsideration.”

Upon being assigned an appeal, the RE reviews the entire claim to determine any deficiencies, and how they can be resolved. All case notes must be reviewed to best understand the history of each claim and ensure all relevant information is considered.

The RE then attempts to contact the claimant to explain the reason for the initial denial and what is needed to change the claim to approved (when legally possible).

1. REs must attempt to make two outbound phone calls to the claimant. If the call is not answered, the RE must leave a voicemail indicating that they are a DFML Appeals representative calling about their recent appeal and leave their direct extension for a return call.

2. REs must leave a detailed note in the claim regarding the reason for the call.

3. After the second unsuccessful phone attempt, the RE must send a written Request for Information (RFI) to the claimant stating that they are attempting to reach them and explain in detail the evidence the DFML is seeking.

4. The Appeals RFI provides claimants with a 14-calendar day deadline to return any evidence required. If the claimant responds and requests more time to provide the evidence required, the RE should allow reasonable deadline extension requests.

5. The RE should also send the appeal to be scheduled for a hearing on the same day as the RFI.

    a. Hearings are scheduled approximately 14 to 21 calendar days in advance. This allows time for any evidence requested to be returned before the start of the hearing.

    b. If the evidence is returned prior to the hearing, the evidence may be reviewed, and the appeal disposed of, without the need for a hearing by the assigned review examiner.

c. If the evidence is not returned prior to the hearing, the hearing can go forward as scheduled, and the claimant will have the opportunity to address there.

d. If not done previously, an Employer Response Form should be sent to the employer when sending to hearing. This will ensure no further delay is required, if the appeal can otherwise be approved after hearing.

6. After reviewing all available evidence, the RE can dispose of an appeal at Reconsideration by:

   a. ***Approving:*** Overturning DFML's initial determination and approving the claim in its entirety.

   b. ***Returning to Adjudication:*** Overturning the element of DFML's determination that was the subject of the appeal and then returning the claim to adjudication for further required action before the claim can be approved. (e.g., after appeal the claim is found to be financially eligible but identify verification and/or certification documents have not yet been received).

   c. ***Modification***: Overturning the element of DFML's determination that was the subject of the appeal of an already approved claim. (e.g., the claim was approved, but the claimant has successfully appealed the benefit rate).

   d. ***Dismiss Exempt:*** The claimant's employer is exempt from the PFML program because the employer has a DFML approved private plan, and the claimant has applied for benefits with the DFML.

      If the employer is exempt because it has a DFML approved private plan and the claimant has applied to the DFML for PFML benefits, the application must be dismissed. The claimant should be advised to apply though the private plan for leave benefits. (See Chapter Eight: Exempt Employer & Private Carrier Appeals).

      NOTE: if an employer that has a DFML approved private plan denies part of a claimant's application for PFML benefits under that plan, the claimant may appeal that decision to the DFML. Those kind of appeals are allowed under G.L. c. 175M, sec. 11(e). (See Chapter Eight: Exempt Employer & Private Carrier Appeals).

   e. ***Dismissed Other:*** for another reason (e.g., duplicate appeal, moot).

   f. ***Withdrawn:*** at the claimant's written request.

   g. ***Sent to Hearing:*** if the appeal cannot be resolved at the Reconsideration level.

C. Administrative Hearings

Since the PFML program launched on January 1, 2021, the significant majority of all appeals have been resolved at reconsideration without the need to send claimants through the more time-consuming process of an administrative hearing.

Not all appeals can be resolved at reconsideration. When this is the case, the appeal is then referred by the review examiner to go to a hearing.

DFML hearings are held in accordance with G.L. c. 30A and follow Informal Hearings Rules pursuant to 801 CMR 1.02. OSS schedule the hearing and send a written Notice of Hearing, informing the claimant of the date, time, and issue to be heard. DFML hearings are conducted via video conference. Claimants who do not have the required technology to participate via video conference may participate over the phone while the Review Examiner conducts the hearing via video conference.

At the hearing, claimants are entitled to a fair opportunity to present their case. The claimant may represent themself, or have another person, including non-lawyers, represent them. They may present additional testimony and/or evidence and can provide witnesses. They may address, dispute, or clarify any evidence found relevant to their claim. At the conclusion of the hearing, the RE issues a written decision, either affirming, modifying, or reversing the initial determination within 30 days from the conclusion of the hearing. The hearing may be left open for additional time to allow the claimant to submit evidence not available at the hearing (typically 14 calendar days).

If the claimant disagrees with the appeals decision for any reason, they have the right to appeal to the District Court in which they live or work within 30 days of the receipt of the DFML Appeals Decision. Instructions on how to file an appeal are included within the Appeals Decision.

V. DFML Appeals Staff Expectations

A. Standard of Conduct

All DFML Appeals staff act as representatives of the DFML Appeals Department, DFML, and the Commonwealth of Massachusetts. As such, the highest level of professional conduct is always expected.

B. Fairness and Impartiality

Appeals staff must treat everyone fairly and with respect. You must not treat anyone especially favorably or unfavorably and you must not use your position for your personal benefit.

Appearance of conflict or partiality is acting in a manner that would make a reasonable person think you can be improperly influenced is prohibited. You may not act in a manner that would cause a reasonable person to think that you would show favor toward someone or that you can be improperly influenced. You must consider whether your relationships and affiliations could prevent you from acting fairly and objectively when you perform your duties for DFML.

C. Confidentiality

As a DFML Appeals representative, you have access to a significant amount of Personal Identifiable Information (PII). This includes, but is not limited to individuals' names, addresses, Social Security Numbers, ages, wage information, medical records, employment history, and banking information.

To accomplish your work, you have access to DFML's claim management system, FINEOS. You may also be granted access to records from the Department of Revenue (DOR), the Department of Unemployment Assistance (DUA), and the Department of Industrial Accidents (DIA).

You may not access, view, browse, or use any information except when authorized to do so and for a proper DFML purpose. For example, it is improper to look up information regarding a family member, friend, neighbor, co-worker, or celebrity for any unauthorized, non-DFML purpose.

Note that working on a matter involving a family member, friend, neighbor, or co-worker should be reported to your manager for case reassignment before you begin working on the claim to avoid any potential conflict of interest.

Likewise, you must protect the confidentiality of all information. You may not disclose it, except when authorized to do so for a proper DFML purpose. For example, it is improper to tell friends details about a claim or issue that you are assigned. **You must notify management of any potential unauthorized disclosure or use of DFML information.**

Improperly disclosing or using confidential information obtained through your job for any non-DFML related purpose is prohibited. You may not improperly disclose confidential information or make personal use of non-public information obtained through your job**. Violations may result in disciplinary action, up to and including termination.**

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CHAPTER TWO: FINANCIAL ELIGIBILITY

General Principle

A PFML claim is financially eligible for benefits if the claimant is a covered individual who has earned sufficient Massachusetts wages during the base period.

If a claimant is working for more than one employer at the time of application, a PFML claim must be filed with each employer. Although overall financial eligibility is determined using all qualifying base period wages, benefit rates are determined using only wages from each employer when the claimant has more than one active employer or has been with their current employer for more than 26 weeks.

When determining a claimant's base period, the DFML must use either the application submission date or the Sunday preceding the first day of protected leave, whichever is earlier. The last four completed calendar quarters prior to this date is the base period.

Relevant Law

G.L. c. 175M, §§ 1, 2(j) & 3.
458 CMR 2.02, 2.04, 2.12.
G.L. c. 151A, §§ 24(a), 6, 6A.

I. Financial Eligibility Concepts and Definitions

A. Completed Calendar Quarter

Employers and self-employed individuals who opt-in to the PFML program are required to submit evidence of PFML contributions to the Massachusetts Department of Revenue (DOR) on a quarterly basis:[3]

Calendar Dates	Quarter
January 1- March 31	1
April 1- June 30	2
July 1- September 30	3
October 1- December 31	4

[3] As explained in more detail below, employers are required to report wages within 30 days from the end of the most recent quarter. 458 CMR 2.04(1) and (2).

B. Base Period

The base period is determined by the last four completed calendar quarters within the previous five calendar quarters immediately preceding the quarter in which an application for a qualified period of paid benefits is filed with the Department, or the quarter in which the Sunday preceding the first day of protected leave begins, whichever is earliest. A completed calendar quarter is one for which an employment and wage detail report has been or should have been filed. 458 CMR 2.02.

Example: a PFML application is filed on February 15, 2023, for a leave beginning March 1, 2023. Because the application date (February 15), is earlier than the Sunday preceding first day of leave (February 26), the base period of this claim would be:

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
	$	$	$	$	X[4]

Example: a PFML application is filed on February 15, 2023, for a leave that began on December 15, 2022. Because the Sunday preceding first day of leave (December 11), is earlier than the application date (February 15), the base period of this claim would be:

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
$	$	$	$	X	

C. Newly Completed Quarters- No Wages Reported

a. Employers have 30 days from the end of a completed quarter to report contributions to DOR. 458 CMR 2.04(1) and (2). PFML claims filed in the months of January, April, August, and October will often not have wages for the most recently completed quarter.

b. In this scenario, DFML will look back to a fifth completed quarter to attempt to capture four quarters of wages in the base period.

Example: a PFML application is filed on April 10, 2023, for a leave beginning May 1, 2023. The base period of this claim would normally be:

Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023	Quarter 2 2023
$	$	$	$	( )	X

However, in this scenario, there are no wages reported for Quarter 1, 2023. This is likely because the PFML application was filed within the 30-day deadline for the employer to report wages. Accordingly, the quarters used to determine financial eligibility and benefit rate will be:

Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023	Quarter 2 2023
$	$	$	$	( )	X

[4] "X" indicates the current, incomplete quarter in which a PFML claim is filed, or the first day of leave, whichever is earlier.

a. DFML only allows a look back to a fifth quarter when the most recent quarter's wages have not yet been reported.

b. If the claim still fails eligibility using the fifth quarter lookback but would pass eligibility if wages were entered for the most recently completed quarter; allow the claimant to submit a recent pay stub showing wages for that quarter to prove financial eligibility. (See Alternate Base Period discussion below).

c. If the 30-day deadline is close to passing, you may wait until the 30th day and check again for reported wages after the deadline has expired.

D. Alternate Base Period (ABP)

If a claim is financially ineligible under the base period as defined above, DFML permits the use of wages from the incomplete quarter in which the claim was filed or in which the leave period/benefit year began. This is called the Alternate Base Period and is comprised of the last three completed quarters and the wages from the incomplete quarter in which the claimant filed their leave request or began their leave/benefit year. G.L. c. 151A, § 1(a),

DOR and DUA will not have records of the incomplete quarter. The claimant must provide sufficient proof of their wages in the incomplete quarter. The most recent paystub showing Year-to-Date wages prior to the beginning of leave is the best evidence.

Example: a PFML application is filed on February 15, 2023, for a leave beginning March 1, 2023. Because the application date (February 15), is earlier than the Sunday preceding first day of leave (February 26), the base period of this claim would be:

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
	$0	$0	$	$	X

However, in this example the claimant has no wages in Quarter 1 and 2, 2022, and the claim is found to be financially ineligible. If entering wages for Quarter 1, 2023 (the current quarter the application is filed in) would make the claim financially eligible, the ABP can be utilized:

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
		$0	$	$	Partial $

Use ABP only if:

- The claim is ineligible with standard base period or:
- If, on the claimant's motion, the ABP wages would result in at least a 10% higher benefit rate compared to the benefit rate set with primary base period wages.

E. Benefit Year

The Benefit Year is unique to each claim and is defined as starting on the Sunday before the first day of leave taken for what would be a qualifying reason under the PFML if they would have been financially eligible with the DFML. The benefit year concludes on the 52nd Saturday following the beginning of the benefit year. G.L. c. 175M § 1, 458 CMR 2.02.

A claim will have only one benefit rate per benefit year, per employer.

Any subsequent claims or extensions within the same benefit year shall receive the benefit rate already assigned.

The maximum benefit rate allowed for the claim is determined by the benefit year, which begins the Sunday preceding the first day of protected leave.

Example: A claim is filed for leave beginning on Thursday, January 4, 2024. The Sunday preceding the leave is December 31, 2023. Accordingly, the benefit rate for this claim would be capped at the 2023 maximum benefit rate and would not be eligible for the 2024 maximum benefit rate.

If a claim crosses over calendar years, the claim's weekly maximum weekly benefit amount is set by the year in which the leave began and is not entitled to the new year's maximum weekly benefit amount.

Example: The claimant was approved for medical leave from September 22, 2022, through January 20, 2023, with a weekly benefit amount of $1,084.31. The benefit year is September 18, 2022, through September 16, 2023. On January 1, 2023, the PFML maximum weekly benefit amount increased to $1,129.82. The claimant's weekly benefit amount will remain $1,084.31 throughout their entire benefit year and they are not entitled to the 2023 weekly benefit amount maximum rate.

Example: The claimant is currently working for two employers (Employer A and Employer B). The claimant is approved for leave with Employer A from September 22, 2022, through January 20, 2023, with a weekly benefit amount of $1,084.31. On February 10, 2023, the claimant is approved for leave with Employer B from January 10, 2023, through March 10, 2023. As the PFML maximum benefit rate for 2023, was increased to $1,129.82, the claimant may be eligible for the 2023 additional PFML benefits from Employer B, so long as the total benefits from Employer A and Employer B do not exceed $1,129.82.

F. Covered Individuals

Some workers' services are excluded from the PFML's definition of employment by the nature of their work or the nature of their employer. If not excluded by law, a claimant is a covered individual if they are an employee (or former employee) of a Massachusetts employer, a self-employed individual that has elected coverage, or a covered contract worker. 458 CMR 2.02.

1. Employees

Any person who receives a W-2 from an employer located in Massachusetts, or whose wages are reported to Massachusetts DOR and DUA, is presumed to be a covered individual for purposes of PFML. A person whose work is performed both in and out of Massachusetts may also be a covered individual if the services provided are localized in Massachusetts. 458 CMR 2.01(2), G.L. c 175M, §1, G. L. c. 151A, § 1(h) and G. L. c. 151A, § 3.

2. Unemployed

A former employee is a covered individual if the date of separation from their most recent employer is **not more than 26 weeks from the start of their leave** and they are not reemployed at the time of filing for PFML.

3. Self-employed

A self-employed claimant is a covered individual if they have chosen to opt-in to the PFML program and have reported PFML contributions for at least two of the four calendar quarters preceding their application.

4. Covered contract worker

A covered contract worker is defined as a self-employed individual for whom 1) an employer reports wages on a 1099-MISC, 2) for whom at least one employer is required to remit contributions to DFML, 3) perform services in Massachusetts, 4) resides in Massachusetts, and 5) is not an independent contractor as defined by G.L. c. 151A, § 2.

5. Personal Care Attendants and Family Childcare Providers

For notice and filing purposes, personal care attendants are deemed to be employed by the consumer to whom they provide care. 458 CMR 2.02 (referencing G.L. c. 118E, § 70).

The employer of "family childcare providers" is deemed to be the Department of Early Education and Care for purposes of certain portions of the PFML. 458 CMR 2.02 (referencing G.L. c. 15D, § 17).

G. Covered Business Entity

Whether a claimant's employer is required to remit contributions depends on whether the employer's work force is comprised of more than 50% 1099 workers. Employers make that determination; DFML will not decide that the employer's work force is more than 50% 1099 workers or that the employer is otherwise required to remit contributions for a specific individual. 458 CMR 2.02.

H. Qualifying Earnings

Qualifying earnings are wages subject to the PFML contribution requirement paid to a claimant, or wages paid to a covered contract worker or earnings from self-employment for which the contract worker or self-employed individual is making PFML contributions.

DFML uses the same definition of wages as used by DUA. G.L. c. 175M, § 1, (referencing G.L. c. 151A, § 1(s)).

1. Eligible Wages

Claimants who receive W-2 earnings from an employer located in Massachusetts (with certain exceptions) are presumed to be covered individuals for purposes of paid leave.

1099 wages can be used if the claimant is self-employed and has chosen to opt-in to the PFML program and made required contributions. See 458 CMR 2.02 (definition of Covered Individual).

For purposes of determining financial eligibility, eligible wages include only those wages or qualifying earnings subject to the contribution requirements set forth in the regulations and statute. 458 CMR 2.12(3)

However, whether an employer remits contributions to the PFML program is outside of the claimant's control. As such, DFML allows use of wages that should have been subject to contributions, even if such contributions were not deducted from the claimant's pay or remitted to the Department.

If wages were reported to DUA, DFML presumes that such wages were for work performed in Massachusetts and subject to PFML contributions (unless there is reason to believe the employer is exempt from making PFML contributions, such as wages from a municipality).

If DUA records show no reported wages, the claimant must present proof 1) that their work was performed in Massachusetts, 2) that their wages were not reported to another state's unemployment and/or family or medical leave program, and 3) which is sufficient to determine their quarterly earnings. Examples of sufficient proof include base period paystubs and/or a W-2.

2. Wages Which Cannot be Considered for any PFML Purpose

a. Municipal Employers

Municipal employers are not subject to PFML (unless the municipality elects to opt in to the PFML program). Accordingly, wages earned by municipalities cannot be considered when determining financial eligibility for paid leave. G.L. c. 175M, § 10.

Examples of municipal employers for which wages cannot be used for PFML include school departments, police departments, fire departments, or public works departments. 458 CMR 2.02.

Note: Many municipal employers are easy to determine based on name (e.g. City of Boston). However, this is not always the case. Employers which include terms such as "Education" or "Collaborative" are often municipal employers.

If there are no wages reported to DOR, but wages are reported to DUA, examiners must take care to ensure the employer is not statutorily exempt from PFML before using wages for financial eligibility and/or benefit rate purposes.

b. Wages Earned Outside of Massachusetts

If the employer is reporting wages to another state's unemployment and/or family or medical leave program, **DFML is bound to accept the employer's reporting and will not consider such reported out of state wages.** If a claimant disagrees with which state wages are reported to, this is a matter for the claimant to take up with the employer. See G.L. c. 151A, § 3.

If the employer chooses to update their filing and retroactively report wages to Massachusetts, those wages can be used for paid leave.

c. Not Considered Employment

The following are not considered "employment" and thus any wages earned cannot be considered as qualifying wages for PFML purposes:

i. employees of federal agencies

ii. employees of religious institutions

iii. trainees at nonprofit organizations

iv. work-study jobholders at a college or university

v. real estate brokers or salespeople paid solely by commission

vi. prison inmates

For more work relationships that are not "employment" for PFML purposes, see G.L. c. 151A, §§ 6 and 6A.

II. Verifying Wage Procedure

A. Initial Financial Eligibility Determination

At time of application, DFML systems automatically make a financial determination based on PFML contributions reported to DOR.

If a claim is found financially ineligible the claimant may file an administrative appeal. G.L. c. 175M, § 8(d), 458 CMR 2.12.

B. DFML Appeals Review

1. Review Examiners access DOR wages to determine if any new wages were reported since the filing of application and to ensure no errors were made based on DOR wage information.

2. Review Examiners access DUA wages as a backup. Sometimes the employer reports wages to DUA, but not DOR.

Wages reported to DUA create a presumption the claimant has earned W-2 wages from a Massachusetts employer. In most circumstances, these wages can be used for financial eligibility purposes for PFML.

1. If no DUA wages are reported, the employer may be statutorily exempt from UI (and thus PFML), or claimant may be self-employed**.**

Note: Wages from self-employment are not subject to UI and thus will never show in a DUA wage report. These wages can only be confirmed through the DOR wage report, if the self-employed individual opted in the PFML program and paid contributions on the self-employed wages.

Self-employed individuals may be eligible if PFML contributions have been paid for 2 of the past 4 completed quarters. This information is recorded by the DOR.

2. If no DOR or DUA wages are found, it is likely that employer is not reporting wages to Massachusetts. The review examiner assigned should reach out to claimant and advise they speak with HR/Payroll to confirm.

3. If employer refiles wages with MA: wait overnight and rerun wages from DOR. If wages are sufficient the review examiner can manually override eligibility.

III. Determining Financial Eligibility Concepts and Definitions

A. Financial Eligibility Test

Financial eligibility for PFML is met by a demonstration that, over the 12 months preceding an individual's application for benefits, the individual has received total wages as an employee or earnings for service as a covered contract worker from Massachusetts employers or Massachusetts covered business entities that in the aggregate equal or exceed 30 times the individual's weekly benefit amount as determined under 458 CMR 2.12, **and** that in the aggregate are not less than the dollar amount calculated annually by the Massachusetts Department of Unemployment Assistance pursuant to G.L. c. 151A, § 24(a).

B. Minimum Base Period Wages

Updated every October 1 to go into effect for claims filed the following January 1.

2021 - $5,400
2022 - $5,700
2023 - $6,000
2024 - $6,300

G.L. c. 151A, § 24.

C. Individual Average Weekly Wage (IAWW)

Has the same meaning as provided in G.L. c. 151A, § 1(w); provided, however, that Average Weekly Wage shall be calculated using earnings from the base period; and provided further, that in the case of a self-employed individual, Average Weekly Wage shall mean one twenty-sixth of the total earnings of the self-employed individual from the two highest quarters of the 12 months preceding such individual's application for benefits under G.L. c. 175M.

If an individual has multiple employers, the Average Weekly Wage will be calculated for each employer or covered business entity separately for purposes of calculating the weekly benefit rate. Wages from multiple employers can be aggregated to determine financial eligibility.

D. State Average Weekly Wage (SAWW)

Updated every October 1 to go into effect the following January 1.

2021 - $1,488.00
2022 - $1,694.24
2023 - $1,765.34
2024 - $1,796.72

G.L. c. 175M, § 3(b)(2)

E. Weekly Benefit Amount (WBA)

The weekly benefit amount for a covered individual on PFML shall be determined as follows: (i) the portion of the covered individual's average weekly wage that is equal to or less than 50 per cent of the state average weekly wage shall be replaced at a rate of 80 per cent; and (ii) the portion of the covered individual's average weekly wage that is more than 50 per cent of the state average weekly wage shall be replaced at a rate of 50 per cent. **Under no circumstances, however, can an individual's WBA exceed the Maximum Weekly Benefit Amount** which is determined for a calendar year on the preceding October 1. G.L. c. 175M, § 3(b).

If a claimant has been with their most recent employer for less than 26 weeks, all earnings within the base period can be used to determine the weekly benefit amount.

F. Maximum Weekly Benefit Amount (Max WBA)

The maximum allowable benefit is determined to be 64% of the state average weekly wage. Max WBA is determined every October 1, to go into effect the following January 1.

2021 - $850.00
2022 - $1,084.31
2023 - $1,129.82
2024 - $1,149.90

G.L. c. 175M, § 3(b)(2).

IV. Determining Financial Eligibility and Benefit Rate

A claim is financially eligible if base period earnings:

1. Exceed the applicable minimum earnings requirement; **and**

2. Exceed 30 times the weekly benefit rate.

Both standards must be met for an individual to be financially eligible!
458 CMR 2.02, 2.12.

A. Determining an Individual's Average Weekly Wage (IAWW)

DFML looks at wages for the last 4 completed quarters prior to filing (base period).

1. If 3 or 4 quarters of wages in the base period: IAWW = sum of two highest quarters / 26.

2. If 1 or 2 quarters of wages in the base period: IAWW = highest quarter / 13.

4. If less than 13 weeks of wages in one quarter- still divide by 13.

B. Determining Weekly Benefit Amount (WBA)- Two Tier Calculation (458 CMR 2.12)

1. If IAWW does not exceed 50% of SAWW: WBA = 80% of IAWW.

2. If IAWW exceeds 50% of the SAWW, the calculation is two-tiered:

Tier 1: 80% replacement rate up to 0.5 SAWW
Tier 2: 50% replacement rate on amount IAWW exceeds 0.5 SAWW

WBA = Tier 1 plus Tier 2

C. Rounding Rules

1. AWW- If such weekly wage includes a fractional part of a dollar it shall be raised to the next highest dollar (e.g. if AWW is calculated as $999.01, round up to $1,000.00). G.L. c. 151A §1(w).

2. WBA- can include cents (e.g. $867.43). Round up to the nearest hundredth place.

V. Determining Financial Eligibility- Examples

Example 1: A PFML application is filed on February 15, 2023, for a leave beginning March 1, 2023.

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
	$6,000	$6,000	$6.000	$6.000	X

1. Determine WBA

IAWW= $12,000/ 26 = $461.54. Round up to $462.00

IAWW < $882.67 ((0.5 SAWW in 2023 ($1,765.34))

Tier 1 Calc: $462.00 * 0.8 = $369.60

WBA = $369.60

2. Financial Eligibility Test

a. Minimum Base Period Earnings Requirement

Base Period Wages = $24,000

$24,000 > $6,000 (Minimum in 2023) = **Pass**

b. 30 Times Rule

$369.60 * 30 = $11,088.00

$24,000 > $11,088.00 = **Pass**

Claim is financially eligible with a weekly benefit rate of $369.60

***

Example 2: A PFML application is filed on February 15, 2023, for a leave beginning March 1, 2023.

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
	$20,000	$20,000	$20,000	$20,000	X

1. Determine WBA

IAWW= $40,000/ 26 = $1,538.46. Round up to $1,539.00

IAWW > $882.67 ((0.5 SAWW in 2023 ($1,765.34))

Tier 1 Calc: $882.67 * 0.8 = $706.14

Tier 2 Calc: $1,539.00- $882.67 = $656.33

$656.33 * 0.5 = $328.17

$706.14 + $328.17= $1,034.31

WBA = $1,034.31

2. Financial Eligibility Test

a. Minimum Base Period Earnings Requirement

Base Period Wages = $40,000

$40,000 > $6,000 (Minimum in 2023) = **Pass**

b. 30 Times Rule

$1,034.31 * 30 = $31,029.30
$40,000 > $31,029.30 = **Pass**

Claim is financially eligible with a weekly benefit rate of $1,034.31

***

Example 3: A PFML application is filed on February 15, 2023, for a leave beginning March 1, 2023.

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
	$50,000	$50,000	$50.000	$50.000	X

1. Determine WBA

IAWW= $100,000/ 26 = $3,846.15. Round up to $3,847.00

IAWW > $882.67 ((0.5 SAWW in 2023 ($1,765.34))

Tier 1 Calc: $882.67 * 0.8 = $706.14

Tier 2 Calc: $3,847.00 - $882.67 = $2,964.33

$2,964.33 * 0.5 = $1,482.17

$706.14 + $1,482.17 = $2,188.31

WBA = $1,129.82 (2023 Max WBA)

2. Financial Eligibility Test

a. Minimum Base Period Earnings Requirement

Base Period Wages = $200,000

$200,000 > $6,000 (Minimum in 2023) = **Pass**

b. 30 Times Rule

$1,129.82 * 30 = $33,894.60

$200,000 > $33,894.60 = **Pass**

Claim is financially eligible with a weekly benefit rate of $1,129.82 (2023 Max WBA)

***

Example 4: A PFML application is filed on February 15, 2023, for a leave beginning March 1, 2023.

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
	$6,000	$12,000	$4,000	$0.00	X

1. Determine WBA

IAWW= $18.000/ 26 = $692.31. Round up to $693.00

IAWW < $882.67 ((.5 SAWW in 2023 ($1,765.34))

Tier 1 Calc: $693.00 * .8 = $554.40
WBA = $554.40

2. Financial Eligibility Test

a. Minimum Base Period Earnings Requirement

Base Period Wages = $22,000.00

$22,000 > $6,000 (Minimum in 2023) = **Pass**

b. 30 Times Rule

$554.40 * 30 = $16,632.00

$22,000 > $16,632.00 = **Pass**

Claim is financially eligible with a weekly benefit rate of $554.40

***

Example 5: A PFML application is filed on February 15, 2023, for a leave beginning March 1, 2023.

Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
	$0	$0	$2,500	$4,000	X

1. Determine WBA

IAWW= $4,000/ 13 = $307.69. Round up to $308.00

IAWW < $882.67 ((0.5 SAWW in 2023 ($1,765.34))

Tier 1 Calc: $308.00 * 0.8 = $246.40

WBA = $246.40

2. Financial Eligibility Test

a. Minimum Base Period Earnings Requirement

Base Period Wages = $6,500

$6,500 > $6,000 (Minimum in 2023) = **Pass**

b. 30 Times Rule

$246.40 * 30 = $7,392.00

$6,500 < $7,392.00 = **Fail**

Claim is not financially eligible

REMEMBER WHEN A CLAIM IS FINANCIALLY INELIGIBLE- ALWAYS ATTEMPT TO GET CURRENT WAGES FROM INCOMPLETE QUARTER TO DETERMINE IF THE CLAIM COULD BE APPROVED USING THE ALTERNATIVE BASE PERIOD (ABP)!

***

VI. Concurrent & Sequential Employment

A. Concurrent Employment- claimant is working at multiple employers at time of filing.

1. Use all base period wages to determine overall eligibility. 458 CMR 2.12.

2. Benefit amount is prorated using wages for each employer separately. Calculate the average weekly wages for each employer separately using that employer's base period wages. 458 CMR 2.12(5).

3. The claimant must file a claim with each employer separately to receive benefits from multiple employers. 458 CMR 2.12(5).

***Total benefits from all employers cannot exceed the maximum benefit. 458 CMR 2.12(4).**

B. Sequential Employment- claimant has multiple employers in a base period but is only working at one at time of filing.

1. If most recent employment is less than 26 weeks:

   a. Use all base period wages to determine overall eligibility.

   b. Use all base period wages to determine benefit rate.

2. If most recent employment is equal to or greater than 26 weeks:

   a. Use all base period wages to determine overall eligibility.

   b. Use only wages for most recent employer to determine benefit rate.

   c. Two quarters of wages reported to DUA and/or DOR within the base period assumes the claimant has been with the employer at least 26 weeks.

3. If most recent employment is less than 26 weeks and previous base period employment was covered by exempt private or self-insured plan:

   a. Use all base period wages (including private exempt wages) to determine overall eligibility and benefit rate.

   b. Can confirm private exempt wages through DUA wage table.

4. If most recent employment is equal to or greater than 26 weeks and previous base period employment is exempt (private/employer plan):

   a. Use all base period wages (including private exempt wages) to determine overall eligibility.

   b. Use only wages for most recent employer to determine benefit rate.

***Wages excluded by statute CANNOT be used to determine overall eligibility or benefit rate.**

VII. Benefit Rate Appeals

Any decision of the DFML may be appealed. Even if a claimant is approved for paid leave benefits, they may file an appeal if they disagree with the weekly benefit amount determined.

All concepts and rules for Financial Eligibility appeals are followed for Benefit Rate Appeals.

A. Benefit Rate Appeal Procedure

1. Review Examiners access DOR wages to determine if any new wages were reported since the filing of application and to ensure no errors were made based on DOR wage information.

The benefit rate was initially determined by PFML system using wages reported to DOR at the time of application. If the application was filed within the 30 days after the expiration of a new quarter, and the review is occurring after the deadline has passed, the newly reported wages may now be present.

2. Review DUA wages for the base period as a backup check.

   The claimant may also submit evidence, such as pay stubs and W2s to establish a new benefit rate.

3. Determine the claimant's benefit rate for the standard base period. If a benefit rate change is warranted, adjust the AWW in both the absence and absence paid leave cases in FINEOS.

   While base period wages from multiple employers can be aggregated to determine overall financial eligibility, the benefit rate is determined based solely on the wages from the employer under which the claimant filed their application if they have at least 26 weeks of earnings with that employer.

A claimant may, but is not required to, take leave with multiple employers. The combined benefits for claimants with concurrent leave requests shall not exceed the applicable maximum benefit.

As described above, the DFML's policy is that claimants have one benefit rate per benefit year, per employer. Benefit rate is determined according to the base period wages preceding the start of the benefit year. Extensions and subsequent claims within the benefit year shall have the same benefit rate as established for the first claim in the benefit year.

If the claimant is financially eligible and the correct wages were used to reach their benefit amount, the alternate base period can only be used to increase the weekly benefit amount if it is greater than 10% of the original weekly benefit amount.

VIII. Employer Not Found

An “Employer Not Found” claim is generated when the claimant files for PFML with an Employer Identification Number (EIN) that does not exist in FINEOS.

A. Employer Not Found Appeal Procedure

1. A claimant may be financially eligible to take leave and may be considered a covered individual, but their employer record may not exist in FINEOS. An employer record being absent from FINEOS does not mean the claimant is ineligible for MA PFML. However, that employer record must be manually created and then loaded into the PFML database before a claim can be processed.

2. The most common reasons for an employer record to be absent in FINEOS is due to:

    a. the claimant entered the wrong employer FEIN at time of application,

    b. clerical errors within the company's internal payroll,

    c. non-compliant employers who are failing to remit the MA PFML contributions to DOR for their claimants, or the specific claimant filing for leave, or

    d. the employer is not located within the Commonwealth of Massachusetts and has no Massachusetts employees. **If the employer is not located within Massachusetts and has no Massachusetts employees, the missing employer record should not be created, and this individual should not be allowed to file MA PFML leave with this employer.**

3. Before requesting a new employer, record be added in FINEOS, the review examiner must search EIN in FINEOS to confirm it does not exist (sometimes the employer record can come in between when the claim is filed and when the appeal is reviewed).

4. If an EIN is found in FINEOS, refile claim under correct EIN to have evidence reviewed.

5. If EIN does not exist in FINEOS- Check claimant’s SSN in EMT (DUA’s wage database)) for base period wages.

    a. If an employer shows in EMT and it is a municipality, or other statutorily exempt employer:

        i. Upload EMT screen showing statutorily exempt employer and add note in FINEOS explaining employer is confirmed statutorily exempt.

        ii. Send to Hearing leaving employer as Employer Not Found.

        iii. Do NOT refer to have an employer created in FINEOS.

6. If non-statutorily exempt employer shows in EMT:

   a. Wages in EMT is a presumption this is a MA employer subject to PFML. The employer is likely a non-filer and is not properly reporting PFML contributions to DOR.

   b. Upload EMT screen showing wages and add note in FINEOS explaining employer record not found in FINEOS.

   c. Refer to have employer record created in FINEOS.

7. If no employment shows in EMT for this claimant:

   a. Search for EIN in EMT= If EIN exists, but no wages for this claimant:

   b. Reach out to claimant to make sure we have the correct EIN.

   - Is the claimant confused as to who their employer is? Did they provide an EIN for a payroll company instead of their employer or vice versa? Has their company recently been acquired?

   - When did the claimant began working for this employer? Brand new employment (started in current quarter) will not show in EMT or FINEOS.

   - Does the claimant currently (or did they previously) have any other MA employment that the PFML claim should be filed under?

   c. Ask the claimant to submit any evidence they have of current, non-exempt, MA employment.

   - A current pay stub showing YTD wages and PFML contributions is the most helpful evidence.

   - W-2 or any other records will be considered. Box 14 will contain PFML contributions removed from the earnings but will also list if other state PFL contributions were removed.

8. If evidence provided by the claimant is not sufficient, or if no evidence is received by deadline provided:

   a. Upload DOR and EMT screens showing lack of wages and add note in FINEOS explaining no wages found to base a PFML claim.

   b. Send to hearing leaving employer as Employer Not Found.

   c. Do NOT refer to have an employer created in FINEOS.

   If evidence provided by claimant is sufficient to support current, non-exempt, MA employment; refer to have employer record created in FINEOS.

CHAPTER THREE: CERTIFICATION DOCUMENTS

General Principle

To be approved, all PFML claims require proper documentation supporting the request for leave.

Relevant Law[5]

G.L. c. 175M, § 5.
458 CMR 2.08, 2.10.

I. Certification for Medical Leave

An application for medical leave for your own serious health condition requires the following:

1. A statement provided by a licensed health care provider (HCP) that you have a serious health condition and any other relevant details about your condition.

2. The date on which your serious health condition started.

3. The probable duration of your serious health condition and what activities you should refrain from doing.

4. An attestation that you can't work due to your serious health condition.

458 CMR 2.08(5)(a).

A. What is a "Serious Health Condition"?

A serious health condition is a physical or mental condition that prevents you from doing your job and involves:

a. inpatient care in a hospital, hospice, or residential medical facility; or

b. continuing treatment by a health care provider.

458 CMR 2.02.

[5] Relevant Standard Operating Procedure:
SOP 5- How to Process a Certification of Serious Health Condition

Inpatient care is an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

Continuing treatment is treatment for a condition that fits any of the following descriptions:

- Any incapacity to work for more than three consecutive full calendar days that also requires medical visits. Your patient's first visit must be within seven days of the start of incapacity. Telehealth appointments are also included. These medical visits must meet one of the following two patterns:
    - Two or more visits within 30 days of a patient's incapacity to work (unless it is impossible to book two appointments in this time frame).
    - One such visit—excluding a routine physical, eye or dental exam—plus a regimen of care or medication under the provider's supervision or prescription, e.g., outpatient surgery or strep throat.
- Any incapacity due to pregnancy or prenatal care.
- Any incapacity due to a chronic condition, which is a condition that:
    - Requires periodic medical visits,
    - Continues over an extended period of time, and
    - May cause episodic periods of incapacity that require leave, e.g., asthma or migraine headaches.
- Any incapacity due to a permanent or long-term condition that may not respond to treatment, Alzheimer's disease or terminal stages of cancer.
- Any absence to receive multiple treatments, plus any recovery time, for either of the following:
    - Restorative surgery after an accident or injury, e.g., joint replacements or reconstruction.
    - A condition that would lead to more than three consecutive days of incapacity if the patient did not receive treatment, e.g., chemotherapy treatments.

An incapacity to do your job means an inability to perform the functions of one's job owing to the serious health condition. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

Serious health conditions can include:

- Chronic conditions, like asthma or diabetes, which prevent you from working periodically and require going to the HCP more than twice a year.

- Permanent or long-term conditions, like Alzheimer's disease, stroke, or terminal cancer, that will need ongoing attention but will not necessarily require active treatment by a certified health care provider.

- Conditions requiring multiple treatments, like chemotherapy, kidney dialysis, or physical therapy.

- Conditions due to pregnancy or post-birth recovery that prevent you from working, as certified by a health care provider.

- Complications related to a diagnosis of COVID-19 that prevent you from working, as certified by a health care provider.

- Substance use disorder may be considered a serious condition if you are receiving treatment from a health care provider.

Voluntary cosmetic surgery is not considered a serious condition and is not covered by family or medical leave, except when inpatient care is required, or complications develop.

B. Acceptable Certification Documents in Support of Medical Leave

- Certification of Serious Health Condition Form (CSHC): The CSHC was created by DFML and is the simplest and easiest form to use to ensure meeting all DFML requirements. The CSHC can be found online at: https://www.mass.gov/doc/certification-of-your-serious-health-condition-form/download

- Family and Medical Leave Act Form WH-380-E: Several employers have created their own versions of the WH-380-E forms. If you encounter one of these forms, they should be treated as valid documents unless they are missing questions not contained in either the CSHC or Family and Medical Leave Act Form WH-380-E.

C. Acceptable Health Care Providers (HCPs)

- Doctors, including surgeons, dentists, chiropractors, podiatrists, midwives, osteopaths
- Clinical psychologists
- Optometrists
- Nurse practitioners
- Nurse midwives
- Clinical social workers
- Physician assistants
- Christian science practitioners

Any of the above licensed in another country (if verifiable).

NOTE: This list is not intended to be exhaustive. If the provider is a verified licensed health care professional, their certification should be accepted.

D. Reviewing a CSHC Form

- *Section 1:* Claimant Applying for Medical Leave
  Confirm name, date of birth, and last four of Social Security Number match information in FINEOS. Any discrepancies must be resolved prior to approving.

  If this section is missing from the submitted CSHC, if the claimant has filed for approved medical leave in the past, their previously approved Section 1 information may be substituted for a missing Section 1 page.

- *Section 2:* Patient's Serious Health Condition

  - Number 7: one option MUST be selected to approve.
    If "none of the above" is selected, the claim CANNOT be approved because they do not have a serious health condition as defined in 458 CMR 2.02.
  - Number 8: a description of the serious health condition is required.
  - Number 9: stating at least one essential job function the claimant is unable to perform due to the serious health condition is required.
    If this section is not completed, discretion may be used to determine whether the claimant would be able to work given the serious health condition listed in Number 8.
  - Number 10: Job related injury
    If yes - this is a flag that the claimant may also have a Worker's Compensation Claim. This must be investigated for a potential reduction (See Chapter Six Reductions).
  - Numbers 11&12: If serious health condition is related to pregnancy, this is an indication that this claim should be filed and processed as "medical maternity/pregnancy leave in FINOES" as opposed to a regular medical leave.

- *Section 3:* Estimated Leave Details

  Either Continuous, Reduced, or Intermittent Leave must be selected. The dates of requested leave MUST be free of edits or other changes unless accompanied by the signature or initials of the person completing the CSHC.

  Note: that there is a known issue of dates being typed out as XX/XX/2023 being shortened to XX/XX/20. It is safe to believe that the intended year is 2023.

  Past leave within the same benefit year also needs to be considered. A CSHC cannot be accepted if all three leave types are completed for the same date range.

  - Continuous Leave Review
    A start and end date are required. A start date with a time duration (i.e., "starting January 1 and for 8 weeks after.") is acceptable.

    Open ended or vague responses (i.e., "TDB" or "as needed") are not acceptable responses and require an updated CSHC form before approving.

    If the end date exceeds the 20-week maximum of medical leave allowable, the claim can be approved but capped at the 20 week maximum.
  - Reduced Medical Leave Review

Same sections required as Continuous except Section 3:

A pattern of leave is required (i.e., "every workday for 4 hours each day" or "every Thursday for 8 hours"). Form asks how many hours the claimant can work, not how many hours they are to be absent.

Vague responses (i.e., "three days per week" or "3 to 4 hours a day") is not acceptable (this response is a flag at intermittent leave may be appropriate).

If the pattern stated is insufficient, call the claimant/ send RFI to request an updated CSHC.

- Intermittent Medical Leave Review

Same sections required as Reduced except Section 3:

More detail required estimating leave (i.e., if a claimant needs to be able to miss their entire work schedule, the intermittent leave prescribed needs to cover that (i.e., "5 days per week for 1 day each" would allow for a claimant to be on leave for an entire week at a time under a normal work pattern).

If frequency permitted exceeds claimant's work hours, the leave can be approved, but leave will reduce proportionally.

Before approving, you must check Availability in FINEOS to ensure the requested amount of leave does not exceed the available leave bank. The leave bank will be reduced by all previous leave taken for a qualifying reason.

FINEOS will approve all intermittent leave, even if the claimant has exhausted all eligible leave. The claimant will not receive a denial until the claimant attempts to report hours taken off during their intermittent leave.

- *Section 4:* Provider's Certification and Information

Redacted: confidential fraud prevention and cybersecurity

[redacted]

What to do if there is more than one CSHC submitted?

a. Use the most recent one submitted.
b. If any questions, contact the claimant (by phone call twice and RFI) to clarify.

II. Certification for Family Leave: to Care for a Family Member with a Serious Health Condition

A Certification of Your Family Member's Serious Health Condition Form (Family CSHC) was created by DFML and is the form to use to ensure meeting all DFML requirements.

The Family CSHC can be found online at: https://www.mass.gov/doc/certification-of-your-family-members-serious-health-condition-form/download

A. Reviewing a Certification Document for Caring Leave

Identical to procedure in Section I, Subsection D above.

B. Family Members Covered for Caring Leave

Caring certs require an attestation/confirmation of the family relationship, specifically, that the caring leave is being taken to care for one of the following Family Members, defined in G.L. c. 175M, § 1 Definitions and 458 CMR 2.02:

- spouse or domestic partner
- children, stepchildren, or domestic partner's children
- parents, stepparents, or parent's domestic partner
- spouse or domestic partner's parents
- grandchildren, step-grandchildren, or domestic partner's grandchildren
- grandparents, step-grandparents, or grandparent's domestic partner
- siblings or stepsiblings

C. "Domestic Partner" Definition

- a person not less than 18 years of age who:

- is dependent upon the covered individual for support as shown by either unilateral dependence or mutual interdependence that is evidenced by a nexus of factors including, but not limited to:
    - common ownership of real or personal property;
    - common householding;
    - children in common;
    - signs of intent to marry;
    - shared budgeting; and
    - the length of the personal relationship with the covered individual; or

- has registered as the domestic partner of the covered individual with any registry of domestic partnerships maintained by the employer of either party, or in any state, county, city, town, or village in the United States. 458 CMR 2.02.

D. "Child" Definition

A biological, adopted, or foster child, a stepchild or legal ward, a child to whom the covered individual stands in loco parentis, or a person to whom the covered individual stood in loco parentis when the person was a minor child. 458 CMR 2.02

E. In Loco Parentis (ILP)

- 'In loco parentis' is not defined in either the PFML statute or PFML regulation; however, it is defined in the FMLA regs (28 CMR 825). Pursuant to 458 CMR 2.02, the FMLA definition of 'in loco parentis' shall be treated as persuasive authority with respect to PFML.

- In loco parentis exists when the covered individual takes on the role of a parent to a child who is under 18, or over 18 and incapable of self-care due to a mental or physical disability.

    - Factors to be considered in determining in loco parentis status include:
        - Age of child;
        - Degree to which child is dependent on covered individual;
        - Amount of financial support provided to child; and
        - Extent to which common parenthood duties are exercise.

- Child can have biological parents, and another person may still be standing in loco parentis to that child.

- No legal or biological relationship is necessary.

- Grandparents and other relatives such as siblings may stand in loco parentis to a child.

- The covered individual can also seek caring leave for an individual who stood in loco parentis to them (Covered individual wants to care for person who stood as their parent).
    - In loco parentis exists when the ILP person took on the role of a parent to the covered individual when the covered individual was under 18, or over 18 and incapable of self-care due to a mental or physical disability.
    - Took on the role of parent means the ILP person had day-to-day responsibilities to care for or financially support the covered individual.

- The same factors apply in determining in loco parentis as above.

III. Certification for Family Leave: to Care for an Active Service Member

The same Certification of a Family Member's Serious Health Condition form can be used for this type of leave, but the form must specify that the serious health condition is related to the service member's military service.

A. Reviewing a Certification Document for Caring Leave

Identical to procedure in Section I, Subsection D above.

B. Family Members Covered for Caring Leave

Identical to definitions in Section II, Subsection B.

IV. Certification for Family Leave: to Manage Family Affairs for an Active Service Member

The certification required for this leave is as follows:

- Certification documents,
    - An FMLA WH-384 Form,
    - A copy of the active-duty orders; or
    - A letter of impending activation from the family member's commanding officer.
- Your family relationship with the service member,
- The name and address of the service member; and
- Information proving the identity of the service member.

A. Reviewing a Certification Document for Caring Leave

Identical to procedure in Section I, Subsection D above.

B. Family Members Covered for Caring Leave

Identical to definitions in Section II, Subsection D above.

V. Certification for Family Leave: Bonding

A. Acceptable Certification Documents in Support of Family- Bonding Leave

- Birth of child:
  - Child's birth certificate or;
  - A document issued by the health care provider of the child or the health care provider of the birthing parent, stating the child's date of birth.

The individual filing for bonding leave must be a named individual on the document otherwise it is not valid.

- Placement of a child for adoption or foster care:

  - A document issued by the health care provider of the child or:
  - A document issued by an adoption or foster care agency involved in the placement or by other individuals as determined by DFML that confirms the placement and the date of placement.

- Adoption is defined as "[l]egally and permanently assuming the responsibility of raising a child as one's own. The source of an adopted child (i.e., whether from a licensed placement agency or otherwise) is not a factor in determining eligibility for leave." 458 CMR 2.02.

To the extent that the status of a covered individual as an adoptive or foster parent changes while an application for benefits is pending, or while the covered individual is receiving benefits, the covered individual shall be required to notify DFML of such change in status in writing. G.L. c. 175M, § 5(a)(5). See also 458 2.08(5)(d).

The Department of Children and Families may confirm in writing on letterhead the status of the adoptive or foster parent while an application for benefits is pending or while a covered individual is receiving benefits.

Bonding leave for "placement" of a child for adoption or foster care – no definition of "placement" in statue or regulation. DFML policy defines placement as the first day the child is placed with the person, not when the child is formally adopted, etc.

B. Bonding Leave Requested After 12 Months from Birth/Placement

- Bonding leave can only be approved within 12 months of birth, placement, or adoption of the child pursuant to 458 CMR 2.02. If the leave request is for a date outside of this window:
  - Approve any portion that is within the 12-month window.
  - Call the claimant/ Send an RFI to explain. The claimant can modify their leave to comply.

VI. Extensions of Approved Leave

DFML accepts leave extension requests filed within 30 calendar days of the end of the approved leave period.

If the extension is requested after 30 calendar days from the expiration of the prior approved leave, the request will be denied by adjudication and can be approved on appeal only if a determination of good cause for failure to request within the 30-day deadline is found. (See Chapter Nine: Good Cause).

When it comes to the Certification Documents required for request extensions of prior approved leave, two separate types are acceptable:

A. HCP's Notes

- A HCP's note may be sufficient to approve a request for extension so long as it is on official letterhead and contains the following information:

    - claimant's name;
    - dates of the requested extension;
    - reason for the extension (which MUST match or be related to the underlying serious health condition; and
    - name and/or signature of the healthcare provider authorizing the extended leave.

Please note that a HCP's notes do NOT need to be from either the same healthcare provider or even provider's office or group to be sufficient for a request for extension. This is because health care can involve multiple specialists.

B. Certification Documents

- The original certification document edited with the HCP's signature and date.

- An entirely new certification document, as discussed above, may be submitted as a request for extension of prior approved leave. Please refer to relevant sections above to determine validity of the submitted document.

CHAPTER FOUR: ID DOCUMENTS

General Principle:

To ensure Program Integrity, the identification of the claimant requesting paid leave benefits must be verified.

Although the identify must be verified, there is no requirement that a claimant prove they are legally authorized to work in the United States.

Relevant Law[6]

458 CMR 2.08(4)(a).

I. Documents Sufficient to Verify Identity

Acceptable forms of Identify Verification documents can be found online at: https://www.mass.gov/doc/get-ready-to-apply-for-pfml/download and include:

A. Proof of Identity

- A valid, unexpired COLOR copy, front and back of ONE of the following documents is required:
  - Massachusetts Residents:
  - REAL ID Driver's License or REAL ID
  - Standard Driver's License or ID Card
  - Junior Operating License
  - Learner's Permit
  - Commercial Driver's License
  - Limited Term License
  - Not for Federal Use license
  - Tribal ID Card
  - Liquor License
  - Out of State Residents:
  - REAL ID Driver's License or REAL ID
  - U.S. Standard Driver's License or ID Card
  - U.S. Junior Operating License
  - U.S. Learner's Permit
  - U.S. Passport or Card (include both the page with identifying information AND the signature page)
  - Permanent Resident Card (Form I-551) issued by the U.S. Department of Homeland Security (DHS) or the U.S. Immigration and Naturalization Servi
  - An Employment Authorization Document (EAD) issued by DHS, Form I-766, or Form I-688B
  - Foreign Passport (include both the page with identifying information AND the signature page)

[6] Relevant Standard Operating Procedure:
SOP 4- How to Complete an ID Review Task

Foreign passports must be verified by Program Integrity.

- If none of the options above are provided a claimant must submit valid, unexpired copies of TWO documents from the following categories:
    - A color copy of any one of these documents:
    - Certified Copy of your Birth Certificate filed with a State Office of Vital Statistics or equivalent agency in your state of birth. (A Puerto Rican birth certificate will only be accepted if it was issued on or after July 1, 2010. For more information on the Puerto Rican birth certificate law, visit the Puerto Rico Federal Affairs Administration.)
    - Certificate of Citizenship, Form N-560, or Form N-561, issued by DHS
    - Certificate of Naturalization (Form N-550 or N-570)
    - And a black and white or color copy of one of these documents:
    - SSN Card
    - W-2 Form
    - SSA-1099 Form
    - Non-SSA-1099 Form
    - Pay Stub with your full name and last four of SSN
    - an Authorized Letter from the IRS displaying your 9-digit individual tax identification number (ITIN)

B. Additional Rules

- Document copies must include both the front and back, be in color, if indicated, and be saved as a PDF or image file (.jpg, .jpeg, .png). Files must be smaller than 4.5 MB.

- Color documents must be mailed or uploaded as faxes are not received in color.

- All documents mailed or faxed should include the NTN number at the top of every page.

- The ID must be unexpired using the date of application and not the start date of the leave, unless the leave is prior to the date of submission.

- Review examiners may use identification documents from other claims if they meet all necessary requirements.

CHAPTER FIVE: EMPLOYER RESPONSE ISSUES

General Principle

In some circumstances, the employer may provide information which can lead to a denial of PFML which can only be resolved on appeal.

Relevant Law[7]

G.L. c. 175M, § 4(b), 458 CMR 2.08(2).
G.L. c. 175M, § 5(c), 458 CMR 2.15.
G.L. c. 175M, §§ 1, 5(a)(3), (7), 458 CMR 2.08(4)(f), 2.08(5)(b), 2.08(f).
G.L. c. 175M, § 2(c)(2)(A), 458 CMR 2.13(1)(a).

I. Employer Response Form

- Upon receipt of a claimant's completed application, DFML sends the relevant employer an electronic request for information ("Employer Response").

- The Employer Response provides the employer with an opportunity to report to DFML:

    - Wage and/or earnings information for the past 12 months;
    - A description of the claimant's or covered contract worker's position;
    - Whether the claimant or covered contract worker currently works a full- or part-time schedule
    - Weekly hours worked
    - Prior requests/approvals for a qualifying reason
    - Amount of paid leave already taken for a qualifying reason during the current benefit year
    - A description of the employer's or covered business entity's own paid leave policies and whether the claimant or covered contract worker has received paid or unpaid leave during the last 12 months under any plan or practice of the employer or covered business entity
    - Whether the claimant or covered contract worker will receive any paid leave benefits from the employer or covered business entity during the requested leave period at issue;
    - Whether the covered individual has applied for concurrent FMLA or other leave and whether the employer or covered business entity has approved the application
    - Whether the covered individual will be receiving any other wage replacement benefits as set forth in 458 CMR 2.12(6);
    - Any other relevant information or records related to the claim, including any evidence of a potentially fraudulent claim. 458 CMR 2.08(6).

[7] Relevant Standard Operating Procedure:
SOP 11- Employer Conflict Response

- The Department shall consider whether the covered individual's request for family or medical leave associated with the application for benefits was approved or denied by the employer or covered business entity and the reason(s) for the approval or denial when making a determination on an application for benefits. 458 CMR 2.09(2)(d).

- The employer has 10 business days to return the Employer Response to DFML.

II. Failure to Provide Adequate Notice

G.L. c. 175M, § 4(b); 458 CMR 2.08(2).

- Claimants are required to provide at least 30 days' notice to the employer of the anticipated starting date of the leave, the anticipated length of the leave and the expected date of return or shall provide notice as soon as practicable if the delay is for reasons beyond the claimant's control.

- For examples of what may be considered "reasons beyond the claimant's control," (See Chapter Nine: Good Cause).

- If an employer fails to provide notice of the PFML program as required by law (G.L. c. 175M, § 4), the claimant's notice requirement shall be waived.

- A covered individual is required to comply with the employer's usual and customary notice and procedural requirements for leave, absent unusual circumstances. A covered individual also may be required by an employer's policy to contact a specific individual to report this information. 458 CMR 2.08(2)(b).

- When planning medical treatment, the claimant or covered contract worker must consult with the employer or covered business entity in advance of an application to the Department and make a reasonable effort to schedule the treatment so as not to disrupt unduly the employer's or covered business entity's operations, subject to the approval of the health care provider. 458 CMR 2.08(e).

III. Employer Reports Potential Fraud

A covered individual shall not be eligible to receive family or medical leave benefits if the department finds, through a process it shall establish through regulations, that the covered individual, for the purpose of obtaining these benefits, willfully made a false statement or representation, with actual knowledge of the falsity thereof, or willfully withheld a material fact concerning the facts required to be certified pursuant to this section. G.L. c. 175M, § 5(c), 458 CMR 2.15.

A. Employer Challenges the Certification Document for Medical Leave/ Caring for a Family Member

- Redacted: confidential fraud prevention and cybersecurity

- Redacted: confidential fraud prevention and cybersecurity

- **Good faith mistakes are not considered fraud.**

For fraud to exist, there must be a willful statement or material omission made by the claimant.

In determining the willfulness of a false statement, the Review Examiner should consider the claimant's age and intelligence, along with the claimant's physical, mental, and linguistic limitations, including their ability to speak and understand English.

- Some reasons that do not constitute a valid employer response sufficient to deny a PFML claim include:
    - The employer alleges the claimant does not have a serious health condition (despite the claimant's submission of a valid certification document signed by a licensed health care professional).
    - The employer cites harm to its business by allowing the leave.
    - The employer alleges the claimant is requesting leave to avoid a poor performance review/ discipline.
    - The employer does not agree with the stated purpose of the PFML program.

IV. Intermittent or Reduced Bonding Leave Not Agreed To

The employer and claimant must agree to a request for intermittent or reduced bonding leave at the time of application with DFML. G.L. c. 175M, § 2(c)(2)(A); 458 CMR 2.13(1)(a).

If the Employer Response is returned indicating the employer's policy is not to allow intermittent bonding leave, the request must be denied.

V. Caring for a Family Member- No Familial Relationship

The Employer Response may challenge the familial relationship of the individual the claimant is requesting leave to provide care for G.L. c. 175M, § 2(c)(2)(A).

If challenged, the claimant must submit an affidavit in support of the familiar relationship. The affidavit can be found at:

https://www.mass.gov/doc/dfml-affidavit-of-qualifying-family-relationship/download

If credible, the claim should be approved, and the affidavit uploaded to the claim file.

VI. No Employment Relationship

If a claimant's leave start date is within 26 weeks of their termination date and meet all other requirements, their employment status is irrelevant, and the claim can move forward.

If a claimant's start date is outside 26 weeks of their termination date, the review examiner should inquire whether the claimant has a more recent employer in which an application should be filed under.

If not, the claimant should be denied for being outside of 26 weeks from their employment termination date.

If the claimant challenges the termination date advanced by the employer, the claimant must provide evidence, such as pay stubs, to rebut the employer's response. The Review Examiner can also obtain DUA records to determine when the claimant's employer stopped reporting wages or if the claimant has filed a claim for unemployment insurance benefits.

* * *

CHAPTER SIX: REDUCTIONS

General Principle

The law requires that paid leave benefits be reduced accordingly due to the concurrent receipt of other employer-sponsored and/or government-issued benefits.

Relevant Law[8]
G.L. c. 175M, § 3(c).
458 CMR 2.12(6)(a), 2.12(8).

I. Circumstances When a PFML Benefit Reduction is Required

A. Receipt of Unemployment Insurance (UI)

458 CMR 2.12(6)(a).

- DFML receives a crossmatch of DUA records to determine if a claimant is filing for PFML and UI benefits at the same time. If both benefits have been received for the same week, a reduction of the PFML benefit must be applied.

  Designated DFML Appeals staff have access to the UI Online system to confirm whether UI benefits were received for the same weeks as PFML.

- If a claimant is receiving concurrent UI benefits, a "dollar-for-dollar" reduction must be placed on the PFML benefits for any overlapping dates.

  - The reduction is based on gross UI received.
  - If the amount of UI exceeds PFML, PFML should be reduced to $0.
  - Can be partial or total unemployment insurance; the reduction is "dollar-for-dollar" regardless.

Check to see the reason why the employee was using UI. If it is a for qualifying reason, a historical absence may need to be added. PFML 458 CMR 2.12(6)(e).

- If a claimant states that they did not file a UI claim, and/or that the claim was filed because of Identify Theft:
  - The claimant must contact DUA and report fraud.
  - DUA will pause the UI claim to investigate and ensure no further UI benefits go out.
  - DFML staff can use UIO and confirm that fraud was reported. If fraud was reported and the UI claim has been closed, the PFML reduction should be removed.
  - If UIO does not show a record of reported fraud, or the UI claim is not closed, PFML reduction must stand until this is done.

[8] Relevant Operating Procedure:
SOP 57- How to Process Other Reported Income

B. Receipt of Worker's Compensation (WC)

458 CMR 2.12(6)(a).

- DFML reviews available DIA records to determine if a claimant is collecting PFML and WC benefits at the same time. If so, a reduction of WC is applied. The claimant can appeal the reduction.
- If a claimant is receiving concurrent WC benefits, a "dollar-for-dollar" reduction must be placed on their PFML benefits for any overlapping dates.
  - The reduction amount is based on the gross WC received.
  - The WC records can be inaccurate because employers fail to report a return-to-work date for their claimant to DIA.
  - Employers can confirm concurrent WC benefits via email. Emails for leave administrators can be found in the employer profile within FINEOS.
  - Claimants can dispute the concurrency of WC benefits with evidence from DIA and/or from the employer on company letterhead.
  - Check to see the reason why the claimant was using WC. If it is a qualifying reason, a historical absence may need to be added. 458 CMR 2.12(6)(e).

    Example: The claimant was on WC due to an injury sustained at work. A historical absence should be entered for medical leave.

II. Circumstances When a PFML Benefit Reduction is NOT Required:

A. Short-Term & Long- Term Disability

Short and Long-Term Disability payments can be used as a "top off" or to combine with PFML to allow the claimant to receive up to their IAWW while on leave.

- DFML is considered the first payor and should issue the maximum benefit rate the claimant is entitled to.

- If the combined PFML and disability benefits exceed the claimant's IAWW, the disability carrier may determine that the claimant needs to return the amount in excess.

- Most employer policies will reduce their benefits by the estimated PFML weekly benefit amount to try and prevent exceeding the IAWW.

B. Private Short-Term Disability

PFML benefits are only subject to reduction for concurrent employer-sponsored or government-issued benefits. Supplemental insurance benefits that are not employer-sponsored or government-issued are therefore not a basis for reduction of PFML benefits.

Example: Claimant pays premiums for a supplemental insurance policy through payroll deductions from their employer, but their employer does not contribute to the premiums. If Claimant receives benefits from that supplemental insurance policy during their PFML leave, those benefits will not require a reduction in their PFML benefit, as they are not employer-sponsored.

C. Termination of Employment and Payout of Benefits/Accrued Paid Leave

The payout of accrued benefits (i.e., unused vacation or sick time) at time of separation, does not require a reduction of PFML benefits, as those benefits are not being paid for the claimant's concurrent PFML leave.

D. SSI, SSDI & Social Security Retirement Benefits

E. Pension Benefits

F. Accrued Paid Leave Use Unrelated to PFML during Reduced Schedule or Intermittent Leave

A claimant who is on reduced schedule or intermittent leave may use their accrued paid leave for reasons unrelated to their approved PFML claim without a reduction being placed on their benefits.

Example: Claimant takes intermittent leave to care for their family member from January 1, 2022, through December 31, 2022. From June 1, 2022, through June 7, 2022, Claimant uses accrued paid leave for a personal vacation and does not report any PFML caring leave hours during this period. This will not result in a reduction.

Example: Claimant is on reduced schedule medical leave of Mondays and Tuesdays off every week from November 1, 2022, through December 31, 2022. Claimant uses accrued paid leave for a sick day for a non-qualifying reason Thursday November 17, 2022. This will not result in a reduction.

III. Circumstances When a PFML Reduction MAY be Required

A. Employer Sponsored Family or Medical Leave Benefit Program/Family or Medical Leave Insurance- Exceeds IAWW

- Some employers that do not qualify for an exemption from PFML provide full salary continuation to their employees when on family or medical leave. 458 CMR 2.12(6)(d)(1) and (2).

- Employer-sponsored family or medical leave benefits/insurance can be used as a top off or true up, but the combined benefits cannot exceed the claimant's IAWW. If it does, a reduction must be placed to ensure the claimant does not exceed their IAWW. G.L. c. 175M, § 3(c), 458 CMR 2.12(6)(a), 2.12(8).

Example: A claimant's IAWW is $1,000. Their PFML weekly benefit amount is $850.00. The employer will provide the claimant with $200/week. The DFML must create a reduction of $50.00.

B. Wages from Another Employer or Self-Employment

- A reduction should only be placed if the earnings from the other employment were used in calculating the IAWW and those earnings, combined with the PFML benefit amount, exceed the claimant's overall IAWW. 458 CMR 2.12(6)(d)(3).

- There will be no reduction if they are not qualifying earnings. 458 CMR 2.02.

Example: Claimant takes leave from November 1, 2022, through December 31, 2022, from Employer A. Their IAWW is based on wages from Employer A only. The claimant then reports a second, part-time Employer B where they are receiving $500 per week, but Employer B is in New Hampshire, where the claimant's wages are not subject to PFML contributions. Employer B wages were NOT considered in the IAWW, thus no reduction.

Example: Claimant takes leave from November 1, 2022, through December 31, 2022, from Employer A. Their IAWW is based on wages from their two current employers. The claimant reports receiving $500/week from the employer they are not taking leave from. A reduction for $500/week must be placed on the claim.

IV. Leave Reductions (reductions in the time available to take PFML leave)

A. Circumstances When a Leave Reduction is Required: Historical Absence (HABS) 458 CMR 2.12(6)(e).

- A historical absence (HABS) is created when DFML receives information that a prior leave was taken for a qualifying reason while the claimant was a covered individual. 458 CMR 2.02.

- A HABS may result in the changing of the Benefit Year to the Sunday preceding the first day of HABS. Furthermore, the time spent on leave from work during a HABS counts against and reduces the time available for a person to take PFML leave during a Benefit Year.

Example: Claimant was approved for PFML medical leave from January 1, 2023, through May 20, 2023. After approval, the DFML receives notice of worker's compensation benefits received by the claimant for an illness from March 1, 2022, through December 31, 2022. A historical absence from work for a serious health condition existed from March 1, 2022, through December 31, 2022, and the leave from January 1, 2023, through May 20, 2023, must be cancelled because the claimant has used at least 20 weeks of medical leave for their own serious health condition during the Benefit Year. The claimant's benefit year, per the HABS, will be changed to February 27, 2022, through February 25, 2023. The claimant may start a claim in their subsequent benefit year beginning February 26, 2023, pending all other eligibility requirements.

- **A HABS is only required if the prior leave was taken within 52 weeks of the claimant's requested PFML leave.**

Example: Claimant is approved for PFML with a benefit year of May 14, 2023, through May 11, 2024. Subsequently, the employer reports prior leave has been taken for a qualifying reason from April 10, 2021, through May 10, 2021. Had a PFML claim been filed at that time, the benefit year for that claim would have been April 4, 2021, through April 2, 2022. Because that benefit year has

ended before this new leave start date, this prior leave does not overlap with the benefit year of the current claim and thus no HABS is required.

- A HABS will result in the reduction of relevant leave banks. Any leave taken by a covered individual for a qualifying reason during the current benefit year will reduce the claimant's leave allotment even if a claim for the prior leave was not filed with DFML.

Example: Claimant is approved for PFML medical leave for January 1, 2022, through January 30, 2022, and the claimant's Benefit Year is set at December 26, 2021, through December 24, 2022. Claimant later files another application for medical leave for December 1, 2022, through December 15, 2022, and reports a prior non-PFML caring leave from work of August 1 through August 14, 2022. A historical absence is created for family leave for August 1, 2022, through 14, 2022, and Claimant's family leave allotment is reduced by 2.00 weeks, but the claimant's benefit year remains the same.

- If the claimant would not have been financially eligible for the historical absence leave, they were not a covered individual, and that leave shall not reduce the claimant's PFML leave allotment.

- If the claimant was a covered individual during the prior leave and that leave was completely unpaid, they may be eligible to receive PFML benefits for that time period. 458 CMR 2.08(4)(h).

- If the claimant wants a HABS to be considered as a PFML claim, in which they may receive benefits, all claim requirements must be met. If the application date for the HABS would be more than 90 days from the leave start date, good cause must be established (See Chapter 9: Good Cause).

V. Returning to Work During Leave

If a claimant returns to work during an approved continuous leave, PFML benefits must be reduced proportionate to the time they were back at work. Leave banks should be restored to account for the time at work and not on leave

Claimants cannot receive PFML benefits during hours/days that they are working!

Example: Claimant is on an approved leave from March 4, 2024, through May 24, 2024. Claimant reports that they returned to work for mandatory training on April 24, 2024, and then returned back to leave.

The RE should enter a PTO (or Jones act) reduction with a start date of 4/24/2024 and an end date of 4/24/2024 to ensure that the individual is not paid PFML on the day that they were working.

VI. Employer-Sponsored Accrued Paid Leave

Accrued Paid Leave can be Sick, Vacation, Compensation Time, Extended accruing service time with the employer.

A. Top Offs

A "top off" or "true up" is a term used by many employers who seek to provide employer sponsored benefits, in addition to PFML, to provide their claimants with their full Average Weekly Wage.

For applications filed on or after November 1, 2023, claimants may supplement their PFML benefits with any available accrued paid leave (sick time, vacation, PTO, personal time, etc.). For claimants who choose to supplement their PFML benefits in this way, **the combined weekly sum of PFML benefits and employer-provided paid leave benefits cannot exceed the employee's Individual Average Weekly Wage (IAWW).**

Employers will be responsible for monitoring and ensuring that the combined weekly sum of employer-provided paid leave benefits and PFML benefits does not exceed an employee's IAWW. If the application is filed on or after November 1, 2023, applications filed retroactively for a leave that began before November 1, 2023, are eligible for topping off.

Example: A claimant's IAWW is $1,000. Their PFML weekly benefit amount is $850.00. The claimant uses $150.00 of accrued paid leave per week to "top-off" their PFML benefit to equal their IAWW.

Example 2: A claimant's IAWW is $1,000. Their PFML weekly benefit amount is $850.00. The claimant reports to DFML that they received $500.00 of accrued paid leave per week to "top-off" their PFML benefit. As the accrued paid leave, combined with the PFML benefit equals $1,350, a PFML reduction of $350.00 must be placed to ensure IAWW is not exceeded.

B. Accrued Paid Leave Taken During Initial Seven Day Waiting Period ("Waiting Week")

No PFML benefits are payable during the first seven calendar days after the date on which job protected leave begins 458 CMR 2.12(7). Therefore, claimants may use accrued paid leave during the initial seven-day waiting period without being subject to a reduction of PFML benefits.

Example: Claimant takes leave from November 1, 2022, through December 31, 2022. The employee's waiting week is November 1, 2022, through November 7, 2022. Claimant uses accrued paid leave to replace their IAWW from November 1, 2022, through November 7, 2022. No reduction should be placed on the claim.

C. Accrued Paid Leave Taken After the Waiting Period Which Results in Excess of IAWW in Combination of PFML

- If an employee begins receiving accrued paid leave on or before the period they become eligible for paid PFML benefits, a benefit reduction should be placed only for the dates in which accrued paid leave, plus PFML, results in an excess of IAWW.

  Example: Employee takes leave from November 1, 2022, through December 31, 2022. The employee's waiting week is November 1, 2022, through November 7, 2022, with benefits beginning on November 8, 2022. The employee uses accrued paid leave November 1, 2022, through November 14, 2022. A reduction should be placed only from November 8, 2022, through November 14, 2022, and only if accrued paid leave, plus PFML, results in an excess of IAWW.

- Employees may pay back the accrued paid leave to their employers. Upon confirmation of repayment (e.g., paystubs showing reimbursement, or other evidence on company letterhead), the reduction of PFML benefits can be removed.

- An employee may also submit evidence from the employer that the employee and employer have a payment plan to recoup the accrued paid leave via future payroll deductions.

* * *

CHAPTER SEVEN: EXTENSIONS, MODIFICATIONS, CHANGES IN CIRCUMSTANCE, WAITING WEEKS, AND OTHER APPLICATION FILING RULES

General Principles

Requests for PFML can be extended, modified, reduced, or cancelled for several reasons.

Relevant Law[9]

G.L. c. 175M, § 2(c)(1), 458 CMR 2.08(8), 2.12(8).
G.L. c. 175M, § 5(a)(1), 458 CMR 2.08(4)(h).
G.L. c. 175M, § 2(c)(1).
458 CMR 2.10(2).

I. Leave Exhaustion

A. Leave Allotment Limits Within a Benefit Year

1. 20 weeks of medical leave for their own serious health condition

2. 12 weeks of family leave:

    - for the birth, adoption, or foster care placement of a child; or
    - family leave to care for a family member with a serious health condition.
    - due to a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces.

3. 26 weeks of family leave to care for a family member who is a covered service member.

4. 26 total weeks, in the aggregate, of family and medical leave.

Under no circumstances may a claimant be approved for more than 26 weeks of PFML in a 52-week benefit year! This includes any prior leave taken for a qualifying reason within the benefit year (aka a historical absence (HABS)).

If a leave request exceeds the maximum approvable limits as described above, the review examiner may approve any portion that is within the limits. Only the portion that falls outside of the maximum allowable leave should be denied.

[9] Relevant Standard Operating Procedures:
SOP 60- How to Process an Approved Start Date Change Request
SOP 61- How to Cancel Time
SOP 70- How to Process a Leave Extension

B. Waiting Week 458 CMR 2.12(7)

By law, the first week of approved PFML is unpaid. The waiting week is afforded job protection and is reduced from the appropriate leave bank.

If approved for intermittent or reduced leave, the waiting period will be 7 consecutive calendar days after the first reported absence from work.

A waiting week will be imposed on each distinct leave within a benefit year (e.g., a claim for medical leave and a subsequent claim for caring leave within the same benefit year).

In the case of medical leave during pregnancy or recovery from childbirth, if supported by documentation by a health care provider that this medical leave is immediately followed by family leave, in which case the seven-day wait period for family leave shall not be required. (See Section IV Below). G,L. 175M, sec.2(c)(1).

1. In the scenario of medical/pregnancy to bonding (or bonding to medical/pregnancy) with no break in between, no second waiting week is served.

2. When a continuous leave is followed by an intermittent leave (or vice/versa) for the same qualifying reason, and there is no break in between claims, the second waiting week should be waived.

3. In all other scenarios (excepted by 1 and 2 above), a second waiting week must be served when there is a break in claim.

3. Claimant Attempts to Return to Work and Must Go Back on Leave- Same Qualifying Reason

Sometimes a claimant attempts to return to work, and, after a short period of time, determines they are not ready and must go back on leave. If for the same qualifying reason, PFML benefits must be reduced proportionate to the time they were back at work. Leave banks should be restored to account for the time at work and not on leave. **An additional waiting week should not be applied in this scenario.**

II. Claim Filing Rules

A. Application Cannot Be Filed More Than 60 Days from the Start of Leave

1. A claimant may file an application for PFML benefits no more than 60 calendar days before the anticipated start date of family or medical leave. 485 CMR 2.08(1).

2. If the application is filed more than 60 days from the start of leave, the claim is automatically denied. The claimant may file a new application within the deadline proscribed by law.

B. Application Must be Filed Within 90 Days of Start of Leave

1. If an application for benefits is filed and more than 90 calendar days have passed since the start of the individual's period of leave, the covered individual may receive reduced benefits. 458 CMR 2.08(4)(h).

2. When a claimant submits their application more than 90 days from their leave start date, the DFML will approve all leave within 90 days from their application date and deny any leave taken more than 90 days from the application date. The claimant may appeal this decision. During their appeal, they must show a good cause reason for filing outside of this window to allow approval of the remaining, denied days. (See Chapter Nine: Good Cause).

Example: Claimant applies for PFML on May 19, 2023, for a leave taken from February 1, 2023, through May 1, 2023. DFML will approve leave from February 18, 2023, through May 1, 2023. The claimant may appeal the denial of leave from February 1, 2023, through February 18, 2023, to determine whether good cause exists to allow benefits for the portion of leave that was filed more than 90 days from the start of leave.

- 458 CMR 2.08(5)(a), provides; If a serious health condition of the covered individual prevents the covered individual from providing the required certification within 90 calendar days of the start of the leave, the Department will allow for a good cause exemption to permit delayed benefits under 458 CMR 2.08(4)(i).

Example: At the hearing, Claimant produces evidence that their serious health condition prevented them from filing earlier than May 25, 2023, because the claimant was in a coma until May 20, 2023. The DFML should approve January 1, 2023, through March 31, 2023, and reverse the decision.

III. Extensions

A. An approved leave may be extended if the claimant submits the following:

1. The reason for the extension;

2. The requested duration of the extended leave;

3. The date on which the covered individual provided notice for the request for extension to the employer (if applicable); and

4. A newly completed or updated health care certification for individual or family leave that otherwise satisfies the requirements of 458 CMR 2.08(5)

For extensions, a new Certification of a Serious Health Condition form may be submitted but is not always needed. The DFML can accept HCP's notes for extensions that are on letterhead and contain all needed information for an extension. Alternatively, the original certification document signed and dated by the HCP is acceptable.

B. Extensions Must be Filed within 30 Days from End of the Original Leave

1. The extension request must be filed with the DFML within 30 days after the existing claim has closed (leave end date).

2. If the claimant submits an extension request and it has been more than 30 days from the leave end date, the extension will be denied. During their appeal, the claimant must provide sufficient evidence that a good cause exception exists. (See Chapter Nine: Good Cause).

C. Approved Extensions are Awarded the Same Weekly Benefit Rate as the Original Leave

- **No new initial seven-day waiting period needs to be applied for an extension, as there is no break in claim. 458 CMR 2.10(4)(e).**

D. Extensions that Span Benefit Year

1. If an extension request spans the end of one benefit year and extends into a new benefit year, only the portion within the current benefit year can be automatically approved.

2. At the conclusion of a benefit year, a new PFML claim must be filed, with a new benefit year, and subject to a new financial eligibility test, with new base period and waiting week.

IV. Medical Pregnancy Leave Followed by Bonding Leave

Claims involving birthing parents are entitled to take medical leave to recover from physically giving birth when all other requirements are met. This is referred to as “Pregnancy/Maternity” leave within the PFML law. Typically, most health care providers approve 6 weeks of leave for vaginal births and 8 weeks of leave for cesarean delivery when no other medical complications arise. Longer leaves may be approved if a CSHC form is submitted by a licensed HCP.

When a birthing parent first takes pregnancy/maternity leave, they may request an extension of up to 12 weeks of family bonding leave (pending all other leave considered within a benefit year that may affect their leave allotment). The DFML allows birthing parents to use their medical leave and have a direct extension of family bonding leave without serving an additional waiting week for the family bonding leave portion. 458 CMR 2.12(7).

V. Modifications to Already Approved Leave

A. Change in Circumstances

1. Following an approval of an application for benefits, if there is a change in relevant circumstances that would justify an extension, reduction, or other modification of the period of leave or the amount of benefits, the covered individual and the employer or covered business entity, if any, shall have an affirmative obligation to notify the Department within seven calendar days of said change using the forms prescribed by the Department. 485 CMR 2.10(2).

2. When an application is already approved, the DFML will modify the application if the claim is still active, and the leave is on-going.

B. Modification Effects on Approved Claims (Benefit Year, Time Allotment, Benefits, Financial Eligibility, and Waiting Weeks)

If a claim is modified, it may impact the claimant's leave allotments, weekly benefit amounts, and waiting weeks, within the claimant's current benefit year. The benefit year itself may also change.

1. Benefit Year Following a Modification

If the first day of leave is changed to an earlier date and no other leave exists prior, the benefit year will need to be updated.

Example: Claimant has approved PFML leave from May 1, 2022, through June 30, 2022. Claimant calls on June 1, 2022, and asks to modify her leave start date to April 25, 2022, through June 30, 2022. The DFML should modify this leave and create a new benefit year from April 24, 2022, through April 22, 2023.

If the first portion of leave is cancelled and a later date is set as the leave start date, it must be determined whether the claimant used the leave that has been cancelled. If leave was taken for a qualifying reason, the leave cancelled will need to be entered as a historical absence and the benefit year will remain the same.

Example: Claimant has approved PFML leave from May 1, 2022, through June 30, 2022. Claimant calls on June 1, 2022, and asks to modify their leave start date to May 14, 2022. The claimant informs the DFML that they still started leave on May 1, 2022. May 1, 2022, through May 13, 2022, should be cancelled and a historical absence should be placed for this timeframe. The benefit year is May 1, 2022, through April 29, 2023.

2. Time Allotment Following a Modification

When leave dates are changed, the claimant's leave allotment will also change.

Example: Claimant has approved continuous PFML leave from June 1, 2022, through August 2, 2022. The claimant asks for a modification of his claim to allow reduced leave. The original leave allotment charged against the claimant is now incorrect and must be fixed.

Example: Claimant has approved reduced PFML leave from January 1, 2022, through December 2, 2022, which is when his 20 weeks exhausts. The claimant asks for a modification of this claim to allow continuous leave instead. The claimant's leave now must be modified to only approve January 1, 2022, through May 20, 2022, in order to not exceed the claimant's leave allotment of 20 weeks of medical leave.

3. Weekly Benefit Amount Effects on Modifications to Reduced and Intermittent Leave

When a reduced or intermittent claim is modified, it will often affect the claimant's prorated weekly benefit amount received. The overall weekly benefit amount will always stay the same, but the amount given to the claimant may differ upon modifications.

When a claimant is approved for reduced or intermittent leave, the benefit amount received is prorated based upon the leave actually taken. When a reduced, or intermittent leave is later modified, the modification may result in a change to leave allotment and/or prorated weekly benefit amount.

Example: Claimant is on reduced leave where they take off 20 hours out of a 30-hour work schedule. Their benefit rate is $800.00, and they did not elect to have State and Federal Taxes removed, so each weekly check will contain $533.33 (800/30= 26.6666. 26.6666 x 20 = 533.33) for the 20 hours not worked during the week. Claimant calls the DFML and informs them that she works 40 hours a week and presents evidence of this. The claim is updated to reflect 40 average working hours per week. Because of this, the claimant's weekly checks will now be $400.00 ($800/40 = 20. 20 x 20 = 400) they will have an overpayment of $133.33 (533.33 – 400) per each week that was issued at the $533.33 rate.

4. Cancelling Leave.

- Any payments issued for the cancelled dates will create an overpayment.

  Example: Claimant has approved PFML leave from January 1, 2022, through May 20, 2022. The claimant cancels all leave taken in January 2022. The claimant will have an overpayment for any payments issued during these dates.

5. Claim has Dates Modified

- Any payments issued for the dates previously approved, but no longer approved, will create an overpayment.

  Example: Claimant has approved PFML leave from January 1, 2022, through May 20, 2022. The claimant cancels all of January 2022. The claimant will have an overpayment for any payments issued during these dates.

6. Modification Effects on Financial Eligibility and Weekly Benefit Amount:

When a claimant requests a modification to their claim that would change their benefit year and base period, financial eligibility must be redetermined.

Example: Claimant applies for leave starting on March 1, 2022, through May 1, 2022. Their application was submitted on March 1, 2022. Their base period that determined eligibility is January 1, 2021, through December 31, 2021. The claimant requests a modification to have their leave start on February 1, 2022. The claimant's new base period is October 1, 2022, through September 31, 2022. This can affect their financial eligibility and weekly benefit amount.

Claims that begin in a new calendar year that are then modified to begin in the previous calendar year require a completely new application for the correct maximum benefit amounts to be applied. These modifications require the old leave to be cancelled and a new claim to be created.

7. Modification Effects on Initial Seven-Day Waiting Period

   When a claimant requests a modification to their claim that would change their start date, their initial seven-day waiting period will be reevaluated.

   Example: Claimant takes leave from January 2, 2022, through April 20, 2022. The claimant's original seven-day waiting period was January 2, 2022, through January 8, 2022. The claimant requests a modification to have her leave start on January 1, 2022. The claimant's new waiting week is January 1, 2022, through January 7, 2022.

* * *

CHAPTER EIGHT: EXEMPT EMPLOYER & PRIVATE CARRIER APPEALS

General Principle

The law allows employers to be exempt from participating in the PFML program if they offer their employees a paid leave plan that provides benefits equal to or greater than those under the PFML and receive DFML approval of their private plan. The paid leave plan may either be a self-insured program administered by the employer, or a private plan administered by a third party (often an insurance company). Self-insured and private carrier plans decisions are subject to appeal to and review by DFML Appeals.

Regardless of if a claimant uses PFML or a private plan, they are entitled to appeal rights under the PFML law with the DFML. If a claimant disagrees with determinations made by their employer's private plan, **they must appeal that decision to the private plan first.** Upon receipt of an unfavorable decision following the appeal, the claimant may then submit an appeal to the DFML.

Relevant Law

G.L. c. 175M, §§ 8(d), 11(a)(2)(e), 458 CMR 2.07(6), 2.14(2).

I. Exempt Employer

A. Background

Note: referring to exempt employers in this context is different from employers exempt from DFML statutorily under G. L. c. 175M, § 10 and under other parts of the PFML law.

1. DFML keeps a list of all employers with approved exemptions. This list is updated quarterly and distributed to all DFML Appeals staff.

2. Employers may receive exemptions from either medical leave claims, caring leave claims, or both.

3. Exemptions are approved for one year and may be renewed at the employer's request. Employers are free to end their exemption and rejoin PFML at the expiration of the current exemption, subject to DFML rules on terminating a private plan.

4. Whether PFML or the private plan controls is determined by the application date or Sunday preceding first day of leave, whichever is earlier. If the exemption status changes after this date, the administrator who owned the claim at its outset will continue to administer through the end of the claim, including any extensions, including intermittent bonding claims that appear as two continuous leaves within the same benefit year.

B. What happens if a claimant files a PFML claim with the DFML instead of with their Employer's Private Plan?

1. If a claim (as opposed to an appeal) is filed against an employer which has been approved to be exempt from PFML because of a private plan, the system will automatically deny. The claimant may file an appeal to DFML Appeals for review.

2. The Review Examiner assigned must review the most up to date Exempt Employer list to confirm whether the employer is exempt and for what types of leave.

3. **If confirmed the employer has a valid exemption, the appeal should be dismissed using the Dismissed-Exempt Notice.**

4. The review examiner should make an outbound phone call to the claimant to inform them that their appeal was dismissed because their employer is not actively participating in the PFML program. The claimant should be advised to speak with their employer to receive the proper information regarding how to file a claim with the private carrier/ self-insured administrator. If a private carrier is used, it should be relayed to the claimant and left in the notes.

II. Private Carrier & Self-Insured Plan Appeal Procedure

If a claimant files a benefit claim with their employer's private plan and wishes to appeal the decision of the employer or its plan administrator, the claimant may file an appeal of the private carrier/self-insured plan's denial of benefits to DFML.

A. Filing of Appeal

- The claimant must first appeal all determinations made by the private plan carrier to the private plan carrier.

- Upon receipt of an unfavorable appeal decision, the claimant may appeal to the DFML under 458 CMR 2.07.

- When an appeal from a private plan carrier is submitted, Appeals OSS creates a claim to be used for the purposes of the appeal.[10]

- OSS notifies the Appeals Manager of the private plan carrier appeal.

B. File Request

- The Appeals Manager will request the claimant's claim file from the private plan carrier via secure method.

- Upon receipt of the file, the Appeals Manager will upload the documents into the claim created by the OSSs and notify the Review Examiner assigned to the claim.

[10] This is done to ensure all documents are stored in FINEOS to ensure record keeping.

C. Initial Review

- The Review Examiner II conducts a review of all documents from the private plan and issues a decision. The documents needed are:
    - Denial letter from the private insurance carrier (provided by the claimant with the Appeal Request form); and
    - Full private insurance carrier claim information (provided by the private insurance carrier directly to the Appeals Manager).
- If these are not provided, contact the Appeals Manager to obtain them. The review of the record cannot occur without these documents.

D. Appeals Decision

- Review Examiner II conducts a review of the record.
- Decides if the private carrier/ self-insured plan's decision should be affirmed or overturned.
- The standard of review is whether the initial determination was made in accordance with G.L. c. 175 and 458 CMR 2.00 et. seq.

E. Sending Appeals Decision

- The Review Examiner II uploads the Appeals Decision to the claimant via FINEOS and notifies the Appeals Manager of the decision.
- Appeals Manager sends Appeals Decision via secure email to the private carrier/self-insured plan contact. A copy is sent via secure email to the employer's leave administrator.
- Appeal rights are included in this decision notice. If either party disagrees with the Appeals Decision, they have 10 business days from receipt to request a hearing with DFML.

II. Hearings for Private Carrier/ Self-Insured Appeals

A. Scheduling Private Carrier/ Self-Insured Appeals

- OSS schedules the hearing.
- Hearings should be scheduled no sooner than 10 days from the appeal creation date.
- These are two-party hearings where both the claimant and employer will be invited to attend.

B. Notices of Hearing

- OSS creates a Notice of Hearing for claimant and employer.
- OSS uploads the Notice of Hearing to the claimant via FINEOS.
- OSS emails Appeals Manager copy of Employer Notice.

- Appeals Manager sends Notice of Hearing via secure email to the private carrier/self-insured plan contact. A copy is sent via secure email to the employer's leave administrator.

C. Hearing

- The assigned Review Examiner II holds the hearing as scheduled. Takes testimony and evidence from both parties.

- Allows each party the right to confront witnesses and cross-examination.

D. Appeals Decision

- Review Examiner alerts the Appeals Decision to the claimant via FINEOS.

- Review Examiner II alerts the Appeals Manager of the decision.

- Appeals Manager sends Appeals Decision via secure email to the private carrier/self-insured plan contact. A copy is sent via secure email to the employer's leave administrator.

- Appeal rights are included in this decision notice. If either party disagrees with the Appeals Decision, they have 30 calendar days from receipt of notice to file an appeal to District Court.

***

CHAPTER NINE: GOOD CAUSE

General Principle

Under the law, a claimant's failure to meet certain procedural requirements can be overcome if the claimant establishes the failure was due to circumstances beyond their control.

Relevant Law

458 CMR. 2.00.
G.L. c. 175M, § 8(h).

I. Definition of Good Cause

A demonstration by a party that a failure to comply with a requirement of G.L. c. 175M, and 458 CMR 2.00 was due to circumstances beyond the party's control. 458 CMR 2.02.

II. Circumstances Which Good Cause Determinations Must be Made:

- Application for Leave Filed More Than 90 Days from Start of Leave
- Late Filing for Extension of Benefits
- Failure to Provide Employer with 30 Days' Notice of leave
- Late Appeals
- Late Request for Reinstatement After a Default at Hearing
- Certification for Family Leave Benefits for a Qualifying Exigency Arising Out of a Family Member in the Armed Forces

III. What Constitutes Circumstances Beyond the Claimant's Control?

A. Examples of good cause for include, but are not limited to, the following:

- The claimant's own serious health condition.
- Death of a household member or an immediate family member (including a spouse, child, parent, brother, sister, grandparent, stepchild, or parent of a spouse).
- A documented serious illness or hospitalization of a claimant's household member or an immediate family member.
- An emergency family crisis which required the claimant's immediate attention.
- Any qualifying exigency arising out of the fact that a family member of the claimant is on active duty or has been notified of an impending call or order to active duty in the Armed Forces.
- An inability to effectively communicate or comprehend English.
- Intimidation, coercion, or harassment by an employer.
- An inability because of illiteracy or a psychological disability to understand that a request for extension must be filed by the deadline proscribed.
- The claimant's need to address the physical, psychological, and legal effects of domestic violence as defined in G.L. c. 151A, § 1(g½).
- A delay, or failure, by the United States Postal Service in delivering the DFML's determination and the claimant promptly acts after they know or should have known that a determination was issued.

- A continuing absence from the Commonwealth, during all or most of the time period action was required.
- Force Majeure- Any other circumstances beyond a claimant's control, as determined by DFML.

B. G.L. c. 175M, § 8(h)

Whenever determining whether good cause exists, Review Examiners should be mindful of DFML's statutory guidance pursuant to G.L. c. 175M, § 8(h):

This chapter shall be liberally construed as remedial law to further its purpose of providing job-protected family and medical leave and family and medical leave benefits. All presumptions shall be made in favor of the availability of leave and the payment of family and medical leave benefits under this chapter.

IV. Acceptable Documents to Support Good Cause

In addition to a claimant's credible testimony, the following documents may be accepted to support Good Cause:

- Note from a HCP
- Hospital records
- Obituary (for deceased family members)
- Military Orders
- Court Orders
- Incarceration Records
- Police Reports

V. Circumstances Which Are Not Good Cause

Some examples which do not constitute good cause are scheduling conflicts which can be rescheduled without serious harm. Examples include:

- medical or dental appointment for non-life-threatening reasons
- inability to secure counsel
- business meetings, vacations, or activities of a non-critical nature
- exigent circumstances created by the individual's own conduct
- other routine responsibilities.

CHAPTER TEN: REIMBURSEMENTS

General Principle

In some circumstances, the law requires that the employer be reimbursed for benefits provided to their claimant through an employer-sponsored family or medical leave program. The employer may be entitled to reimbursement for the amount the claimant would have received if they had elected to utilize PFML benefits.

Relevant Law

458 CMR 2.12(9)

I. Reimbursement Application Procedure

A. Initial Reimbursement Request Reviewed by DFML Operations (Ops)

- Employers submit reimbursement applications via Formstack. The request must include attachments showing:
  - Proof of payments
  - The employer's self-insured benefit policy.

- Initial Questions Employer Must Answer in Support of Reimbursement Request.
  - Do you, as the employer, fully fund your plan without assistance from an external insurer?

  Answer must be Yes.

- For which reasons may an claimant take leave through your plan?
  - Provided Choices Are:
    - Manage your own serious health condition
    - Care for a family member with a serious health condition
    - Bond with a child during the first 12 months after the child's birth
    - Bond with a child during the first 12 months after adoption or foster care placement
    - Care for a family member who is or was a member of the Armed Forces, National Guard or Reserves and developed or aggravated a serious health condition while on active duty
    - Manage family affairs when a family member is on or has been called to active duty in the armed forces, including the National or Reserves.

For the option selected, Ops reviews PFML claim to confirm that it matches the qualifying reason the employer selected.

- Does your plan run concurrently with and reduce the time allotted under the Commonwealth's Paid Family and Medical Leave program?

  Answer must be Yes.

- Does your plan provide the same job protections afforded to claimants who take leave under the Paid Family and Medical Leave law?

  Answer must be Yes.

The Operations team then reviews the PFML claim within FINEOS.

- Is the employer benefit equal to or greater than the PFML weekly benefit amount?

  Answer must be Yes, but can be prorated.

- Do the dates sought for reimbursement cover the dates the claimant has approved PFML?

The dates requested for reimbursement do not have to match the PFML claim exactly. The DFML reimbursement with the approved PFML claim.

- The Ops team then issues a reimbursement determination and makes all appropriate adjustments to the claimant's PFML claim within FINEOS (adding reductions, sending benefit change notices, etc.).

- Reimbursement shall not be permitted for the payment of accrued sick pay, accrued vacation pay, or other Accrued Paid Leave provided under an employer policy.

B. Reimbursement Appeals Procedure

- If an employer appeals, they submit their reimbursement appeal via their employer portal, which is then uploaded to Formstack.

- The Formstack reimbursement appeal will create an email notification that is sent to a designated Review Examiner II. The Appeals Manager and OSS also get email notification.

- The designated Review Examiner II then reviews the appeal and the policy submitted by the employer. This is an informal reconsideration phase. If the reimbursement denial cannot be reversed, the Review Examiner II must create the Appeal Tab, close the Review Appeal Task, and turn it into a scheduled hearing task, which should also be marked on the Master Tracker.

Within the description of the schedule hearing task, it should state, "Assign to (Designated REII), Reimbursement Denial #39, Documents to: […]" and then all identifying information about the leave administrator from the reimbursement appeal form should be added to the description of the schedule hearing task.

- The appeals OSSs will then schedule a one-party hearing with the employer.

- The Review Examiner II will hold the hearing and issue a decision within 30 days of the close of the hearing. The Review Examiner II may hold the hearing open to allow the employer to submit additional evidence.

- If the decision results in some reimbursement to the employer, the Review Examiner II must reach out to Ops and ask them to redirect the weekly benefit amounts to the employer for the

dates the reimbursement was approved. A note should be left on the claim, indicating which dates may be approved for reimbursement.

C. Reimbursement Denial Reasons

- The claimant receives concurrent PFML and employer benefits for the same dates. 458 CMR 2.12(9).
    - If the employer did pay the claimant for the same dates in which the overpayment for the claimant, then the DFML cannot reimburse the employer unless the claimant has satisfied the overpayment.
    - If the overpayment only covers a portion of the dates sought by the employer for reimbursement, the DFML can issue a decision that would deny the dates in which the claimant received duplicate payments but approve the reimbursement for any dates outside of that timeframe.
    - Review Examiners should allow the 30 days once the hearing has closed as additional time for the claimant to pay back the overpayment if they have indicated they agree with it.

Example: The Department issued payments to the claimant from November 1, 2022, through December 31, 2022. The employer is seeking reimbursement from November 1, 2022, through December 31, 2022. A reduction should be placed from November 1, 2022, through December 31, 2022, creating an overpayment for that timeframe. The reimbursement should be denied unless the claimant can pay back the overpayment before the decision is due.

- The amount in which the employer is paying the claimant is less than the claimant's PFML weekly benefit amount. 458 CMR 2.12(9).
    - The DFML should look at gross amounts paid to the claimant.
    - The DFML may look at individual hours for reimbursement approvals/denials.
    - This may require the hearing officer to take the PFML weekly benefit amount and divide by the total number of hours claimant works to determine a daily, PFML benefit amount. This is often due to pay periods not aligning with the DFML.
    - For intermittent claims, the hearing officer may need to take the PFML week by the claimant to determine an hourly, PFML benefit amount.

Example: The PFML weekly benefit amount is $850.00. The employer is providing the claimant with employer benefits at a rate of $900.00 weekly. The claimant should have a full reduction on their PFML claim and the employer would be eligible for reimbursement pending other requirements.

- The claimant does not have approved leave with the Department. 458 CMR 2.12(9).
    - If the claimant does not have approved leave with the DFML, there is no approved claim to then reimburse the employer with.
    - Employers do not have appeal rights for their employees and cannot appeal their claimant's denials.
    - The hearing officer may find that the claim should be reopened and approved if good cause allowing such a late appeal could be established, but this route is not preferred when the claimant has had no interaction with the DFML.

Example: The claimant applied with the DFML, which was denied for failure to provide identification documentation. The claimant never appeals the denial within 10 days, receives full salary continuation from their employer while on leave, and then the employer seeks

reimbursement from the DFML. The reimbursement should be denied unless the claimant, before the reimbursement decision is due, appeals her claim and receives a favorable decision.

- The employer is seeking reimbursement within the initial seven-day waiting period.
    - Because the claimant would not have received PFML benefits during the during this timeframe, no reimbursement can be provided to the employer for any payments they made to the claimant during the waiting week. G.L. c. 175M, § 2(c)(1) & 458 CMR 2.12(7).

Example: Claimant is approved for medical leave from November 1, 2022, through December 31, 2022. Their waiting week is November 1, 2022, through November 6, 2022. The employer seeks reimbursement from November 1, 2022, through December 31, 2022. The employer can only be approved for reimbursement from November 7, 2022, through December 31, 2022, if all other requirements are met.

- The employer is seeking reimbursement for days outside of the claimant's approved PFML leave. 458 CMR 2.12(9).
    - The DFML can only approve reimbursement for days in which the claimant has approved PFML leave that fall outside of their initial seven day waiting period.
    - Historical absences may need to be considered in these situations.

Example: Claimant is approved from November 1, 2022, through December 31, 2022. The employer requests reimbursement from October 1, 2022, through December 31, 2022. The claimant has a waiting week from November 1, 2022, through November 6, 2022. The employer can be approved for reimbursement from November 7, 2022, through December 31, 2022.

- The employer's plan is not fully funded by the employer, without assistance from an external issuer. 458 CMR 2.12(9).
    - The plan offered by the employer must be a benefit that is fully funded by the employer.

Example: The employer, claimants, and a third party insurer contribute into an extended illness leave bank. The employer should be denied reimbursement.

- The employer is seeking reimbursement for the claimant's usage of accrued paid leave. 458 CMR 2.12(9), 2.12(6)(d)(3).
    - Claimants cannot use accrued paid leave on the days in which the employer is seeking reimbursement. Take note of when the accrued paid leave is used and the effects it has on the claimant's benefits.
    - See reductions, accrued paid leave. All rules for accrued paid leave should be made.

Example: Claimant takes leave November 1, 2022, through December 31, 2022. The claimant uses accrued paid leave from November 1, 2022, through November 10, 2022. The employer is seeking reimbursement from November 1, 2022, through December 31, 2022. The employer's reimbursement will be denied from November 1, 2022, through November 10, 2022.

- The employer does not offer the type of leave the claimant is taking. 458 CMR 2.12(9).
    - The benefit program offered by the employer must cover the type of leave that their claimant is on with PFML to be eligible.

Example: Claimant takes family bonding leave from November 1, 2022, through December 31, 2022. The employer's benefit plan only covers medical leave. The employer reimbursement should be denied.

  - With family bonding and medical pregnancy/maternity claims, a careful program must be done to determine what type of leave the employer truly offers.

- The plan is not intended to run concurrently with he time allotted under the commonwealth's paid family and medical leave program. 458 CMR 2.12(6)(e).
  - The DFML regulations require that employer sponsored plans run concurrently with MA PFML. Most employer policies will have a statement at the end, forcing their plan to run concurrently with all applicable laws. This will typically mirror, "All state and federal laws trump."

Example: Employer applies for reimbursement and marks that the plan does not run concurrently with PFML. The policy, included with the reimbursement application, states, "All applicable laws trump this policy." The employer can be reimbursed pending all other requirements.

- The employer's benefit program does not offer the same job protections afforded to claimants who take leave under the Paid Family and Medical Leave law. 458 CMR 2.12(9) & 2.16.
  - However, when an employer states their plan does not provide job protections, if their plans forces claimants to have a concurrent PFML claim, then job protections are provided via their PFML claim.

Example: Employer applies for reimbursement and marks that the plan does not run concurrently with PFML. The policy, included with the reimbursement application, states, "All applicable laws trump this policy." The employer can be reimbursed pending all other requirements.

THE END

APPENDIX A

Contact Information

I. DFML Contact Center

Department of Family and Medical Leave
Attn: Claims Processing
P.O. Box 838
Lawrence, MA 01842

Hours of operation: Monday-Friday, 8 a.m. – 4:30 p.m.
(833) 344-7365 (phone)
(617) 855-6180 (fax)

DFML Fraud Reporting Hotline
(857) 366-7201

DFML Intermittent Leave Hours Reporting Line
(857)-972-9256

Department of Revenue (For questions about contributions and exemptions)
Hours of operation: Monday-Friday, 8:30 a.m. - 4:30 p.m.
(617) 466-3950

II. DFML

Department of Family and Medical Leave
100 Cambridge Street. 5th Floor
Boston, MA 02114

DFML home page:
https://www.mass.gov/orgs/department-of-family-and-medical-leave

DFML Appeals home page:
https://www.mass.gov/how-to/appealing-a-paid-family-or-medical-leave-decision

DFML Appeals
Hours of operation: Monday-Friday, 8 a.m. - 5 p.m.
(617) 988- 3223

DFML Operations (for internal use only)
Hours of operation: Monday-Friday, 8 a.m. - 5 p.m.
617-988-3224

Language Line (to assist customers with Limited English Proficiency)
(844) 929 3166

APPENDIX B

DFML Forms

Certification of Serious Health Condition Form (CSHC)

https://www.mass.gov/doc/certification-of-your-serious-health-condition-form/download

A Certification of Your Family Member's Serious Health Condition Form (Family CSHC)

https://www.mass.gov/doc/certification-of-your-family-members-serious-health-condition-form/download

Acceptable forms of Identify Verification documents can be found online at:

https://www.mass.gov/doc/get-ready-to-apply-for-pfml/download

Affidavit of Qualifying Family Relationship

https://www.mass.gov/doc/dfml-affidavit-of-qualifying-family-relationship/download

APPENDIX C

Relevant Law

I. DFML

M.G.L. c. 175M
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175M

458 CMR 2.00
https://www.mass.gov/resource/paid-family-and-medical-leave-statute-and-regulations

II. DUA

M.G.L. c. 151A
https://malegislature.gov/laws/generallaws/parti/titlexxi/chapter151a

430 CMR
https://www.mass.gov/law-library/430-cmr

III. Massachusetts Administrative Procedure

M.G.L. c. 30A
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIII/Chapter30A

801 CMR 1.00
https://www.mass.gov/doc/801-cmr-1-standard-adjudicatory-rules/download

APPENDIX D

DFML Hearings Training

DFML Procedural Speech

DFML Hearings Training: Roles and Responsibilities of the Review Examiner

DFML Hearings Training: Conducting the Hearing

DFML Hearings Training: Evaluating the Evidence

Procedure

Good Morning/Afternoon; my name is _____ from the Department of Family Medical Leave. I am the Review Examiner assigned to hear this case and issue a decision. This hearing will be recorded in its entirety and the recorder is on right now. Are you ready to begin?

Participating in the hearing today is *[confirm claimant's name]*

Our records show your address is *[read claimant's address]*. Is that correct?

Do you have any representatives or additional witnesses participating today? *[If yes, have each witness state and spell names for the record]*

Before I begin the hearing, I just want to take a moment and explain the procedures that we will be following today.

This is an administrative hearing, held in accordance with Massachusetts laws and regulations. All testimony will be taken under oath, and I will be swearing you in shortly.

You will have the right to make a full and complete statement relevant to the issue before me. I will begin by asking you a series of questions. When I am finished with my questions, I will give you the chance to add anything that you feel is important that we did not discuss.

[If represented] I will also allow the representatives to ask questions directly to their witness(es) if they wish to do so.

If there are documents you believe are relevant, you can bring them to my attention during the hearing for possible inclusion in the exhibits. I note that the record may contain information provided by your employer, which may have been considered in the initial determination for PFML benefits. By allowing information provided by the employer onto the administrative record, it does not mean that you agree with the information provided or that you believe the statements to be true, they are being offered to provide a full and

accurate record of all information provided to DFML regarding your initial determination of benefits. Although your employer is not a party to these proceedings, it may be necessary to discuss any statements or documents they have provided to DFML leading up to this hearing. In the event they are discussed during this hearing, you will have the opportunity to provide your own testimony and/or evidence to address, dispute, or clarify any information found relevant to your case.

I ask that no one interrupts while another is talking- even to give a helpful answer. As a reminder, this hearing is being recorded, and it is extremely important that the record is clear about who was speaking at any given time.

At the conclusion of this hearing, the video conference will be terminated. I cannot have any further contact with you after the hearing is over that is not on the record.

After the hearing is over, I will consider the testimony and evidence presented and make a decision. A copy of that decision will be mailed to you within thirty days of the conclusion on this hearing. If you disagree with my decision, you have the right to appeal it to the district court where you reside, and instructions on how to file that appeal will be included with the decision.

Do you have any questions about the procedures we will be following today?

Introduction of Case

This hearing is being held in accordance with Massachusetts General Laws Chapter 175M, Chapter 30A, and the regulations that fall thereunder. This is application number ---------. The hearing is being held via video conference, on [date] at [time].

The issue to be heard today, as indicated on the Notice of Hearing, is whether [read issue].

The claimant in this matter is [claimant name], with an address of record of

[address]. I note that the claimant is present today and is representing his/herself in this matter [if represented, identify rep by name, do not need office address].

I am now going to place you under oath. Please raise your right hand.

Do you swear or affirm that the testimony that you are about to give is the truth, the whole truth, and nothing but the truth? ***[If there are witnesses, read the oath once and then ask each person individually to affirm]***

Before we begin, I would like to review the documents in the agency file. (Briefly identify documents). I would like to enter these on to the record as exhibits which can be referred to at today's hearing, do you have any objections?

I will now read the exhibits into the record. [Identify exhibits].

Begin taking testimony- ask claimant to state name prior to beginning.

DFML REVIEW EXAMINER TRAINING

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

2020

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Representative of the Commonwealth

The Examiner at a DFML hearing is a representative of the Commonwealth of Massachusetts. To the public, the Examiner is a symbol of the Commonwealth's authority and a person who exercises control over an important financial issue. The Examiner must always act in a manner that brings credit to DFML and the Commonwealth. Through appearance, demeanor and speech, the Examiner must convey knowledge and competence. They must always be respectful towards all parties and maintain an open attitude. The Examiner must not only be unbiased but must also maintain an appearance of being unbiased. This means the Examiner must choose words carefully; monitor their body language and facial expressions; keep a neutral tone when speaking with both parties; and give equal and full attention to each witness.

Professionalism carries over into writing the decision. The decision itself should have a professional appearance by being grammatically correct and having few typing errors.

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Knowledgeable

The Examiner's responsibilities are set both by state law and regulation as well as federal standards.

- M.G.L. c. 30A governs administrative proceedings.
- The regulations for conducting an informal hearing, such as a family/medical leave hearing, are found at 801 CMR 1.02.
- The Massachusetts paid family and medical leave law is found at M.G.L. c. 175M; implementing regulations are at 458 CMR 2.00. The Examiner is expected to be knowledgeable of and comport with all of these laws, regulations, and standards.

These statutory, regulatory and administrative requirements can be located on the Sharepoint: https://massgov.sharepoint.com/sites/EOL-DFML-Teams/SitePages/Welcome-to-DFML!.aspx

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Fact-Finder, Assistant, Judge

Paid leave hearings are meant to be quick, informal proceedings that a party can effectively participate in without hiring counsel. The parties will often have little exposure to or understanding of legal proceedings, statutory interpretation, or how to effectively take or give testimony. In order to conduct a fair hearing in this environment, the Examiner is called upon to play a variety of roles.

Parties at paid leave hearings (whether or not they are represented) may not understand which facts are relevant to the determination. It is the responsibility of the Examiner to inquire about all elements of the issue. If a party does not pursue a pivotal line of questioning, the Examiner must do so. It is common for a party to have difficulty framing questions. The Examiner must assist any party who needs help in asking questions.

The Examiner also functions as a judge. It is their responsibility to sift through testimony and evidence to determine the relevant facts and write a well-reasoned decision. As with any lower-level judge, an Examiner will have decisions appealed that are reversed or remanded. The Examiner should conduct remands with an open mind and a good faith effort to obtain the information requested by the Court. Remands and reversals are an excellent way for Examiners to learn and improve their craft.

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Remands- Additional Evidence

Returned to the original review examiner for an additional hearing to:

Explore a line of questioning not pursued at the original hearing.

Consider evidence or testimony not presented at the original hearing.

Other reason ordered by the Court.

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Remands- *De Novo*

Sent back for a new hearing before a different review examiner.

Like new- start over as if the first hearing never happened.

For Due Process violations.

AVOID!

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Standards of Behavior – General

Confidentiality

Examiners have access to a considerable amount of information about parties. Respect for the privacy rights of all claimants and hearing participants must be shown. Specific information learned about claimants and employers should not be shared outside DFML and should only be shared within DFML if there is a legitimate business purpose for doing so. Documents containing any information about a case (including names), must be kept confidential.

Do not share your passwords to access your computer, network, email, or system applications with anyone!

When on the phone or holding a hearing for work- if other people can hear your conversation- you must wear headphones!

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Standards of Behavior – General

Teamwork

Examiners are solely responsible for holding hearings and writing decisions, and yet are expected to act as members of a team. Teamwork is expressed by willingness to assist colleagues by providing examples of decisions or discussing a difficult case, appreciating the demands placed on administrative staff and trying to reduce demands placed on them, periodically volunteering for special assignments, graciously accepting back-filled cases, being honest and forthright with all co-workers, and dealing sensitively with interpersonal issues.

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Standards of Behavior – At Hearings

Professional and Impartial Demeanor

The Examiner must:

- Conduct the hearing in a fair and impartial manner – do not demonstrate bias or prejudice.
- Avoid gratuitous comments and observations.
- Avoid ex parte communications

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

Standards of Behavior – At Hearings

Attitude

The Examiner must:

- Allow and encourage parties to speak freely
- Provide necessary assistance to parties in developing their case
- Act engaged and interested versus indifferent or antagonistic

Clear Language

The Examiner must:

- Use clear and understandable language throughout the hearing
- Avoid unnecessary use of legal and technical jargon
- Be sensitive to the participants' level of understanding – clarify difficult language used by others (e.g., instead of "would you like to exercise your right to cross-examine?" say, "do you have any questions for the witness?")
- Use only single point questions

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

DFML Appeals Equipment Policy

DFML's computers and other equipment should not be used for non-work purposes. While at work, Examiners are expected to make judicious use of their time. While personal cell phones are allowed at work, they should not distract the Examiner.

Examiners must never use, or look at, a cell phone during a hearing *unless* they are expecting an emergency call and have received prior permission from a manager. At the start of the hearing, inform the parties you may receive a call for an urgent matter and may need to take a brief recess. If an emergency call is received, the Examiner should recess and return the call outside the hearing room.

The Examiner not only needs to mute their phone, but also should make sure their settings are configured to disable any assistive device – Siri, Google Assistant and the like – to ensure that something said at hearing does not elicit a response from the phone.

ROLES AND RESPONSIBILITIES OF THE REVIEW EXAMINER

DFML Appeals Recordings

All DFML Appeals will be recorded (audio & video). Records of each hearing must be saved for records keeping and appeals purposes.

Parties have the right to receive a recording of their hearing free of charge, upon request. If a party makes a request- an examiner should refer them to DFML Appeals Office Support.

Parties may NOT make their own recording of the hearing via phone or other device. DFML keeps the official record!

No one may use cell phones to casually or secretly record conversations or take pictures.

It is illegal in Massachusetts to secretly record a conversation. M.G.L. c. 272, §99(C)(3).

Overview: Examiner's Duties and Powers

- Conduct a fair hearing to ensure that the rights of the parties are protected
- Define the issues
- Receive and consider all relevant and reliable evidence, including witness testimony
- Exclude irrelevant or unduly repetitious evidence
- Ensure an orderly presentation of the evidence and issues
- Assist the unrepresented in presenting their case
- Ensure a complete record is made of the hearing
  - Make all evidence relied on in making the decision part of the record
  - Record all evidence and testimony
- Reach a fair and impartial decision based upon the issues and evidence presented at the hearing and in accordance with the law
- Continue hearings to allow an opportunity to provide critical evidence when required.

De-escalating a situation before it becomes threatening or dangerous

If a party or witness is becoming angry or aggressive during a hearing, you should remain calm, and remember you are the professional and it is your responsibility to maintain control of the hearing. There are things you can do that may help de-escalate the situation.

Let the person "vent". When someone is upset it can sometimes help to let them get their frustration out and allow them to feel heard. If you choose to let someone vent, make sure you remain in control of the hearing. You should not allow a participant to take over the hearing with their rant.

Use active listening skills to help recognize and acknowledge the person's feelings. Do not take the participant's anger or criticism personally: remember that the frustration is not directed at you, just the situation.

> *"I understand that this process can be confusing and frustrating, and you are upset…"*

When someone in a hearing is expressing their dissatisfaction about a situation with the claim, it is not directed at you personally. **Remember not to argue**. Show empathy and take responsibility for the issue without placing blame on other departments / organizations. Service is the priority, and customer satisfaction is important. When a participant is frustrated, there is a possibility that quality service has not been delivered before the situation reached you.

> *"I apologize that you were not given the correct information regarding the appeal process. Let me explain to you the procedures / law / reason and make sure you understand the process."*

Abusive or threatening hearing participants

Unfortunately, there will be times when the behavior or demeanor of a hearing participant will go beyond aggressive and become abusive. They may raise their voice or yell, use profanity, or make threats and try to take control of the hearing.

When a person in a hearing becomes abusive, you can provide the following options:

Calmly remind the person of the purpose of the hearing and your role and ask them to stop the behavior (e.g., sit down, lower their voice, stop using profanity).

> *"Mr. Claimant, it is my responsibility to gather all relevant information about this matter. To do so I need participants to remain calm and follow the procedures I have explained. Please lower your voice so we may continue."*

If the person continues to act abusively, state the following:

> *"If you continue to [stand / use profanity], I will be forced to end this hearing."*

If the behavior continues after you've warned the participant that you will have to end the hearing if the behavior does not stop, state:

> *"As I have explained, this hearing cannot continue if participants are not calm. Since you are unwilling or unable to remain calm, I will be ending this hearing now. You will receive a notice of default in the mail with an opportunity to request that your appeal be reinstated. Thank you."*

***Notify your manager immediately!

<u>Medical Emergencies</u>

If a medical emergency happens during your hearing, do not delay, call 911 immediately and then alert your manager.

RELEVANT LAWS

- M.G.L. c. 175M
- 458 CMR 2.00
- M.G.L. c. 30A
- 801 CMR 1.02

DFML REVIEW EXAMINER TRAINING

CONDUCTING THE HEARING

2020

CONDUCTING THE HEARING

Due Process Requirements

Adequate & timely notice of hearing

- Parties are entitled to receive adequate and timely notice which includes notification of specific issue(s) to be heard.
- For DFML hearings we provide at least 10 days notice to parties of any upcoming hearing. The notice contains the statutory provision(s) at issue for the hearing.

CONDUCTING THE HEARING

Due Process Requirements

Opportunity to be heard at a meaningful time in a meaningful manner

- Hearing is tailored to the needs and capabilities of parties
- Parties have the right to call and question their own witnesses
- Review Examiner has a duty to develop the relevant facts of the case
- Review Examiner must assist parties to develop the evidence, including questioning their own witnesses

CONDUCTING THE HEARING

Due Process Requirements

Impartial decision-maker (Review Examiner)

- No personal or financial interest in outcome of case
- Conduct hearing fairly and impartially

Right to confront and cross-examine adverse witnesses

- Right of party to be present during all testimony and to confront all opposing witnesses
- Provide opportunity for cross-examination directly after each witness testifies
- Control cross examination
- Assist unrepresented parties

CONDUCTING THE HEARING

Due Process Requirements

Right to representation at own expense (does not need to be an attorney)

Decision must be based on evidence in the record

- Written decision based solely on substantial evidence presented in the hearing
- Includes statement of the issue(s), all necessary facts, reasoning, decision, & effect on the claim

CONDUCTING THE HEARING

Opening Statement & Procedural Speech

Before taking testimony:

- Identify self
- State video recorder is on
- Identify parties and/or representatives present
- Verify each party's address
- Ask if anyone else not already identified will be participating in the hearing
- Explain Order of Testimony
- No ex parte communications
- Decision Mailed w/ Appeal Rights
- Ask each party if s/he has any questions about the hearings process or procedure
- If represented- ask the representative if any questions

CONDUCTING THE HEARING

Introduce the Case

- Indicate relevant laws
- Identify the Application Number
- State date & place of hearing
- Identify the issue(s) to be considered
- Confirm participants
- Testimony taken under oath- Swear witnesses in!
- Review exhibits and ask for any objections before being entered onto the record

CONDUCTING THE HEARING

Witnesses

- Provide parties chance to question their own witness(es)
- When necessary, assist the unrepresented party or lay representative in framing questions
- Provide assistance in an impartial manner

CONDUCTING THE HEARING

Witnesses- Two Party Issues

Confrontation

- Party has a right to be present to hear all evidence and review all documents presented by the opposing party

Cross Examination

- Offered timely (before testimony of another witness)
- Effectively control cross examination
- Do not allow questioner to harass, badger, or argue with the person being questioned
- Limit if unduly repetitious
- Assist unrepresented party, when necessary
- Do not allow party to testify instead of asking questions

CONDUCTING THE HEARING

Communication and Attitude

Clear Language

- Use clear, understandable language
- Avoid unnecessary legal phrases or technical language
- When it appears party did not understand, tactfully confirm and rephrase statement or question

Single-Point Questions

- Avoid compound questions
- Each question should relate to only one point and require only one answer
- Do not permit the parties or their representatives to ask compound questions - must make a reasonable attempt to clarify the question or response

CONDUCTING THE HEARING

Communication and Attitude

Clarification of Testimony

- When witness offers a conclusion or opinion, make an effort to obtain the factual basis
- Clarify ambiguous or unclear testimony

Attitude

- Make necessary effort to put parties & witnesses at ease
- Be pleasant, professional, courteous
- Avoid demeanor that is antagonistic, judgmental, indifferent

CONDUCTING THE HEARING

Communication and Attitude

Gratuitous Comments

- Do not make unnecessary comments or uncalled for remarks (attempts to be “smart” or “funny”)
- Avoid making observations that are not helpful or pertinent to the issue(s)

Bias & Prejudice

- Conduct hearings in an impartial manner
- Do not show bias or prejudice – intensity of questioning, type of questions, treatment of parties, time allowed to speak
- The need to maintain control and ask questions is not an excuse to bully or badger

CONDUCTING THE HEARING

Communication and Attitude

Interpreters

- Give clear instructions to the interpreter
- Administer interpreter oath
- Ensure that interpretation is complete and accurate - to the extent possible
- Do not allow interpreter and witness to engage in a back and forth
- Allow time for the translation. Do not let another speak until the translation is completed.
- Speak to the translator as if speaking to the claimant directly.

CONDUCTING THE HEARING

Controlling the Hearing

Repetitive and/or Irrelevant Testimony

- Keep hearing moving expeditiously
- Diplomatically inform witness when testimony is repetitive or irrelevant
- Do not ask repetitive or irrelevant questions
- Address nonresponsive or evasive answers appropriately

Interruptions

- Effectively and tactfully control disruptive parties
- Do not interrupt unnecessarily

CONDUCTING THE HEARING

Developing the Evidence

Leading Questions

- a question asked of a witness suggesting an answer or putting words in the mouth of the witness. Often can be answered by yes or no.
- E.g. “Your medical condition prevents you from working, correct?”
- Instead, “Tell me how your medical condition affects your ability to work.”
- Do not ask leading questions on a material matter
- Do not permit a party or representative to ask leading questions on a material matter when asking questions of their own witnesses
- Leading questions are acceptable to avoid unnecessary delay gathering simple background information (name, address, etc.).
- Leading questions are allowed on cross examination

CONDUCTING THE HEARING

Obtain Reasonably Available, Competent Evidence

- Function as a fact-finder; Develop the facts of the issue
- Reasonably available: The evidence or testimony that is available at the hearing and which is critical to the issue(s) to be decided
- Accept offered evidence that is critical to the issue

CONDUCTING THE HEARING

Controlling the Hearing

Hearing Within Scope of Notice

- Conduct the hearing within the scope of the issues raised on the notice of hearing
- If new issue arises during the hearing, provide notice and obtain a waiver of proper notice or continue the hearing

Continuances

- Grant only for necessary and compelling reason(s)
- Avoid when reason is not necessary and compelling
- Exercise good judgment

CONDUCTING THE HEARING

Closing the Hearing

- Must ask parties if they have anything else to say or evidence to present
- Do not solicit a “no” answer by words or tone
- Only close abruptly if necessary – tried to close properly and party kept offering repetitive or irrelevant testimony

CONDUCTING THE HEARING

Creating a Complete Record

Exhibits

- Describe and mark all exhibits
- Allow parties to review the exhibits and offer objections
- Authenticate offered exhibits (to the extent possible) when questionable or challenged
- Rule on any objection to admitting the document
- Receive (enter/admit into the record) all competent exhibits

CONDUCTING THE HEARING

Creating a Complete Record

Going Off the Record

- Avoid going off the record
- Correctly account (on the record) for what happened off the record
- Summarize the essentials of what took place
- If recording stops unexpectedly, repeat or have last speaker repeat, any missing portion
- Obtain the concurrence of each party that the summary is accurate

CONDUCTING THE HEARING

Claimant Fails to Attend Hearing- Default Procedure (Part I)

1. Review Examiner (RE) enters VirtualQ to conduct hearing at date and time scheduled.
    a. Claimant is not in virtual waiting room at the scheduled start time.
    b. RE can monitor claimant arrival via VirtualQ waiting room.
    c. RE will allow 10 minutes from the scheduled start time.
2. If the claimant does not arrive by 10 minutes after the scheduled start time:
    a. RE begins hearing.
    b. Notes the time and that claimant has not arrived.
    c. States a default will be entered.
    d. RE ends hearing.
3. RE goes into FINEOS
    a. Enters note that appeal defaulted.
    b. Generate notification that appeal has been dismissed due to default.

CONDUCTING THE HEARING

Claimant Fails to Attend Hearing- Default Procedure (Part II)

4. Claimant receives Notice of Dismissal- Default with attached Request for Reinstatement.
    a. Claimant has 10 days to return Request for Reinstatement to establish that failure to attend was beyond the claimant's control.
        i. If request received and good cause established- appeal reinstated and rescheduled.
        ii. If request not received/ good cause not established- send notification that appeal is not reinstated and determination remains unchanged.
    * Claimant can appeal denial of reinstatement to District Court.

DFML REVIEW EXAMINER TRAINING

EVALUATING THE EVIDENCE

2020

EVALUATING THE EVIDENCE

Standard for Admissibility of Evidence

"Unless otherwise provided by any law, agencies need not observe the rules of evidence observed by courts, but shall observe the rules of privilege recognized by law. **Evidence may be admitted and given probative effect only if it is the kind of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs.** Agencies may exclude unduly repetitious evidence, whether offered on direct examination or cross-examination." G.L. c. 30A, § 11(2)

Evidence with probative value tends to establish or prove an issue.

Standard for Decision

Decision must be based on substantial and credible evidence

- "Substantial evidence means such evidence as a reasonable mind might accept as adequate to support a conclusion…. "G. L. c. 30A, § 1
- 'after taking into consideration opposing evidence in the record.' (Mass. courts)

EVALUATING THE EVIDENCE

Evaluating/weighing the evidence

Is the evidence firsthand testimony or hearsay?

Hearsay – a statement (oral or written assertion or nonverbal conduct if intended as an assertion) made by a person not at the hearing and submitted for the purpose of proving the truth of the statement

Concern: The person who made the statement is not present to be questioned on direct or cross examination. Reliability of the evidence cannot be probed or established.

- Prior statements of one party offered by the other party - not hearsay
- Business and hospital records – exception to the hearsay rule, if: Made in the regular course of business (not in preparation for hearing) and it was the usual course of the business to make the entry at the time of the event recorded

Hearsay is not at issue when the matter is not disputed, irrelevant, or immaterial

EVALUATING THE EVIDENCE

Evaluating/weighing the evidence

If consistent, plausible, and otherwise believable, the greatest weight is usually given to first-hand testimony.

Hearsay evidence can constitute substantial evidence if it has "sufficient indicia of reliability". Some considerations to determine reliability:

- Specificity, detail and consistency
- Corroborated by other non-hearsay evidence
- Does the declarant have a motive or lack thereof to lie
- Was the declarant or witness reporting the declarant's statement a person whose job it was to investigate and/or report findings
- Was the statement under oath and subject to cross examination

To determine how reliable the hearsay evidence is, consider the circumstances under which the statement was made.

If the hearsay has sufficient indicia of reliability, it can be given more weight than direct, first-hand testimony.

EVALUATING THE EVIDENCE

Credibility

A party's testimony need not be supported by corroborating evidence to be deemed credible. The fact that testimony is not corroborated is not a reason for not believing it.

Testimony is not more credible merely because it was corroborated by a witness. You need to consider the witness' motive and partiality.

A party's testimony is not automatically credible just because there is an absence of testimony to the contrary. "[t]he examiner is not required to believe uncontroverted evidence."

In determining credibility, cannot ignore unrefuted testimony on critical matters.

Final thoughts on evaluating the evidence

Look for inconsistencies:

- Within the testimony of the witness;
- Between the present account and past accounts given by the witness;
- Between the testimony - facts clearly established by other witnesses or documentary evidence.

Use the rules of evidence thoughtfully:

- Drawing inferences from a failure to produce a witness.
- Is the evidence really hearsay; if so, is it an exception to the hearsay rule?
- Is the hearsay statement just background information, or does it involve a critical issue in the case?
- Does the hearsay have 'sufficient indicia of reliability'?

When appropriate, try to obtain additional witnesses or documents.

Look at the evidence of each party as a whole and determine which version of the disputed event is more plausible or likely in light of common experience and common sense.

REFERENCES

- M.G.L. c. 30A
- 801 CMR 1.02